Foreword

This is a compilation of the existing War Pensions Medical Advisers Instructions and Procedures Manual and the many training minutes which have been issued over the last 7 or 8 years since the manual was first prepared

Some sections are incomplete because advice is awaited These gaps will be filled in as soon as possible.

Other areas are also under review. It is intended that the manual will be updated regularly as policy/legal advice is received and issues are clarified. MAs will be informed of any changes.

The manual should be read in conjunction with the MPM 57A, Medical Adjudication Guidance and Policy Statements.

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Superannuation and new entrants

Option 1 - Preservation of pension in NHS

10000 Calculations are carried out at Hesketh House, Fleetwood (HH).

GPs

10001 "Practitioner" pension is calculated. based on the global earnings, which consist of the total earnings, each year's earnings being "dynamised"

1 4% of Global Earnings	=	annual pension
4.2% " "	=	lump sum

10002 Ex-GPs should however remember that part of their pension rights will refer to superannuable work in hospitals, such as houseman's appointments, clinical assistant work etc This part of the pension is known as "officer" pension and is calculated as for any other NHS hospital doctor. Ex-GPs should ensure that any such past employment has been taken into consideration by HH.

Hospital Doctors

Number of Years/80 x best salary in final 3 years = annual pension
Annual pension x 3 = lump sum

10003 Pensions and lump sums, calculated as above, increase annually by the cost of living index increase and are then paid at age 60.

10004 If you wish to have estimates of the above benefits, these can be obtained from HH, but they will take some time

10005 Further information can be obtained from HH

10006-10029

Option 2 - Transfer of pension rights into Principal Civil Service Pension Scheme (PCSPS)

10030 In this case, HH calculate a notional sum, which equates to the value of your rights in the NHS. The value of this sum is not available to us. nor would it mean much to us By ascertaining your NHS pension rights, you can, however, ensure that ALL your NHS employment has been considered in reaching the notional sum!

10031 HH notify the PCSPS at Newcastle Central Office [CS(N)] of the value of the notional sum and a calculation then converts this into the number of years of service in the Civil Service, which would be credited. Broadly speaking, the credits would be on a year to year and day to day basis.

(10031)

Number of years service/80 x Final Salary = annual pension Annual Pension x 3 = lump sum

10032 The pension becomes payable at age 60, or ACTUAL date of retirement, whichever is later. The lump sum may be taken at age 60, if notional retirement is elected. Any service after 60 still attracts pension and lump sum rights. These are then calculated at actual retirement, and the lump sum is paid, less the sum already paid at notional retirement.

10033 Having transferred your benefits, these are converted into 80ths of officer service

10034 Should you re-enter NHS service, the transfer would be on that basis and any practitioner service in your earlier NHS employment would have lost its separate identity

10035-10099

Considerations

10100 Option 1 rights increase by cost of living index increases, whereas option 2 rights increase by salary increases. In times of high inflation, salary increases have usually not been up to cost of living increases

10101 If you intend to work full time after the age of 60 (and are allowed to do so) and your NHS pension is substantial, then you would receive your salary PLUS your NHS pension during your over-60 employment, if you take option 1. The younger you are at entry, the smaller will be your NHS rights and the less likely it is that you will be able to continue working full time after 60.

10102 For the younger entrant, it is likely that transfer of rights to the PCSPS will be the best option. The over-50 entrant will have to think the options over very carefully - and then make a "best guess" decision.

10103 In any case, it would be advisable to contact HH to obtain the NHS figures and then to ascertain from the PCSPS the number of years which would be credited on transfer. At the same time you may wish to ascertain the cost of any "added years" you may wish to purchase. Remember that all these calculations do take time, but if the delay seems to be excessive, it is worth while tracing the area of delay.

10104 **Keep copies of all correspondence!**

10105 Should you need any help please contact WPA Personnel or Hesketh House.

10106-19999

Contents

Medical library

20000 The medical library is essentially a reference library with limited lending facilities

Staff

20001 There is one Library Officer, one MA Medical Librarian, and one Library Assistant.

Inventory

20002 The medical library holds medical textbooks, reference works journals, codes, miscellaneous papers and a "medical archives section" containing early editions of medical textbooks These earlier books ensure we can confidently establish the state of medical knowledge at specific dates in the past. There is also a historical section, mainly the history of the various wars and conflicts in which our claimants were involved Books from the historical section can be borrowed to be read at home.

20003 The medical works in the library are kept up to date with copies of current editions and new works regularly added Medical journals, those most relevant to our work are obtained and circulated to medical staff, as requested.

20004 You can find the catalogue of the library contents on Cardbox on one of the computers held in the library.

20005 There is also a photocopier, and the Library Assistant will copy any medical material eg medical articles, pages from medical textbooks etc. NB Copyright law

20006-20039

Layout

20040 The library furnishings are clearly marked. The sections are labelled A-K with each book or folder individually numbered. The latest editions of each textbook are housed on the shelves nearest the door (section A) at levels as convenient as possible. Other medical books are on other shelves in date ie decade order The historical books are on separate shelves roughly in subject order. Codes, circulars, statutory instruments, copies of various Departmental Reports, High Court cases, and a large selection of miscellaneous papers, medical and other, are on remaining shelves.

Using the library

20041 If the required document or book is not easily found it can be quickly located by using the library computer. All items in the library are listed with the relevant rack and shelf number recorded

20042 Should the article or book appear to be unavailable the Library Officer should be asked to help. If the Library Officer cannot locate the item other libraries can be contacted and the work borrowed. This can take up to 7 days. If it is necessary to obtain other related articles the Library Officer can institute an Internet search using PUBMED or a specialised website eg JBJS, JAMA, BMJ etc.

Borrowing

20043 When it is necessary for any item to leave the library the borrowers name and the reference number of the item should be recorded. There is a list on the inside cover of each of the box files and a card in an envelope on the inside cover of each book The card should be handed to the Librarian

Note Books marked REFERENCE ONLY are not to be removed without prior permission.

Returning borrowed items

20044 When returning a book or document it should be handed to the Library Staff rather than being placed on the sheif. This helps the Librarian to keep an overall check on the library.

Footnote

20045 Apart from our individual offices the library is the only room available for study or for reading and is always open to MAs Any suggestions for improvements are most welcome. Any difficulty or suggestions can be discussed with the Library Officer or raised with the MA Medical Librarian

20046-29999

Contents

Referral of files to WPAMS

To Special Section

30000 All FEPOWS, Civilians, Mercantile Mariners, Naval Auxiliaries, Polish, UDR/RIR, 1914 War, Gulf cases (as defined in the *Claims guide Vol 1 Part 4*)

To Widows Section

30001 All widows cases

30002-30049

The Role of the Expert Case Worker (ECW)

30050 The ECW holds the key role at the centre of the WPA medical network involving communication of medical issues between the groups of MAs, the Medical Director, the Medical Services Administrative Support Manager and the MAs of the Business Analysis Unit

30051 The ECWs:

- advise claims and appeals workers on any aspect of their case work
- feedback to MAs any cases which come to light where inappropriate medical advice has been given
- inform the Training Officer if a training need is identified

30052-30089

Cases which must be discussed with an ECW

30090 The following must be discussed with an ECW:

- any case where the MA wishes to overturn a previous Entitlement or Assessment decision and there is no additional supporting evidence or any change of medical opinion ie the previous decision is thought to be unreasonable
- any case where a RC report is considered necessary
- any case where a change to the detriment of the claimant is being considered under Art 67 of the SPO
- any other case causing doubt or difficulty or likely to cause future problems.

30091-39999

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Evidence and evidence collection

Introduction

40000 Whenever a first claim to war pension is received by the War Pensions Agency a "**Disablement Awards**" file is opened This file will include all the medical and non-medical documentation relevant to the claim held by the Agency. The non-medical papers are tagged to the left-hand cover of the file, the medical ones to the right-hand cover, often in an inner folder (WPA947 formerly MPR1A) The non-medical documents include "Award Sheets", letters, copies of official certificates (marriage certificates etc) and minutes The medical documents contain both service and non-service records with a variety of "medical" minutes, instructions and certificates.

40001 There may be several supplementary files, both lay and medical. One such file, commonly included in older cases but no longer in use as a separate file, was the Local Medical File (LMF) This was opened by the local offices in all ex-service cases when medical examination was required. It contained a synopsis of the medical history and a summary of the Medical Board's findings. It is now tagged to the Awards file.

40002 Sub files may be raised for supplementary allowances and may be used separately or with the main Awards file

40003 When a claim is received certain evidence is automatically sought and included in the file. As the action continues other evidence may possibly be called for by lay or medical staff

40004-40049

Service records

40050 These are the property of the Ministry of Defence though the DSS holds many of the medical notes. Depending on the reason for the member's release certain medical documents are forwarded to DSS when the member leaves military service Other documents can be requested. When a claim to a war pension is received at War Pensions Agency there is no single focal point in the Ministry of Defence for enquiries for other documents. Our lay colleagues must seek these documents from a variety of appropriate offices. (See MPM57A Appendix 3)

40051-40059

Service related records

40060 There are other sources of medical evidence relating to service, including war-time service. Some prisoner of war camps "Admission and Discharge" books are held and can be helpful Other official, less common, records, such as Interrogation Reports can be sought even though not automatically included when a file is constructed. Ship's Medical Officer's Journals can also be useful. The Medical Adviser handling the case should ask the Lay Officer to seek these reports when they are required

40061 Interrogation Reports for both ex-European and ex-Far East POWs were prepared when the member arrived in the United Kingdom Most repatriated POWs were invited to complete this security document. This was over and above any other recorded medical history concerning the member, including the report of the routine Repatriation Medical Examination. Reference AIC 28/90 Medical Library.

40062 The main purpose of the Interrogation Report was to record evidence of brutality, breaches of the Geneva Convention regarding conditions in the POW camps including references to "working Stalags", and reports of any cases of collaboration with the enemy These documents were originally classified as Top Secret but have now been de-classified and are available on request from MOD.

40063 These reports may be of help in both first considerations and appeals eg when an incident is claimed as occuring during captivity but no corroborative evidence is found in the recorded evidence Evidence of harsh working conditions could be relevant eg in Silesian Mines

40064 In addition to the various records held by Government Departments other organisations such as Shipping Companies or ex-Service Organisations may also hold relevant evidence During the 1939 War the Registrar General of Shipping and Seamen notified the Ministry of Pensions of damage or loss to British Merchant ships and of any consequential casualties as a result of enemy action. The ship's owners were the main suppliers of information regarding survivors and dependants, and the Shipping Companies may still hold relevant information. The International Committee of the Red Cross may hold reliable evidence on ex-prisoners of war and Polish claimants Reference N5 Note 462 Medical Library.

40065-40099

Hospital casenotes (HCNs)

40100 The claimant is asked for details of any hospital attendances on the claim form The administrative staff will obtain any HCNs requested by the MA. The MA should provide as much information as possible to precisely target the required HCNs. Details of the conditions treated, the names of the Consultants, the Specialities and the dates of attendance are useful and, if known, all should be included in the request. A typical request from an MA for HCNs would be:-

"Please obtain all notes from Blackpool Victoria Hospital in respect of eczema treated in the Dermatology Department from 1994 onwards under the care of Dr K".

40101 Copies of HCNs are included in the file X-rays or X-ray reports may also be requested. The following items are usually excluded when hospital casenotes are photocopied at Norcross and must be specifically requested if required:-

- temperature charts
- nursing notes
- prescription sheets
- electrocardiographs
- Departmental correspondence
- pathological and laboratory reports
- treatment sheets

40102 In Widows' claims the file is submitted with the claim form and the death certificate. If the medical adviser can decide entitlement on this evidence he/she does so, otherwise he/she indicates what evidence is required. The original, complete hospital casenotes are used for the initial decision and are copied if the claim is rejected. If entitlement is certified, extracts from the hospital case notes may be copied if the MA thinks it is necessary.

40103 Hospitals do not keep records indefinitely and a list of hospitals and the length of time the documents and X-rays are retained is obtainable from the medical library (Addendum to Appeals Memorandum 106, Box File, Medical Library) Retention periods are also recorded in the administrative Claims Guide Volume 1 para 61384

40104 Non National Health Service Hospitals, both in the United Kingdom and Overseas, can also be asked for evidence. Our lay colleagues, following well established guidelines, approach the various hospitals for these records. Often only extracts can be obtained. This also applies to pensioners living in Eire.

40105 In the past, hospitals have charged for the supply of HCNs and X-rays. This was a particular problem when hospitals acquired Trust status, as the practice was seen as a useful form of income generation. However, an arrangement has now been made with the Department of Health, and all NHS Hospitals and Trust Hospitals should provide HCNs within 10 working days, free of charge A letter (DL77) can be issued by the lay staff if there is any problem A copy is shown at Appendix one.

40106 This arrangement is not binding on private hospitals. Some private hospitals can request payment for providing WPA with copies of their HCNs If a claimant has been treated at a private hospital, before requesting case notes, consider whether the information needed can be obtained from another source such as the GP If case notes from a private hospital are essential, then it is important to target the request so that only relevant notes are copied and the cost is kept to a minimum.

40107 Prior to the National Health Service the Ministry of Pensions administered its own hospitals The following NHS hospitals were previously Ministry of Pensions Hospitals until the Ministry of Health assumed their administration in 1953:-

- Chapel Allerton Hospital, Leeds
- Dunston Hill Hospital, Gateshead
- Edenhall Hospital, Musselburgh
- Mossley Hill Hospital, Liverpool
- Mount Pleasant Hospital, Chepstow
- Musgrove Park Hospital, Taunton
- Penley Hospital, Wrexham
- Queen Alexandra Hospital, Cosham
- Queen Mary's Hospital, Roehampton
- Rookwood Hospital, Cardiff
- Stoke Mandeville Hospital, Aylesbury

40108-40179

National Insurance records and reports for other benefits

40180 On occasion it can be of value when seeking evidence in a war pension case to study reports obtained by the DSS when civilian benefits are under consideration, (Industrial Injury Benefit, Industrial Disablement Benefit, Attendance Allowance 65+, Disability Living Allowance, Incapacity Benefit, etc). The lay officer will request the relevant Industrial Injuries medical boarding papers when the medical officer considers them necessary

40181 In deafness claims, Industrial Injury documents may be helpful The claimant is asked if he/she has received compensation for any industrial deafness, if so, the amount, the source etc. If it is clear that ENT reports have already been completed the War Pensions Agency may obtain these and use them in the adjudication of the War Pension claim

40182 Solicitors' Branch have been consulted and they have confirmed that evidence obtained for National Insurance purposes can be used to determine War Pensions claims and this material may be disclosed to members of PATs

40183 The Department's Solicitors were approached in June 1990 when a medical officer wished to see an Attendance Allowance report. One Solicitor wrote,

> "A report which belongs to the Secretary of State may be used by him in dealing with more than one benefit The question is: does the examining doctor's report belong to the Secretary of State or to the Board. There is an indication on the file that the report belongs to the Board. The answer is not entirely clear from the Act. Such reports obtained to deal with the Attendance Allowance claim should not be passed to the war pensions section unless the claimant consents.
>
> A report in relation to one benefit, even if it belongs to the Secretary of State and can be referred to by him in considering a claim for another benefit, is of course only part of the evidence to be taken into account. It could not be relied on to the exclusion of the examination and investigation of entitlement appropriate to the benefit concerned".

40184-40199

Local Authority reports

40200 Various reports can be obtained from the Local Authority such as school medical reports. These may prove of considerable value, though many eg the school reports are destroyed after a number of years. The medical adviser handling the case should ask the lay officer to seek these reports when they are required.

40201 Even more significant may be the local authority records of bombing of civilian areas during Wartime The War Pension Archives also hold files on Air Raids. These have been prepared from Civil Defence and Ministry of Pension reports and they show the day to day bombings in specified areas. The records of the Clerk to the Local Authority Councils of these bombings may show considerable detail of the areas and of the casualties

40202-40219

Radiation reports

40220 Radiation cases were previously dealt with by Special Section but they have now been transferred to all operational groups. (This does not include FEPOW cases which remain with Special Section).

40221 Radiation cases are those where it is contended that exposure to ionising radiation in service has caused the claimed condition.

40222 The Atomic Weapons Establishment (AWE) holds details of all Participants in UK Atmospheric Nuclear Weapon Tests. A report from the AWE must be obtained in all cases where the claimant was a Participant and the claimed condition is one in which a link with exposure to ionising radiation is medically recognised.

40223 The template for requesting a report from the AWE is attached at Appendix four. The report must include the claimant's full name, NINO, full address and date of birth. Middle names must be included otherwise the tracing process may not succeed.

40224 If the claimant was a Participant but the claimed condition is not recognised as having a link with exposure to ionising radiation, then a report from the AWE must **not** be requested. The medical appendices are of assistance in determining whether or not a condition is related to ionising radiation.

40225 The AWE hold no information on service personnel who claim exposure to ionising radiation aboard nuclear powered submarines/ships or who claim that they handled or were in the vicinity of nuclear or radioactive materials during their service. Therefore, an AWE report should **not** be obtained in these cases. Instead, the Secretary of State should obtain information regarding exposure to ionising radiation from the MoD but **only** if the claimed condition is a radiation linked disorder. The MA will need to advise the administrative staff of the relationship between the claimed condition and ionising radiation exposure, before any enquiries are made.

40226-40239

X-rays for War Pensions purposes

40240 In the past MAs have requested X-rays for diagnostic purposes to elucidate a basic injurious process and obtain a label. However, in the light of the current Ionising Radiation Regulations, it has been agreed that MAs must **not** request or authorise X-rays for War Pensions purposes. This is in practice with the Ionising Radiation (Medical Exposure) Regulations 2000 which have replaced the Ionising Radiation (Protection of Persons Undergoing Medical Examination or Treatment) Regulations 1988. The regulations together with notes on good practice are included at Appendix 5.

40241-40249

Other reports

40250 For certain very specific cases approaches may be made to other organisations. These reports are almost always confined to the one case and concern individual problems. Occupational Health Department (OHD) records can be a useful source of information. Companies and hospitals keep these for many years. Hospital OHD records are kept separately from HCNs and would need to be requested from the OHD directly. Reports may be obtained from any medical or ancilliary medical source eg Dentists, Chiropodists, Opticians, Physiotherapists, Homeopaths, Naturopaths, Osteopaths, Herbalists, Acupuncturists. There are no special forms for these reports and the information is normally requested by letter either by the medical or administrative staff at Norcross. (Except for Regional Dental Officer reports on form WPA 323).

40251-40259

Reports prepared for the Agency

40260 These include:

- Audiology reports
- ERA requests
- General Practitioner reports
- WPA medical examinations
- Supplementary Allowance reports
- Specialist reports
- Regional Consultant reports
- Regional Dental Officer reports
- IME reports

40261-40279

Audiology reports

40280 British Medical International (BMI) is contracted by WPA to provide an audiology service. On receipt of a claim for deafness, the administrative staff will arrange an Audiology test from BMI before the case is submitted to the MA. The BMI contract does not apply to cases from overseas nor does it apply to cases from Northern Ireland, Eire, Channel Islands and the Isle of Man. Alternative sources of audiometric evidence will be needed for these areas. Often a Specialist ENT report has to be obtained.

40281 If a claimant submits an acceptable audiogram but there is no occupational history, the administrative staff will, on request, send an occupational history questionnaire to the claimant for completion. This is known as a WPA 61.

40282 Please see *Part 13 "Quality Assurance Procedures"*.

40283-40289

ERA examinations

40290 ERA examinations are necessary for assessment purposes only. They are of no value in making a diagnosis They are indicated when the assessment is based on current hearing loss and the current pure tone audiogram is unreliable or there is a conflict of evidence. Copy Types prepare referrals to BMI for ERA examinations. The MA prepares a minute to Copy Types indicating that an ERA is necessary and the reason. The typists prepare one of two standard letters indicating the reason for the request, that is, unreliable pure tone audiometry or conflict of evidence.

40291 The minute to Copy Types is put on file and must contain the following information:

- Reason for ERA (the MA should identify the unreliable audiogram or the conflicting pieces of evidence for the typists because photocopies are included with the request)
- Domiciliary visit (if appropriate)
- MAs signature
- Name stamp
- Date stamp

40292 It is also necessary to inform the administrative staff of the need for ERA by completing the reverse of the WPA 361 (lay submission form).

40293 Once the request for ERA has been prepared by the typists, the file containing the referral letter is sent back to the MA for signature The MA returns the signed letter with the file to Copy Types who action the request.

Note: ECWs sign sessional MAs' referrals.

40294-40299

General Practitioner reports

40300 The general practitioner normally reports on the WPA 306 series of forms The Medical Adviser handling the case directs the general practitioner's attention to the relevant subject. The report may inform Entitlement and/or Assessment decisions. These are often among the most helpful reports in the file, for the family doctor may well hold the earliest and possibly the most complete records for that individual. This report must be requested by the medical adviser and it often obviates the need for other reports.

40301-40329

War Pensions Agency Medical Examinations (WPMEs)

40330 These are one of the most informative sources of information.

40331 Until 1991 War Pensions Scrutiny Report, a medical board normally consisted of 2 doctors, one of whom acted as Chairman. There were no regulations governing the composition of a Board and, without the need for the pensioner's consent, one experienced examiner could complete a War Pension Board especially in the following circumstances:

(40331)
- for domiciliary examinations when war pensioners were housebound or when disablement or age made travelling a hardship
- when a Board in hospital was necessary
- if one doctor failed to attend when a 2 doctor Board had been arranged.

40332 The Department's medical officers could serve on Boards. The Board was purely advisory though its advice was usually followed, especially in assessment matters. Its functions were to inform the Secretary of State of:

- the clinical history and condition of the claimant or pensioner in respect of the disablement claimed or under review;
- the particular evidence on which the Board based their opinion on the diagnosis of the condition(s);
- the degree of permanent or temporary impairment of function produced by the condition(s);
- the diagnosis, the date of onset and the degree of permanent or temporary impairment of function of any other condition found;
- the nature of treatment which may be necessary to restore health, improve function or prevent the deterioration of any abnormal condition;
- the Medical Board's opinion on prognosis

40333 The 1991 Scrutiny Report advised a significant change in Medical Boarding. No longer is the Board asked to assess disablement, previously one of its most important functions. It must now study the records which are made available to it, normally only the details of the accepted disablements and a copy of the last Board report (if any). It must take careful note of the directions from the War Pensions Agency and then record a detailed and accurate history and the clinical findings during a careful comprehensive clinical examination of the relevant systems. The report should include the recent medical history with details of hospital or other treatments, the occupational history, the man's signed statement(s) and a comprehensive description of the effect on function of all relevant conditions present.

40334 The assessment of disablement is the responsibility of the MA at Norcross. Medical Boards are now more accurately termed War Pensions Agency Medical Examinations.

40335 The War Pensions Agency Medical Examination (WPME) was previously arranged through the Disablement Benefit Centre using Examining Medical Practitioners (EMPs) from Benefits Agency Medical Services (BAMS). With effect from 1 September 1998, BAMS work has been contracted out to SEMA Group, who are now responsible for obtaining EMP reports on behalf of the War Pensions Agency. The SEMA contract excludes Northern Ireland, Eire and overseas cases

40336 For all cases, it is essential that our referrals for WPMEs are of good quality and contain all the necessary information. Lack of information places our EMP colleagues in a difficult and potentially embarrassing position. The EMP may end up recording exactly what the claimant has said without qualification and this results in incorrect diagnoses. Poor quality referrals result in cases being delayed and rework by the MAs. Inadequate referrals will be returned by SEMA and WPA will be charged for obtaining the further information resulting in additional expense to WPA.

40337 Requests for WPMEs are made on the WPA 851 series of forms The following general guidelines should be used when completing the WPA 851

- **Provide a good history** - it is essential to provide a brief resumé of the relevant medical history, including details of any injuries. If no service documents or other information are available, make this clear and give a resumé of the claimant's account on the claim form, clearly indicating the source
- **Give service details** - give brief details of the claimant's service eg Royal Artillery 1940-1946 This information gives the EMP a starting point and an idea of the claimant's experiences during service
- **Ask specific questions** - this improves the yield of information from the WPME Write questions which are brief and to the point The EMP cannot be expected to guess what is required.
- **Do not use War Pensions jargon/abbreviations** - War Pensions examinations are a small part of the EMPs work Many have no knowledge of the War Pensions scheme and do not understand abbreviations such as "AD" and "Agg" Use of the abbreviation "BNISHL" is a common source of complaint to WPA.
- **Provide a word processed document or write legibly** - illegible handwriting causes considerable difficulties. This problem will be resolved when there is universal word processing of the WPA 851
- **Suggest a realistic time allocation** - the standard War Pensions Medical Examination is one and a half hours. More time may be needed if the claimant has made multiple claims It is usually easy to identify claimants who are likely to be longwinded Less time will be needed for a young claimant with, for example, a simple fracture of the ankle
- **Identify domiciliary cases** - domiciliary examinations should be considered when the claimant is aged 70+, if the claimant's mobility is impaired or if he/she is in poor health
- **Identify potentially violent persons/situations** - where appropriate annotate the WPA 851 with the recognised red "chequerboard" rubber stamp

40338 Any report from SEMA which is sufficiently below the required standard to prevent the MA from adjudicating will be classed as REWORK and will be returned to SEMA for remedial action at no charge to WPA

40339 The categories for returning reports as rework are as follows

A Report is not fair or impartial, or could compromise adjudication or decision making

B Advice is not legible and concise

D. Advice is not comprehensive and does not clearly explain the medical issues raised

F. Advice given is not complete and information is missing, or some questions are unanswered

Note. The omitted categories C & E apply to Social Security benefits other than War Pensions.

40340 To return an EMP report, form WPA 1067 should be completed. The nature of the problem should be explained in the boxes provided The completed form WPA 1067 should be sent to the Special Projects Team A copy of this form is at Appendix six.

40341 Please see *Part 13 "Quality Assurance Procedures"* for further information on rework.

40342 It is possible to request that a named EMP does not examine the claimant if this is appropriate eg The claimant has been examined by the EMP before and has expressed a wish not to be examined by the doctor again.

40343-40399

Supplementary allowances examinations

40400 Sometimes it may be necessary to request a WPME in order to come to a decision in respect of a supplementary allowance. A WPA 851 should be completed in every case.

40401 The relevant forms are:

- WPMS WPA332
- WPMS (Posthumous) WPA902
- CAA WPA335
- CAA (Posthumous) WPA384
- UNSUPP/ALSO WPA333
- CLOTHING WPA357

40402-40419

Specialist reports

40420 As with WPMEs, UK mainland Specialist reports are arranged by SEMA who have subcontracted this work to Definitech Ltd (The National Medical Examination Network). The contract covers mainland UK, which includes all off lying islands, but excludes Northern Ireland, Eire and overseas cases.

40421 Requests for Specialist reports are made on the WPA 314 series of forms. The forms for SEMA, Irish and overseas cases vary slightly from each other. The WPA 314 series are the forms almost invariably employed when a definitive diagnosis is required. They enable the relevant history to be given to the specialist and specific questions to be asked. Some of the more common conditions have been considered so often that proformas have been developed which include most of the relevant questions. It is expected that MAs will word process the WPA 314 requests.

40422 When preparing a Specialist referral it is vital to give the Specialist as much information as possible in order to enable him/her to provide an accurate report. The referral should summarise the man's claim, including any history he has given on the claim form. It should be made clear if this is the man's own statement. The service history and clinical findings, and any additional information from the GP and/or hospital should also be summarised. It may be preferable to photocopy one or two key documents which can be more informative than a precis. If there is no information available then this should be pointed out as this is evidence that will help the Specialist to formulate an opinion.

40423 The standard questions for general, eye, ear and psychiatric cases are shown below. These are for guidance. Referrals should be customised to reflect the information required from the Specialist in individual cases. Any additional specific questions should be added in the opening "Questions" section and should not be included at the end of the "History" section. Questions on aetiology are not included in the standard text. It may be necessary in some cases, for example when specific contentions are made to ask the Specialist about causation These questions should be tailored to the individual case and are added at the discretion of the MA.

40424-40449

General cases

40450 Will you please take a history, examine the above named and provide a report on the present condition in respect of .

40451 **Please record the history, your clinical findings and answer the following points:-**

1. The history of all conditions, past and present.
2. The present condition of the .....
3. Diagnosis of all disorders of the .....

40452-40459

Eye cases

40460 Will you please take a history, examine the above named and provide a report in respect of the eyes.
Please record the history, your clinical findings and answer the following points:-

1. The history of all eye conditions, past and present.
2. The present condition of both eyes with the visual acuity aided and unaided.
3. Diagnosis of all disorders of both eyes.

Ear cases

40461 Will you please take a history, examine the above named and provide a report in respect of both ears.

Please record the history, your clinical findings and answer the following points:-

1. The history and present condition of the ears and any symptoms relating to the ears.
2. An audiogram showing air and bone conduction at 1, 2, 3, 4, 6 and 8 kHz. (Please include the original with the report).

   Please note that in order to comply with current legislation, the hearing levels at 1, 2 and 3 kHz are essential. If any of these levels are not tested, a retest will be necessary.
3. The diagnosis of all ear conditions and types of deafness.
4. Is the ability to hear the conversational voice consistent with the audiometric findings?

40462-40479

Psychiatric cases

40480 Mr . . . .. has claimed that he has .... , and that this is due to service in the armed forces.

By law, War Pension is only paid for disablement which is caused or aggravated by service. Under the legislation material facts can be accepted only if they are recorded in official records or there is other reliable evidence of them

In Mr ... . .'s case the claimed material facts . . .. are not supported by official record or other reliable evidence.

Please could you examine in respect of his claim and provide a report including the following information, using DSM-IV or ICD-10 classifications*:-

1 The full psychiatric history.

2 The mental state examination

3. Given the psychiatric history and mental state examination, is any psychiatric disorder present? If so, please give your opinion as to the preferred diagnosis and differential diagnosis and identify the clinical features on which this is based.

4. Similarly. please give your opinion as to the preferred diagnosis and differential diagnosis of any past psychiatric disorder. including the clinical features on which this opinion is based

5. The effects on function of any current psychiatric disorder In particular to what extent, if any, has the claimant suffered significant impairment or loss of function?

6. What treatment has the applicant received to date? What are the current treatment requirements?

7. The prognosis.

* War Pensions Agency Medical Services use these classifications in the interests of consistency and equity

40481-40499

WPA 845

40500 This form accompanies the WPA 314 series (not overseas cases) It is a general form requesting arrangement of the Specialist examination and specifying the exact requirements

40501-40509

Return of Specialist Reports

40510 To return Specialist reports for rework from SEMA/DEFINITECH, the same procedure should be adopted as for EMP reports. The same categories for returning work apply and the same form (WPA 1067) should be completed The nature of the problem should be explained in the boxes provided. The completed form must be sent to the Special Projects Team A copy of this form is at Appendix 6

40511 In some cases, the Specialist report from SEMA/DEFINITECH will be entirely adequate but an additional issue may come to light which requires clarification from the Specialist. If the additional issue is a major one which will require the Specialist to reformulate the case, or to re-examine the man. then a new WPA 314 should be prepared.

40512 In cases where the Specialist report is inadequate but is not arranged by SEMA/DEFINITECH, the MA should write directly to the Specialist giving details of the problems and enclosing a copy of the original WPA 314 and of the Specialist's original report.

40513 Please see *Part 13 "Quality Assurance Procedures"* for further information on rework

40514-40519

Regional Consultant Reports

40520 In certain cases a specialist opinion on WPA 314 may be considered insufficient or inappropriate. The Department has arranged for eminent members of the medical profession to serve as Regional Consultants and a list of these consultants is available on the Customised Document System (CDS). Regional Consultant reports for mainland UK, excluding Northern Ireland are arranged through SEMA/ Definitech.

40521 The advantage of a Regional Consultant report is that it is from a very senior member of the profession who has all the recorded evidence for his/her perusal, not a summary. These reports are most useful.-

- When there is an unresolved conflict of medical opinion (this refers to conflict between doctors, not doctors and paramedicals eg physiotherapists. The doctor's opinion should prevail).
- When an opinion is required which needs a study of the full documentary evidence.
- In cases of special difficulty in diagnosis or aetiology or when there is doubt regarding the effects of service or the effects of the claimed condition.
- In rare conditions where there is insufficient information in textbooks or other sources to enable a decision to be made on the case.

40522 The procedure for dealing with these cases is as follows:

Step	Action
1	The decision to obtain a RC report is agreed by the ECW and MA.
2	The Terms of Reference are also agreed by the MA and ECW.
3	The referral letter to the Regional Consultant is prepared by the MA
4	The MA minutes the lay section on the evidence to be despatched, the name and address of the nominated Regional Consultant, the Specialty, the Terms of Reference to be included in the Statement of Case and any individual instruction eg acceptance of a claimed injury. It is not necessary to make a summary of the history. All the medical information on file is included in the Statement of Case.

(40522)

Step	Action
5	The lay section prepares and submits the Statement of Case in a pink folder with photocopies and items of evidence as requested A second copy of the page which includes the Terms of Reference is provided The file is submitted to Copy Types.
6	The referral letter is prepared by Copy Types and returned to the ECW for signing. The file is then passed on to the appropriate administration team for despatch.
7	The case is then despatched with one copy of the Statement of Case, photocopies of the selected documents, and any X-ray films or slides and a copy of the Terms of Reference
8	As with specialist reports, it may be necessary to go back to the RC. The same procedures should be followed as for specialist reports. If a major additional issue arises necessitating a reformulation or a re-examination, the lay section should be asked to add the RC report to the Statement of Case Supplementary Terms of Reference must be supplied and the file returned to the RC.

40523-40539

Specimen Terms of Reference to Regional Consultant

40540 **Disablement cases - home**

"Will the Regional Consultant please study the Statement of Case, noting in particular the entry/claim dated ..... . on page ..... (the attached X-rays, audiograms, slides etc) examine Mr .... and give his/her opinion on the following points

1. Present condition
2. Diagnosis (of the condition claimed as .....)
3. Aetiology
4. Likely date of onset of the condition
5. Whether any factors of service from ..... to .. .. caused or adversely affected the .....

Will the Regional Consultant please give reasons in detail for the opinions expressed".

40541 **Death cases or pensioners residing overseas (or where examination is definitely not required)**

"Will the Regional Consultant please study the Statement of Case (X-rays, audiograms, slides etc) and on the documentary evidence give his opinion on the following points

1. Diagnosis
2. Aetiology
3. Whether any factors during service caused or played any part in the condition leading to death.

Will the Regional Consultant please give reasons in details for the opinions expressed.

Note

40542 In Article 4 cases the following should be added:

1. Will the Regional Consultant please note that this appeal is for consideration under Article 4 of the Service Pension Order 1983 The effect of this Article is to place all onus of proof on the Department. There is no onus whatsoever on the appellant who must also be given the benefit of any reasonable doubt.

2. Bearing in mind the heavy onus of Article 4 will the Regional Consultant please give his opinion on each of the following points

   (and here the questions should follow but, where appropriate, use the phrase "does the evidence show beyond reasonable doubt .....")

40543 Medical Policy has supplied a paragraph for use in cases where the effects of alcohol or tobacco are of relevance to the claim. This is not intended for use in every case but can be included when considered appropriate by the MA. A copy of the paragraph is at Appendix seven.

40544-40579

Regional Dental Officer reports

40580 When claims are made for "loss of teeth", gingivitis etc. it is often difficult to make the entitlement decision. It may appear on the surface that giving entitlement in "dental" cases is a relatively trivial matter However, it should be remembered that giving entitlement opens the gates to claims for treatment allowances. Modern dental treatment is very expensive and claims are being made running into many thousands of pounds. In cases of difficulty, reports may be obtained from the Regional Dental Officer. Administrative staff will obtain the report on a standard form WPA 323. It may be necessary to advise the administrative staff of any special questions on a minute.

40581 A copy of WPA 323 is shown at Appendix eight

Independent Medical Expert

40582 Under Article 1(4)(b)(ii) of the SPO 1983 the Secretary of State can seek an opinion from "one or more of a panel of independent medical experts nominated by the President" of a Royal College.

Though this alternative was used not infrequently soon after the War it is now almost never called into action. It is reserved for the most unusual cases.

The CMA to the DSS asks the relevant President to nominate a suitable medical expert and the opinion of this expert is accepted without question and actioned in full

40583-40589

Reports requested/obtained by the Pensions Appeal Tribunal

40590 Under the authority of the PAT rules the Tribunal can, sometimes must, arrange various examinations and reports when the case is under their consideration.

- Rule 15
- Rule 17
- Rule 21
- Rule 23
- Rule 14

Rule 15 reports

40591 When the Tribunal is of the opinion that expert advice, medical or technical, is required arrangements can be made to obtain this. The Tribunal sends for the reports, specifying the questions to be asked.

40592 Once the report is completed, copies are sent to the appellant and to the Secretary of State. Either may comment in writing or the Secretary of State may prefer to address the Tribunal at a future hearing. The completed report is referred to the MA who advises the Secretary of State on the reply. A FOMD is prepared if necessary

40593 There may be a conflict between a WPA Specialist report and the Rule 15 report. Policy advice is that a WPA Regional Consultant report should not be obtained at this stage. MA action should be confined to making pertinent comment on the Rule 15 report in a FOMD where appropriate. It is for the PAT to resolve any conflict of evidence.

40594-40599

Rule 17 reports

40600 This rule allows the medical examination of the appellant by the medical members of the Tribunal at a Tribunal hearing. The findings are not revealed.

40601-40609

Rule 21 reports

40610 If the appellant is unable to attend the Tribunal hearing a domiciliary visit can be arranged under this rule Replies can be made to these reports, so the case is handled in the same way as a Rule 15 case. (See AIC 37/90 Medical Library).

40611-40619

Rule 23 reports

40620 In overseas cases, the Tribunal may arrange examination in entitlement cases but must arrange examination in all assessment cases. The Secretary of State may not comment on these reports. The cases may be referred to the MA but an FOMD cannot be produced. The MA is asked to make any comments which might be helpful to the DR at the Tribunal.

40621-40629

Rule 14 adjournments

40630 There are a number of cases in which an appeal is adjourned under Rule 14 This is an adjournment for further information or evidence. In this situation, there are three possible scenarios. The information is obtained by the Tribunal itself, by the appellant or by the Secretary of State.

40631 Not uncommonly, cases are adjourned under Rule 14 for the Secretary of State (in practice WPA) to obtain further medical evidence Problems have arisen where the Medical Adviser does not consider that further medical evidence is necessary In this situation, is there any option to decline to obtain the evidence requested by PAT?

40632 Legal advice has been received. Rule 14(1) provides for the Tribunal **requiring** the Secretary of State to produce further evidence, not requesting. Rule 14(3) provides that "the evidence **shall**" be communicated to the Pensions Appeal Office. It has been confirmed, therefore, that **WPA does not have a choice and the evidence must be obtained and presented to PAT.**

40633 The common contentious areas are where a PAT adjourns under Rule 14 for the WPA to obtain reports from specialists or ERA testing. In such circumstances, no matter how irrelevant the MA considers it to be, the evidence must be obtained.

40634 PATs should know the WPA policy in respect of radiological examinations and there should not be any adjournments under Rule 14 for WPA to arrange for appellants to be examined radiologically. If this does occur, the MA should ask the EO to contact the PAT, pointing out that it is not appropriate to authorise X-rays for War Pensions purposes and that this complies with The Ionising Radiation (Protection of Persons Undergoing Medical Examination or Treatment) Regulations 1988. The PAT should then re-commence the hearing

40635-40649

Handling overseas files

40650 The adjudication of overseas SPO claims does not differ from the adjudication of any other SPO claim However, the evidence gathering process differs in some important respects

40651 Not surprisingly, overseas files generally take longer to clear and it is particularly important in these cases to avoid sequential evidence gathering wherever possible. It is unfair on the claimant if an MA waits 6 months for a GP report and then decides that a War Pensions Medical Examination is necessary. A long delay is then inevitable before the claim is answered.

40652 On any kind of request for information, be aware of the different meanings of words in different countries. An important feature to note, particularly on USA files, is that a date in the form 7/6/93 means the 6th of July. This point is important in appeals work

40653 It is worth bearing in mind that many overseas claims are made for the purpose of gaining entitlement to treatment. particularly in those countries with no National Health Service.

40654-40659

Hearing cases

40660 Many overseas hearing cases require a Specialist referral on the WPA 314 series of forms. There is no WPA 845, and the MA must specify clearly the type of Specialist required ie Specialist Otologist. **Please note that although Eire cases are dealt with as overseas cases, there is a DBC in Dublin, and a WPA 845 is required.**

40661 It is worthwhile amending the WPA 314 to include permission for ERA if deemed appropriate, although the facility may not be available; this precludes the possibility of further delay at second submission.

40662 In almost all New Zealand cases, and, in some Australian cases, the file will arrive with a report already available at first submission.

40663-40669

Other Specialist reports

40670 Always specify the type of specialist required on the WPA 314.

40671-40699

WPA Medical Examinations

40700 Medical Examinations are requested on the WPA 851 series of forms. The standard of report can vary considerably from country to country and the report may arrive back in an unfamiliar form. It is important to remember that the doctor who receives the request has, at best, English as a second language. Please ensure that the questions asked are clear, legible, unambiguous and free of subordinate clauses. Photocopies of previous examinations or other documents cannot be sent. The information entered on the WPA 851 by the MA is, thus, of particular importance and clarity of expression is essential.

GP reports

40701 Requests for information from GPs (or their equivalent) are prepared in letter form by our Administrative colleagues. The information required should be clearly specified by the MA and written in such a way that it is easily understood.

Hospital case notes

40702 These are requested in exactly the same way as for any other case. However, unlike Britain, such requests cost money, and the absolute need for HCNs should be carefully assessed. It is likely that the entire hospital record will be sent, relevant or not.

UK NI records

40703 These may be helpful, especially if the claimant spent some time in this country after service.

New Zealand files

40704 In many NZ cases, there will be a notification on the file from the New Zealand authorities that medical reports have already been requested Usually, no further evidence need be obtained, but such files should be checked carefully to make sure that all relevant evidence has been arranged

40705-49999

Contents

Entitlement considerations

Identification of claims

50000 The Secretary of State recognises that a claim (in the widest sense) has been made. In some areas of work (Special Section, Current Invalidings) the MA identifies the claimed conditions. Otherwise, by custom and practice, the claimed conditions are identified by a member of the administrative staff, usually the EO, though the AO identifies the claim where deafness alone is claimed.

50001 The claim form and all other communications about the claim must be read carefully by the MA to ensure that all the claims have been identified. In addition, any contentions should be noted. The MA must answer the claims and any contentions made in full.

50002-50029

Claims made at a War Pensions Examination (WPME)

50030 In the past, the EO caseworker carried out a post examination scrutiny and identified fresh claims made at the medical examination. This no longer happens as it was seen as a duplication of effort, in that the MA was obliged to read the WPME report as part of the decision making process.

50031 The responsibility for identifying claims made at the WPME therefore now falls to the MA. It is important not to overlook such claims, as if they are identified subsequently, there may be a question of backdating. It is advisable to minute the EO, so that there is a record on file that the MA has acted appropriately, even if the SoS does not agree.

50032 The file may be walked to the EO to save time. If this is not possible, the claim is obvious, and can be dealt with there and then, you may answer the claims and minute the EO, explaining what you have done. If the EO disagrees, they can return the file to you for further discussion.

50033-50049

Answering the claim

50050 It cannot be too strongly emphasised that when dealing with a claim to War Pension, it is essential to read the claim carefully in every case.

50051 The adjudication process should then continue with the identification of the basic injurious process (or processes) underlying the claimed disablement, and the selection of accurate labels. Apart from the clearly defined instances where they may be used in hearing cases, it should be very rare to use a symptomatic label. The basic injurious process(es) should be sought assiduously in all cases. The routine to be followed can be summarised as follows:-

i. What is the man claiming? (symptoms and pathology)

ii. Has he got it? (pathology)

iii If not, what has he got? (pathology)

50052 If there is more than one pathological process underlying the claimed disablement then each pathology must be considered individually, and its relationship (or not) to service established.

50053 In some cases, the claimant gives details of the particular service compulsions which, in his opinion, caused or aggravated his claimed disablement. These contentions must be considered, and should be seen to be considered, when the claim is adjudicated. Acceptance or rejection of service compulsions is a matter for the Secretary of State (SoS), and if necessary, when dealing with the claim the MA should return the case to the EO for clarification of the SoS position. If the case comes to appeal, any contentions must be answered in the OMD.

50054 For the most part, the compulsions contended are fairly standard, eg, stress and strain, adverse weather conditions, exposure to military noise etc. Sometimes the contentions and health effects of the alleged exposures are more complex or medical understanding not yet definitive, eg, exposure to chemicals at Porton Down, radiation in nuclear tests, organophosphates, depleted uranium, NAPS tablets and vaccinations in the Gulf War etc and expert advice may be required If you are at all concerned, please discuss the case with your ECW. If necessary the case may be referred for Policy advice.

50055-50079

Labelling

Historical

50080 The intention in choosing a label is to select a term which accurately denotes the basic injurious process, ie, one which will clearly indicate the true pathological process present

50081 This is not always straightforward. Over the years, symptoms, treatments and causes have all been included - either alone or as extensions to the label. The initial claim is often for a symptom, the claimant's main complaint eg angina. From the very early days of War Pensions considerations there was a tendency to use this symptom as a label as it particularised the main "disablement" and did so in the claimant's own words.

50082 Equally as common was to label the basic injurious process correctly but then to extend the label to include the main symptom eg peptic ulcer with dumping syndrome.

50083 Another early method of labelling was to choose a major complication such as stroke or a major surgical treatment such as partial gastrectomy. These terms could be used alone or attached to the basic injurious process, for example, peptic ulcer with partial gastrectomy.

50084 This method has some apparent advantages, for not only has the basic injurious process been established but the acceptance of the effects of the major surgery is clearly indicated and this can be of importance when assessing disablement in the future, especially in aggravated cases.

50085 These various choices of labels often followed criticisms by the Tribunals or by Consultants. Whole series of labels sometimes ensued: angina - myocardial ischaemia - coronary thrombosis - myocardial infarction - coronary atherosclerosis - atherosclerosis. This was obviously very unwieldy.

50086-50099

Choosing a label today

50100 The label should be as precise as possible. The MA should make every reasonable effort to identify the basic injurious process and select the correct label. It is helpful to select labels used in our appendices. This facilitates subsequent defence at appeal.

50101 If the basic injurious process is not identified correctly at the claims stage, and the label is wrong (or a symptomatic label is used), problems may arise at the appeals stage For example, the man could be notified of a condition which he does not have but nonetheless, he has appeal rights in respect of that condition.

50102-50119

Injury

50120 It is essential to distinguish between an "incident", often claimed as an injury, and "injury" meaning an injury, wound or disease in SPO 1983 terms. Entitlement, not only in the Service Pension Order, but also the Civilian and other schemes is dependent upon the evidence that the claimant has suffered an "injury".

50121 It is for the Secretary of State to accept whether the claimed incident occurred. The MA has then to determine whether or not disablement has resulted from the incident which the lay officer has accepted.

50122 In view of the ambiguity in its meaning. it is wiser to avoid using the term "injury" in the label. It is preferable to use a specific term, eg, laceration, contusion, bruise. etc, if this is what the evidence shows

50123 The MPM57A indicates that when the use of the word "injury" cannot be avoided, the label should be as specific as possible, for example, Injury Left Palm, June 1944, attrib nil.

Note: Labels should not prevent Tribunals from reaching a decision that the conditon is attributable to service. Some labels inevitably result in this, for example, "personality disorder", which cannot by its very nature be attributable to service. Such labels should be used only when the diagnosis is firmly established.

50124 Terms such as congenital, idiopathic, essential, familial, may all pre-empt a decision that the condition is attributable to service factors. "Traumatic" can also pre-empt the Tribunal's decision. All these terms should be avoided.

50125-50139

Symptomatic labels

50140 Symptomatic labels should be used only as a last resort. Every reasonable effort should be made to establish the underlying pathology If the claimant has been investigated thoroughly and the basic injurious process still remains obscure, or if invasive investigations would be required to reach a diagnoses, it may be permissible to use a symptomatic label.

50141 On occasons in the past, symptomatic labels have been qualified by the phrase "not yet diagnosed" in brackets after the label. This has been interpreted as an extension of the label and has resulted in confusing notifications. Usually, there is no forthcoming diagnosis. To avoid confusion, it is not appropriate to add the phrase "not yet diagnosed" to any symptomatic label.

50142-50149

Change of label

50150 It must be remembered that once a certificate has been given, a change of label is an alteration to a certificate, a legal document upon which the Secretary of State must base his decision Therefore, any change in the label when entitlement of attributability or aggravation has already been notified must be in accordance with Article 67 SPO 1983. If there is no notification of entitlement then Article 67 does not apply and the label can be changed.

50151 During the course of a review or an appeal there may be a sound reason to change the label The appellant may however wish to continue the appeal under the original label. In such a case both labels can be presented to the PAT, provided both labels refer to the same injurious process or we can show that the label used by the appellant refers to a condition which does not exist. The Agency may not be able to accept a label used by an appellant for other reasons eg "partial gastrectomy". Entitlement cannot be considered under that label for the term refers to treatment for a peptic ulcer, not the basic injurious process itself. If the appellant insists on the use of the term "partial gastrectomy" the OMD must outline the reasons for the decision on the basic injurious process present, "peptic ulceration" and explain why the term "partial gastrectomy" cannot be used as a label

50152-50169

Labelling of atherosclerosis and related events

50170 At the present time, in this condition, we may employ 2 labels, "atherosclerosis" to indicate the basic injurious process and, if a coronary thrombosis has occurred, "myocardial infarction (dated)" to enable entitlement to be considered in respect of both the basic injurious process and the atherosclerotic event, as the infarction itself could well have additional causative factors.

Labelling in deafness cases

50171 Labelling in deafness cases has varied over the years. When the pathology is firmly established, for example, otitis media or otosclerosis the precise diagnosis is used, not "conductive deafness", which is a symptom, not a basic injurious process

50172 Where noise induced sensorineural hearing loss is present, we use a term which is accepted by the Tribunals, the Ex-service Associations and WPA: Bilateral noise induced sensorineural hearing loss (service dates). This is a combination of a symptom and a cause. it does not specify the basic injurious process, yet it has proved to be the most acceptable label for a commonly claimed condition.

50173-50199

Part and parcel

50200 There is no legal basis for "part and parcel". As described already, labels were often extended in the past to include further symptoms claimed, operations etc, becoming long and unwieldy in the process. Legal advice was obtained to the effect that the label should reflect the basic injurious process only. The practice of "part and parcel" was adopted as a result.

50201 As a general rule, once you have identified and labelled the basic injurious process, symptoms of that same injurious process may be made "part and parcel".

Note: A separate disease process must be labelled separately, and its relationship to service established.

> **Example**
>
> The pensioner has entitlement in respect of internal derangement, right knee. Later in life, he develops osteoarthritis of the same knee. This condition represents a new injurious process and should be labelled separately. In such a case, it is likely that the decision will be that osteoarthritis right knee is consequentially attributable to service.

Sometimes the man may claim a specific operation. We need to respond to this, in such a way that he understands that we have answered his claim.

> **Example**
>
> A pensioner has entitlement to Peptic Ulcer, attributable to service. Subsequently, he has a partial gastrectomy and develops stomach cancer. He claims "stomach taken away" and cancer. The correct approach is to make the partial gastrectomy part and parcel of Peptic Ulcer. Cancer of the stomach is a new injurious process, and is not an inevitable accompaniment of Peptic Ulcer. It is a consequential condition, and should be labelled and given entitlement in its own right.

Not found

50202 If a claim is made for an injury, wound or disease, and it is established that the injury, wound or disease does not exist now, and never has existed, then we can reject the claimed condition as "not found". Strenuous efforts should be made to establish whether the condition does, or ever has existed. "Not found" should never be used to reject a symptom or a non-specific label. A common scenario is, for example, a claim for "injury to the left knee", which the man relates to an incident in, say, 1944

50203 The Secretary of State does not accept the claimed incident, and there is nothing of relevance in the service medical documents. However, GP records reveal that the man presented in 1991 with a painful left knee, subsequently diagnosed as early osteoarthritis In these circumstances, the correct approach is to reject:-

- "Injury to left knee 1944" - not found
- "Osteoarthritis left knee" - NANA

50204 It is not sufficient to reject the claimed injury alone The basic injurious process causing the current disablement must also be identified and its relationship to service (if any) must be determined

50205 In the event of an appeal, the PAT is presented with both labels, and the man is thereby given the fullest possible rights of appeal. The PAT is able to pronounce upon both the claimed injury and the pathology giving rise to the current disablement.

50206 If, as a question of fact, the PAT decides that the injury did occur as claimed, and overturns our decision, then it is possible for us to certify an assessment of Nil in respect of the injury (dated) The PAT may well uphold the rejection of the osteoarthritis. If this label alone is put before the PAT, their options are restricted, and they may feel that their only choice is to overturn our decision, which would then result in our having to certify an assessment encompassing all the current disablement, which is non-service related.

50207-50229

Summary

50230 Note the following:

- Read the claim form, plus all accompanying letters/documents
- Be alert for claims made at the WPME.
- Identify the basic injurious process.
- Select the correct label
- Avoid the use of "injury" in the label.
- Do not use symptomatic labels except as a last resort.
- Part and Parcel - include symptoms, not diseases.
- Answer the claim fully

Suggested reading

50231 Paras 117-121 MPM57A.

50232-50299

TLTY and TMTY Cases

50300 TLTY and TMTY cases can cause problems for both medical and lay officers

50301 When an assessment is made on a TLTY or TMTY basis the case should be reviewed after 9 months or 24 months respectively to determine whether or not that assessment was correct. If review reveals the decision to have been correct, then a final decision of nil assessment should be made in attrib cases and a decision that agg no longer remains (ie APA) should be made where the entitlement is one of aggravation If such a review has not been made at the end of the period, subsequent action is much more difficult, especially if the decision is not recent This can be a problem when a TLTY/TMTY period of award was advised many years ago.

50302 If no appropriate review has previously been undertaken but there is concrete evidence that disablement ceased by the envisaged time (very unlikely if there has been no review), then that evidence can be used as a basis for action as at paragraph 1.

50303 If there is no concrete evidence that all disablement had ceased by the end of one or two years respectively, then neither TLTY nor TMTY can be defended. In such cases the assessment should be converted to one of the indeterminate duration, and maintained at the previous level. The new period of award will be notified.

50304 If the ID assessment is not appealed against at the time but at some later date a deterioration claim or an appeal is made, then fresh evidence will be required. If this evidence shows that there is no persisting disablement, a 'NIL-FINAL' or an 'APA' decision can then be given from the date of the fresh evidence.

50305 If the evidence shows that the original TLTY or TMTY was in error and that disablement still persists, then the assessment should be revised accordingly.

50306 Please see *Part six Assessments and Part nine "Current Invaliding"*.

50307-50399

Miscellaneous Consequential Conditions

50400

Alveolar cancer	may be consequential attrib to	Pul TB scarring
Cancer stomach	may be consequential attrib to	partial gastrectomy
Cholelithiasis	may be consequential attrib to	truncal vagotomy
Hiatus hernia	may be consequential attrib to	upper abdominal surgery
Hiatus hernia	may be consequential attrib to	thoracotomy

Partial Answering of Claims

50401 In certain cases it may be appropriate to only partially answer a claim.

50402 There are rigid criteria for partial answering of claims:

- the case must be beyond secondary target
- there is sufficient evidence to reach a decision on one or more of the conditions
- the decision on those conditions must be favourable ie not rejected conditions
- there must be written agreement from the HEO.

50403 For full instructions on how to proceed if you are considering partial answering of a claim, you must refer to the *Claims guide, Volume 1, Part 4, 'Partial answering of claims'*.

50404-59999

Contents

Assessments

General

60000 The Desk Card, MPM 200, lists both scheduled and non-scheduled assessments. Scheduled assessments are obligatory and must be certified once the condition is stable and there are no additional features (see Note 2 of the Desk Card).

60001 The other assessments, listed "for guidance only" or "suggested assessments", are not obligatory and are given for help and guidance only. They do however reflect Pension Appeal Tribunals, Medical Boards (both War Pensions and Industrial Injury), and War Pensions Medical Advisers' assessments over very many years and can normally be followed. They are included to aid consistency in the assessment of disablement.

60002 Certain assessments have proved difficult to defend eg 15-19 per cent for a single accepted disablement. It is too close to 20 per cent. Except for eye cases under the Hambresin scale and some uncomplicated loss of hearing cases, it should be avoided

60003-60059

Head and neck

Head injuries

60060 In assessing symptoms resulting from associated injury of the brain the following points should be taken into consideration:-

- gross sensory disorders [defective recognition of changes in passive position and of size, shape and form of objects, etc are as disabling as a well-marked motor paralysis],
- defects of speech;
- visual defects;
- auditory defects.

60061 Mental deterioration may be transient or permanent. After all severe head injuries some degree of mental deterioration is present for a considerable time, and in a large proportion of cases it causes permanent disablement of material degree. It must be remembered that, owing to its greater velocity, a bullet may inflict more remote damage to the brain with permanent mental deterioration than a splinter from a shell or bomb. The external signs of injury from a bullet wound may be much less and there may even be no palpable evidence of loss of bone substance.

60062 A post-traumatic headache usually occurs in attacks of intense pain which may last for a few hours to several days. Between attacks there may be complete freedom from pain, or a moderate degree may persist. An attack is characteristically provoked by any form of straining and develops with great rapidity The pain is described as bursting or throbbing, and may be so intense as to incapacitate completely. Some cases of this type are amenable to treatment.

60063-60099

Epilepsy

60100 In assessing disablement from epilepsy, whether traumatic or idiopathic, regard should be had, not only to the frequency of the fits, but also to the devastating effects of the fits on the individual's whole life including his general and social activities. The mere fact that the epileptic himself knows of his liability to fits and that he knows that his employer and acquaintances know, places him at a serious disadvantage. Furthermore, quite apart from the unpleasantness of the fits themselves, there is the ever-present fear of having a fit on some important occasion The well-recognised mental deterioration of the epileptic, and the mental effects associated with the taking of anti-convulsant drugs, must also be considered.

60101 Added disablement caused by injuries resulting from epileptic fits, where the epilepsy itself is pensionable, must not be included in the assessment for the epilepsy. Any such consequential injury should be fully considered for entitlement and assessment, keeping in mind the likely period of disablement

60102 Because an examinee's account of his seizures, and especially the degree and length of his impaired consciousness, cannot be regarded as entirely reliable, reports from doctors and eye witnesses are of importance

60103-60149

Facial disfigurement

60150 Cases of facial disfigurement will also require careful attention. The SPO (see Section 1a of the Desk Card) lays down an assessment of 100 per cent for "very severe facial disfigurement", but many cases arise which, while not qualifying for the description "very severe", will nevertheless merit substantial assessment. A factor to be taken into account is the psychological impact of disfigurement which is sometimes very great in its effects upon self-confidence, social life etc

60151-60199

Limbs

Initial assessment in amputees

60200 Certificates of satisfactory limb fittings (MHM 326) and certificates of stump measurement (MHM 325) are issued by the Disablement Service Centres (DSC) or Artificial Limb and Appliance Centres (ALAC) in Scotland. Certificates can be requested from the appropriate Centre by the administrative staff (see paragraphs 62640 and 62641 of the Claims Guide Volume 1). These certificates should be obtained in all new amputation cases.

60201 The scheduled assessment in amputation cases is applied only when the limb is stable and without complication. War Pension Agency assesses disablement at 100 per cent for 3 months followed by the appropriate scheduled assessment (section 1 of the Desk Card) for 12 months. At the end of this penod, the case is referred to War Pensions Agency Medical Services. A further stump certificate should be obtained. The scheduled assessment should then be maintained, provided the condition is reported as stable and uncomplicated.

Injuries to limbs not involving amputation

60202 The scale of assessment of amputations will serve as a guide to the assessment of injuries to limbs, the loss of function of a limb or part of a limb being regarded as equivalent to a corresponding amputation, provided that the condition cannot be remedied by treatment. Thus, if a hand is useless the appropriate assessment will be at the same rate as for amputation of hand

60203 It must be borne in mind, however, that disablement may be greater for a period than the ultimate condition is likely to be because of lack of adaptation and muscular weakness. This will be due not only to the injury itself but also to the period of disuse. Much higher assessments may also be justified temporarily where there is much pain or a discharging sinus.

60204-60229

Ankyloses and flail joints

60230 As regards ankyloses, the assessments can generally be determined by reference to Section 2 of the Desk Card which gives a list of suggested assessments which are applicable where fixation has taken place with the joint in the position of greatest usefulness. When a joint is ankylosed in an unfavourable position some addition may need to be made to the assessment suggested at Section 2 of the Desk Card.

60231 If, however, a joint is not truly ankylosed but is limited in its movement, a lower assessment than that suggested at Section 2 of the Desk Card may be appropriate; but it should be remembered that some of these cases of incomplete fixation are often accompanied by a great deal of pain which, when taken into account, may justify an assessment level with, or even higher than, that suggested in Section 2.

60232 Flail joints will normally be assessed at a higher degree than ankylosed joints.

60233 Improved function may sometimes be effected in both flail joints and partially ankylosed joints by orthopaedic treatment; this should be borne in mind, and when treatment is being considered, review of assessment should be advised.

60233-60269

Eyes

Definition of blindness

60270 A man is held to be "blind" if he is "so blind as to be unable to perform any work for which eyesight is essential".

60271 The words "blind" and "blindness" do not ordinarily admit of any precise meaning - certainly they do not imply absolute loss of sight. For pension purposes the statutory schedule of assessments in the SPO is concerned with "loss of vision" and the provision for the assessment of other disablement freely allows for the ad hoc assessment of visual defects which are not complete It may however be useful to know what is meant by the terms "blind" and "blindness" in two particular contexts

60272 The Blind Persons Act 1938 (which is concerned with lowering the age which blind persons must have attained in order to be entitled to old age pension under the Old Age Pension Act 1936 and with amending the law regarding provision of assistance to such persons by local authorities) lays down that for the purpose of the "Blind Persons Act" the expression "blind person" means a person so blind as to be unable to perform any work for which eyesight is essential.

60273 In 1954, the World Assembly of the World Council for the Welfare of the Blind adopted the following minimum definition of blindness (this definition was also adopted by the Conference of World Organisations Interested in the Handicapped, and endorsed by the United Nations Technical Working Group on Rehabilitation of the Handicapped at its fifth session).-

1 total absence of sight;

2 visual acuity not exceeding 3/60 or 10/200 (Snellen) in the better eye with correcting lenses; or

3 such limitation of the field of vision that the angle of vision does not exceed 20 degrees.

60274 This definition is designed to facilitate assessment of the magnitude of blindness with a view to the development of services for the blind. It is also intended as a basis for determining the eligibility of the blind for such services. The minimum definition should be regarded as a target only for those countries which at present have no legal definition, or whose existing definition describes a degree of vision less than 3/60 or 10/200 (Snellen). The proposed definition may be modified in its application in the light of economic and social conditions to suit special needs, such as education and vocational rehabilitation.

60275-60299

Assessments of visual handicap

60300 Section 1a of the Desk Card shows the statutory assessments laid down by the SPO in respect of total loss of sight, loss of an eye and loss of sight of an eye without loss of the eye itself. The basis on which suggested assessments for eye injuries are calculated for war pension purposes was changed on 1 January 1970. Assessment for partial loss of vision in one or both eyes is now based on the valuation table prepared by Dr Leon Hambresin and shown at Section 4 of the Desk Card. Care should be taken in war pensions cases to ensure that when the Hambresin assessment is over 20 per cent the advised assessment is given in multiples of 10 per cent, rounding up or down as appropriate In the less than 20 per cent range assessments should be given in the bands used for war pensions purposes, 1-5 per cent, 6-14 per cent and 15-19 per cent

60301 All the assessments, which relate to total vision, are applicable only where the condition is without complication or disfigurement. When there are complications a suitable addition to the rate given in the valuation table at section 4 of the Desk Card would require consideration:-

- where an eye has been removed and the socket is discharging;
- where active disease is present;
- where the field of vision has been markedly reduced, eg hemianopia (see below);
- in cases of diplopia, aphakia, etc (see below);
- in cases of loss of central vision The disablement is much greater than when there is blindness in the peripheral part of the field only. If the central scotoma is large the defect amounts practically to total blindness;
- in cases of blindness of the lower half of the visual field the disablement is greater than in those of blindness in the upper half.

60302 Modification of the visual field arises in cases of hemianopia, diplopia and aphakia and these conditions were discussed in detail in the report by Leon Hambresin (see Medical Library). The following extracts are taken from that report.

60303-60319

Hemianopias

Homonymous Hemianopia

60320 "In this case there is loss of half the total field of vision, the deficiency extending as far as the immediate neighbourhood of the macula. The subject is incapable of undertaking work which necessitates a certain breadth of the visual field as he bumps into things and is liable to injure himself. The damage must be regarded as serious and is greater than that caused by the loss of vision of one eye".

60321 The Hambresin Report advises 35 per cent assessment for this disablement.

Heteronymous Hemianopia

60322 **"Bitemporal Hemianopia:** The nasal field of vision of the opposite eye compensates in part the absence of the temporal field. The depreciation should be evaluated at 20 per cent

60323 **Binasal Hemianopia:** This defect is certainly very rare and the inconvenience arising from it is much less serious The injury is evaluated at ... 10 per cent."

Diplopia

60324 "One must distinguish between those cases requiring permanent occlusion of one eye and those requiring temporary or intermittent occlusion.

60325 When permanent occlusion is necessary the subject is in the situation of a person who has only one eye However, there is no question of classing the case along with the loss of an eye. Supposing that the other eye should happened to be lost the member will use the eye which had to be occluded. It is logical not to award the same percentage in the case of diplopia, requiring the occlusion of an eye, as in the case of the loss of an eye.

60326 Requiring the occlusion of an eye: 22 per cent.

60327 The cases where double vision does not require the occlusion of an eye are certainly more complicated Diplopia is more serious in its effects when it arises in the lower part of the field.... We consider that no fixed rate can be formulated for cases of diplopia which do not require the occlusion of an eye....

60328 Not requiring the occlusion of an eye: according to the degree of deficiency and according to whether double vision exists in the upper or lower vision: 5-17 per cent".

Aphakia

60329 "NOTE it always concerns corrected vision, both for unilateral and for bilateral aphakia Also that the compensation should not be increased because of an iris coloboma, even an inferior one".

60330 **"Unilateral Aphakia:** It has been suggested that vision of the aphakic eye is nil from the working point of view, since the correcting lens is not tolerated, at least when the visual acuity of the phakic eye is superior or equal to the vision of the aphakic eye with a lens But the aphakic eye is nevertheless useful for finding one's bearings, since it has its visual field and this eye would be of great use if the other eye happened to be lost The damage resulting from unilateral aphakia is not really the same as that which results from the loss of an eye.

60331 Thus we consider three eventualities of unilateral aphakia:

1 The case where the phakic eye has working vision with or without a lens.

2 The case where the vision of the phakic eye, with or without lens, while not being equal to working vision, is superior to the vision of the aphakic eye, with a lens.

3 The case where the vision of the aphakic eye is superior to the vision of the phakic eye, with or without lens, the superiority being such that in the opinion of the expert the subject will use the aphakic eye.

60332 In the first case, starting from the scale of 27 per cent for the loss of vision of one eye, we estimate that it is appropriate to grant 18 per cent ie 2 thirds of the scale of pension given by the valuation table, taking into account the corrected vision of the aphakic eye, the 18 per cent compensating the disadvantages of aphakia.

60333 In the second case we judge 18 per cent should be allowed, plus the disability rate given by the valuation table

60334 In the final case, we are in favour of granting 21 per cent plus the disability rate given by the table. So we increase the pension given for the aphakia because the wearing of the lens correcting aphakia causes an additional inconvenience".

60335 **"Bilateral aphakia:** One starts off from a basic scale compensating the disadvantages of the loss of both lenses. To this basic allowance will be added the rate corresponding to the diminution of central vision .. We think it just to fix (the rate) at 30 per cent".

60336-60399

Contact lenses

60400 The value of a contact lens in the treatment of unilateral aphakia depends upon the acuity obtainable, the type of binocular vision with contact lens wear, and the patient's tolerance to the appliance. When all three are of high order almost 100 per cent normal binocular vision is attainable, even for near fixation, with some types of corneal lenses. In general, the restoration of binocular vision is related to the age of the individual and the severity of the injury responsible for producing the aphakia The younger the individual is the worse is the prognosis for binocular vision.

60401 When contact lenses are worn and well tolerated, ie, can be worn all day without difficulty, the assessment of disablement should be based on the corrected vision with spectacles or contact lenses, whichever is better Where contact lenses cannot be worn regularly assessment based on the visual acuity with spectacles is appropnate.

Loss of one eye, without complications, the other being normal

60402 The term "loss of one eye, without complications, the other being normal" as employed in the SPO, will be interpreted as follows:-

1 Where an eye is conolusively proved to have been totally blind on enlistment and there was no subsequent recovery or possibility of recovery of sight. and that eye is subsequently lost as a result of service, the appropriate assessment is up to 6-14 per cent ID, according to whether the eyeball was, from a cosmetic point of view, perfect or otherwise. If, however, the vision of the remaining eye is impaired ***and the impairment is due to service***, the assessment will be determined by reference to the scales in Section 4 of the Desk Card.

(60402) 2 Where there was any degree of vision or perception of light on or after enlistment, or if the proof required in (1) is lacking, the appropriate assessment on discharge will be 40 per cent unless the vision of the remaining eye is impaired (from any cause prior to the accepted visual defect), in which case the scales in Section 4 of the Desk Card will be applied.

60403-60449

Greater Disablement (GD) and paired organs

60450 Where the vision in one eye is defective due to service factors, and the vision in the other eye is defective due to non-service factors, consideration should be given to the application of the Greater Disablement Principle or the appropriate Paired Organs Rule Whichever is the more favourable to the pensioner should be used in arriving at the combined assessment Application of GD and Paired Organs should be relatively straightforward in eye cases, as there are actual numbers with which to work.

60451 When applying GD, the total disablement due to both service and non service factors should be assessed The disablement which is not due to service is subtracted and the remainder is awarded:

TOTAL DISABLEMENT - NON AD = COMBINED ASSESSMENT

COMBINED ASSESSMENT - AD = GD FACTOR

Example		V/A	Assessment from Hambresin table
AD Eye	=	6/60	20%
Non AD Eye	=	6/60	20%

Total Disablement

80%-20% = 60% (COMBINED ASSESSMENT)
60%-20% = 40% (GD FACTOR)

60452 The same example using paired organ Rule 1 (Hancock Rule)

"Where the combined assessment of a pair of organs or limbs is less than 100%, but more than twice that of the AD, the assessment can be increased to half that of the combined assessment".

AD EYE = 20% NON AD EYE = 20% TOTAL DISABLEMENT = 80%

The assessment can be increased to 40%.

60453 In this case, GD is clearly more beneficial to the pensioner.

60454 There is only one exception to the rules of calculating GD. If a pensioner sustains total loss of vision in one eye due to service, and subsequently loses the sight in the other eye, due to non-service factors, ie he is totally blind, then the full 100% is awarded.

60455 In the very rare case where on enlistment, the man had total loss of vision in one eye and during service lost the sight of the other eye due to service factors, then a pension is awarded at the 100% rate.

60456-60499

Assessment of respiratory disability

60500 Four factors should be taken into consideration in the assessment.

1 **Claimant's Complaints:** It is useful to get an idea of how the claimant views his disability eg shortness of breath. No attempts should be made to grade this, eg MRC grades of dyspnoea. One should ask how the claimant fares on hurrying, walking and climbing upstairs to bed.

2 **Clinical Evidence:** The extent and nature of the physical signs of the chest will give some indication of the extent of the disease.

3 **Results of Lung Function Tests:** (See Section 6A of the Desk Card).

The tests routinely carried out are only those using a Peak Flow Meter or a Spirometer. FEV1 relates to volume of air blown out in forced expiration in one second, FVC relates to the volume of air expired up to the point that the claimant cannot blow out any more. The FEV% relates to the ratio of the FEV1 to the FVC expressed as a percentage. Values for total lung capacity (TLC), transfer factor (DLCO) etc are available only if the claimant has been referred by his GP Respiratory Function Unit.

Chronic obstructive airways disease and the more severe grades of pneumoconiosis are characterised by an obstructive ventilatory defect. Here the FEV1 is reduced proportionately more than the FVC and the FEV% is below 65. The claimant has no difficulty filling his chest but finds it quite a problem emptying his chest quickly. Diseases such as diffuse interstitial fibrosis are characterised by a restrictive ventilatory defect (he has difficulty filling his chest but no difficulty in blowing the air out) as well as a reduced total lung capacity and gas transfer. Emphysema produces an obstructive defect and is characterised by large floppy lungs while conditions such as asbestosis produce a restrictive ventilatory defect and are characterised by small stiff lungs.

4 **X-rays:** Usually the more severe the X-ray abnormality, the greater the disablement.

60501 **Every case must be judged on its own merits.** A summarised clinical description of progressive disablement from respiratory illness with appropriate assessments is given in Section 6B of the Desk Card as a guide in assessing reports.

Pulmonary Tuberculosis Cases Undergoing Treatment

60502 In the past it has been the practice to increase the assessment to 100% in cases of accepted pulmonary tuberculosis undergoing treatment. This reflected old therapeutic methods often involving protracted treatment However, policy advice has confirmed that we are free to assess pulmonary tuberculosis in the usual way. The assessment should be based on clinical findings and should reflect the modern therapeutic approaches. There should not be an automatic award of treatment allowance and/or increase in assessment to 100% for the duration of treatment. Award of treatment allowance should be in line with the legislation and current policy ie there must be loss of earnings as a result of treatment.

60503-60599

Assessment of psychiatric disorders

60600 Section 3 of the Desk Card (MPM200) includes the 9 point GAF scale (Global Assessment of Functioning) from DSMIV with the scale equated to the War Pension Assessment bands.

60601 The DSMIV instructs the examining clinician to "consider psychological, social and occupational functioning on a hypothetical continuum of mental health-illness" and not to "include impairment in functioning due to physical (or environmental) limitations".

60602 This should be covered by the reporting psychiatrist when completing Axis 5 of the DSMIV profile.

60603 Axis 5 permits the clinician to indicate his or her judgement of an individual's highest level of adaptive functioning (for at least a few months) during the past year. This information frequently has prognostic significance, usually because an individual returns to his or her previous level of adaptive functioning after an episode of illness.

60604 Adaptive functioning is a composite of three major areas: social relations, occupational functioning, and use of leisure time. These three areas should be considered together, although there is evidence that social functioning should be given greater weight because it is of particularly great prognostic significance.

60605 An assessment of the use of leisure time will affect the overall judgement only when there is no significant impairment in social relations and occupational functioning or when occupational opportunities are limited or absent (eg the individual is retired or physically handicapped).

60606 **Social relations** include all relations with people, with particular emphasis on family and friends. The breadth and quality of interpersonal relationships should be considered.

60607 **Occupational functioning** refers to functioning as a worker, student or homemaker. The amount, complexity, and quality of the work accomplished should be considered. The highest level of adaptive functioning should be used only when high occupational productivity is not associated with a high level of subjective discomfort.

60608 **Use of leisure** includes recreational activities or hobbies. The range and depth of involvement and the pleasure derived should be considered.

60609 The level noted should be descriptive of the individuals functioning regardless of whether or not special circumstances, such as concurrent treatment, may have been necessary to sustain that level.

60610-60649

60650 In addition to the DSMIV Axis 5, assistance in assessing individual cases may be obtained from the clinical history and examination.

60651-60689

Collection and interpretation of evidence

60690 It is essential to bear in mind that a War Pensions Medical Examination (WPME) can in many cases be the least useful type of evidence on which to base a review of a psychiatric assessment. Of much greater importance than the "one-off" WPME interview is the collection of documentary evidence which shows how the individual has been functioning in terms of social, psychological and occupational areas, what treatment has been received and what the response to treatment has been. Such information will be available in hospital case notes and GP records.

60691 Until March 1996, Consultant Psychiatrists were asked to complete all axes of the DSMIV system. This includes a rating on the Global Assessment of Functioning (GAF) scale. Such a rating can seem to tie us down. Often we receive reports with a GAF rating which applies only to a single point in time, which is not the correct way to make the rating The GAF is meant to be given for two time periods:

i. the level of functioning at the time of the psychiatric evaluation and

ii. the highest level of functioning for at least a few months during the past year

60692 We do not have to base an assessment on a GAF rating if in our clinical opinion it is not appropriate for the period of assessment for which we are providing a certificate.

60693 Section 3 of the Desk card (MPM 200) is helpful However it is, as it says, for **guidance only.** For instance, code 4 would seem to indicate that an assessment of 60-70% is warranted in cases where there has been a single suicidal gesture - this is misleading and of course is not necessarily correct in all cases. There is an enormous difference between a failed true suicide attempt and the more common deliberate self-harm without true suicidal intent

60694-60749

ADs and non-ADs present

60750 There are numerous situations in which all psychiatric disablement is not accepted even though there is entitlement to a psychiatric condition Examples are as follows:

1 The AD is an adjustment disorder. Another psychiatric condition such as a personality disorder is present, but is not accepted Because of the nature of the condition, an adjustment disorder should normally have a dated label. Its duration is closely related to duration of exposure to the causative stressor. (See the relevant medical appendix) It would be very rare indeed to accept deterioration of such a condition. Further or later psychiatric disorder would by definition be a different disorder.

2 The AD is any other psychiatric illness and an additional psychiatric condition, eg personality disorder or an organic mental illness (such as dementia) is also present.

3 There is a physical AD which is associated with some psychological disablement, but a non-service-related psychiatric illness is also present. For example, the AD is Burns to Face 1943. The pensioner has lately developed a depressive illness which is not service-related. However, he also has long-standing symptoms that relate to the burns sustained when his ship was torpedoed in 1943, namely fear of fires and avoidance of sea voyages. The depressive disorder would be NANA but the psychological symptoms that are associated with the AD can then be accepted as being part and parcel of the AD. The particular psychiatric features that are accepted with the AD must then be **clearly specified** in the "part and parcel" section of the entitlement certificate. In the above example, the label of the AD **remains** Burns to Face 1943, "fear of fires and avoidance of sea voyages" are specified in the 'p and p box', and the depressive disorder is rejected NANA. The assessment would reflect acceptance of only a small proportion of the overall psychiatric disablement.

60751 In the past we have sometimes extended the label of an AD to include "associated nervous symptoms", in for instance the type of case referred to in the paragraph above However, this device is **not** sufficiently specific.

60752 As above, it is essential that the precise psychological features that are being accepted as part and parcel of the AD are clearly recorded on the entitlement certificate. The extension of the label of an AD by the use of the term "associated nervous symptoms" must therefore not be used. The only exceptions are the FEPOW cases, where use of the term "associated nervous features" remains appropriate.

60753-60789

Advice on time periods - PTSD

60790 Post-traumatic stress disorder (PTSD) is a condition that is usually amenable to treatment Recovery or improvement is to be expected in most cases, with appropriate treatment and/or the passage of time. Younger War Pensioners with PTSD can in general be expected to have a better prognosis than for example World War II veterans who have the condition. Long Term Assessment (LTA) periods of assessment should normally be avoided in the younger group and in those undergoing active treatment, particularly in any cases involving an assessment of 20% or more. A review at anything between 9 and 48 months would be appropriate in most, if not all, of these cases

60791 The points raised above may also apply to other acute psychiatric conditions Remember that other psychiatric disorders, of varying duration, may arise in response to external factors. Examples are adjustment disorders and prolonged depressive reactions.

60791-60999

Splenectomy

60900 It is now recognised that patients who have had a splenectomy remain at indefinite risk of overwhelming infection As a result it is recommended that these patients be given long term antibiotic prophylaxis and routine immunisation against pneumococcal, influenza, haemophilus and meningococcal infections Antibody levels should be monitored regularly with repeat immunisation as required.

60901 In the light of these recommendations and feedback from assessment appeal tribunals, it has been decided that the present recommended assessment for uncomplicated splenectomy of 1-5%, as noted on the desk card, should be **increased to 6-14%.**

60902-60999

1914 War - reserved rights

Amputations

61000 Final awards in respect of amputations arising out of the 1914 War were assessed in accordance with the First Schedule of the 1919 Royal Warrant Where the amputation was originally assessed under the First Schedule of the 1918 Royal Warrant it should subsequently have been reviewed and, where appropriate, reassessed under the 1919 Royal Warrant, the latter being more precise in regard to detail and length of amputation stump. Scheduled assessments in both the 1918 and 1919 Royal Warrants differentiated between right and left arm amputations. The recommendations of the Hancock Committee in 1946 advising on the assessment of disablement due to specified injuries, were adopted by the Department and introduced in April 1947 These increased the assessments for the right arm and made certain other upward adjustments in assessments. In the case of 1939 War amputees the pension award was, where appropriate, adjusted to the new rates automatically. In 1914 War cases, however, individual application was necessary, the pensioner being advised of the various changes by leaflet. Occasional cases may still come to light where a 1914 pensioner eligible for an increase under the Hancock report failed to respond to the leaflet invitation and whose pension, consequently, has never been adjusted. Where the First Schedule of the 1919 Royal Warrant is more favourable than the "Hancock" rates, eg below knee amputations with stump exceeding 13 cm (5 inches) (1919 Royal Warrant - 50 per cent, Hancock rate - 40 per cent), the 1914 War pensioner will retain (or be given) the benefit of the higher 1919 Warrant rate

Eye cases

61001 Under the First Schedule of the 1919 Royal Warrant, loss of vision in one eye, with or without the actual loss of the eye, was assessed at 50 per cent. Assessments under the "Hancock" schedule are 30 per cent for loss of vision of one eye and 40 per cent for the actual loss of one eye. When in 1947 these rates were adopted, 1914 War final awards were maintained at the 1919 Royal Warrant rates. A pensioner should be given the benefit of the assessment contained in the original schedule to the Royal Warrant of 1919 where it is to his advantage See section 4(3) of the Desk Card

61002-61099

Periods of assessments

Abbreviations and terms

61100 ID - indeterminate duration Used in under 20% cases where the assessment of the accepted disablement is unlikely to improve to the point of being less than the present assessment.

61101 Final - this term is used when it is considered that the accepted disablement is stable and will never worsen.

61102 Interim LTA - interim long term assessment Used when worsening is not expected for a considerable time The long term assessment period does not now have an end date. Previously the pensioner was notified at four yearly intervals that it was proposed to continue the assessment for a further four years and was asked to report any change. This practice has ceased and the interim LTA assessment will be reviewed only at the instigation of the pensioner.

61103 TLTY - temporary, less than a year Used in current invalidings when the MA is confident that the disablement will cease to exist within a year of removal from service factors.

61104 TMTY - temporary, more than a year. Used in current invalidings when the MA is confident that the disablement will cease to exist within 2 years of the end of service. Very rarely used now

61105-61119

Summary of options for initial periods of assessment

61120 **Assessments of 100%:** Time periods of between **6/12** to **24/12 + 24/12** if improvement expected **Final** if stable. **Interim LTA** if not stable.

61121 **20% or more**

CURRENT INVALIDINGS	ARTICLE 5 and POST DISCHARGE ARTICLE 4(2) cases
9/12 If improvement possible. or Interim LTA If improvement unlikely or if a period of 9/12 has almost elapsed since the invaliding date or FINAL if stable	Periods of 6/12 to 24/12 + 24/12 if change likely or Interim LTA If change unlikely or FINAL if stable

61122 **Less than 20%**

CURRENT INVALIDINGS	ARTICLE 5 and POST DISCHARGE ARTICLE 4(2) cases
ID Interim LTA or TLTY REVIEW 9/12 Very rarely ID FINAL TMTY REVIEW 24/12	ID Interim LTA or ID FINAL

61123 **Attrib nil condition:** ID FINAL.

61124-61199

Examples of options for less than 20% current invalidings at 9/12 review of assessment

61200

INITIAL DECISION	RESULT OF 9/12 BOARD	ATTRIB	AGG
eg 1-5% TLTY Review 9/12	Nil Disablement	NIL ID FINAL	APA
	Continuing Disablement Condition Static	1-5% ID FINAL	1-5% ID FINAL (Consider limitation)
	Continuing Disablement Change Expected	1-5% ID Interim LTA	1-5% ID Interim LTA
	Increased Disablement No Further Change Expected	6-14% ID FINAL	6-14% ID FINAL (limitation may not be appropriate having accepted deterioration)
	Increased Disablement Change Expected	6-14% ID Interim LTA	6-14% ID Interim LTA

61201 If the initial decision was delayed, the review date is passed and the board confirms full recovery, the period TLTY FINAL should be given from the date of invaliding followed by Attrib Nil ID FINAL from the date of the board In AGG cases advise that APA is appropriate from the date of the board.

61202-61299

Reduced assessments

61300 The award (payment) of War Disablement Pension is based on the certified composite assessment where there are multiple accepted conditions or on the sole certified assessment where there is one accepted condition.

61301 Article 67 of the Service Pensions Order (SPO) and Article 76 of the Personal Injuries (Civilians) Scheme (PICS) govern the review and revision of assessments. An amendment was made to these Articles which affects assessment decisions made on or after 9 April 2001.

61302 It is necessary to consider whether the SoS or the PAT has made the existing assessment decision.

61303 For SoS assessment decisions made before 9 April 2001, the SoS has the power to revise an existing assessment to the detriment of the pensioner only where:

- the assessment was made in consequence of:
  - ignorance of a material fact; or
  - a mistake as to a material fact; or
  - a mistake as to the law; or
- in the case of **an interim** assessment, there has been a change in the degree of disablement due to service since the assessment was made.

61304 *Paragraph 61303* also applies to SoS assessment decisions made on or after 9 April 2001 apart from the fact that the phrase 'in the case of an interim assessment' as in the second bullet point has been omitted in the amended legislation. This means that for SoS assessment decisions made on or after 9 April 2001, **both final and interim** assessments can be revised to the detriment of the pensioner where there has been a change of circumstances leading to an improvement in the degree of disablement due to service since the assessment was made.

61305 For PAT assessment decisions made before 9 April 2001, there is **no** provision to reduce a final assessment. There is provision to reduce a PAT interim assessment where the decision was made before 9 April 2001 but **only** if it is appropriate to finalise the reduced assessment. If the assessment cannot be made final, the PAT interim assessment cannot be reduced even if there is evidence of an improvement in the degree of disablement.

61306 For PAT assessment decisions made on or after 9 April 2001, the new paragraph Article 67(2A) applies. This allows the SoS to review and vary any assessment decision made, given or upheld by the PAT at any time, if he is satisfied that there has been a relevant change of circumstances since the assessment was made. In other words, where there is evidence of an improvement in the disablement, it is possible to certify an appropriate reduced assessment irrespective of whether the existing PAT assessment decision is final or interim.

61307 The following table summarises the situation in respect of reducing assessments where the reduction is due to a change in circumstances leading to an improvement in the degree of disablement:

(61307) **SUMMARY OF ACTIONS WHEN CONSIDERING A REDUCTION IN ASSESSMENT WHERE THERE IS A CHANGE OF CIRCUMSTANCES LEADING TO AN IMPROVEMENT IN THE DEGREE OF DISABLEMENT**

		REDUCE	
		yes	no
Type of assessment decision	SoS Final made before 9 April 2001		✓
	SoS Final made on or after 9 April 2001	✓	
	SoS Interim made any time	✓	
	PAT Final made before 9 April 2001		✓
	PAT Interim made before 9 April 2001	if the reduced assessment can be made final	if the reduced assessment remains interim
	PAT Final or Interim made on or after 9 April 2001	✓	

61308 Where a revised assessment is of detriment to the pensioner, the SoS retains the discretionary provision that allows him to maintain an award where otherwise he would reduce it.

61309 In order to assist the SoS, an explanation by the MA is needed to clarify the reason(s) for the reduction in the certified (composite) assessment. To facilitate this, form WPA1096 must be completed in all cases where certification results in a reduced (composite) assessment upon which an award will be based.

61310 If an individual assessment which forms part of a composite assessment is reduced, but the composite assessment remains the same, there is no need to complete form WPA1069. However, it is good practice always to explain why an individual assessment has been reduced when giving the reasons for decision.

61311 There is no need to complete form WPA1069 if the reduction is in respect of a NISHL case where there is a true reduced assessment but the previous assessment is maintained on an advisory basis (i.e. green certificate cases).

61312 Form WPA1069 is addressed to the appropriate EO whose function is to act for the SoS in these matters. The MA is asked to enter the date of the certificate in question, to complete the relevant tick box(es) and to provide a brief explanation. When MA actions are complete, the file must be charged back to the EO. An amended form WPA1069 is shown at *Appendix nine*.

61313 The first tick box covers mistakes as to the law and material facts or ignorance of material facts. For example, a mistake as to the law may have occurred if a 7.1.93 NISHL case has been handled under pre 7.1.93 legislation, or vice versa. An example of a mistake as to material fact could be a straightforward arithmetical error when calculating an assessment in a hearing case.

61314 The remaining tick boxes are self explanatory. The last box is to cover any other situation, for example a reduction in assessment because of extinguished disablement.

61315 It is important to bear in mind that the assessment cannot be judged unreasonable merely because you disagree with the previous doctor's decision. A medical opinion is not a medical fact.

61316 You must remember that:

- a CLR assessment is an interim assessment and any revision to the detriment of the pensioner must comply with Article 67 and form WPA1069 must be completed in all cases where that assessment is reduced;
- PAT assessments will often cover a specified period when they are interim. Sometimes there is no formal reassessment at the end of the specified period and the assessment determined by PAT continues. Even if the period has expired, the assessment determined by the PAT remains to be considered as a PAT interim assessment and the same principles apply when considering a subsequent review;
- if you are reducing an assessment, discuss with your ECW.

61317-61399

Individual and composite assessments

61400 With certain exceptions, only the composite assessment is notified and the appeal rights lie against the composite assessment and not assessments of individual ADs. However, from time to time a pensioner may request details of the assessments of individual ADs. In such cases, breakdown of the assessments of individual ADs should be given to the pensioner.

61401-61499

Greater disablement (GD)

61500 The 1972 letter from the Department to the PAT President made it clear that application of GD should be exceptional. For greater disablement to apply:-

- there must be an AD and a non-AD,
- AD and non-AD must interact,
- the direction of the interaction must be to worsen the NON-AD and increase the overall disablement (ie the interaction of the AD and non-AD leaves the pensioner significantly more disabled than would the effects of the two conditions taken separately).

61501 When applying GD the percentage assessments of disablement arising from both the AD and non-AD should be decided and a figure for the overall disablement. If the situation is as described above, the following formula may be used:-

(61501) GD = TOTAL DISABLEMENT - (AD + NON-AD)

eg AD = 60% NON-AD = 20% TOTAL DISABLEMENT = 100%

GD = 100 - (60 + 20) = 20%

COMBINED ASSESSMENT = AD + GD = 60 + 20 = 80%

61502 ADs and non-ADs may interact in such a way that there is an overlap of disablement or the effects of the AD have been extinguished by the non-AD. In these circumstances, Greater Disablement is not appropriate and should not be applied.

61503-61599

Limitation of Aggravation

61600 Aggravation, "agg", means that service was not the cause of an injury or disease. It implies that the condition was or would have been present even if the man had not served, but that service made it worse. Therefore when considering limitation we have to decide whether or not service has been responsible for the man's present condition in its entirety or only for a proportion of it, and if a proportion, how much.

61601 We must identify the extent of the aggravation and restrict the award to that amount, bearing in mind that at the termination of service we do recompense the full disablement ie disablement due to the aggravation by service and the disablement not due to any service factor.

61602 There are two basic categories of "agg" conditions

1. those that were manifest before service
2. those that manifest themselves during service.

61603 This second category includes

- conditions of a genetic or constitutional nature eg flat feet
- conditions where some service factor resulted in a delay of diagnosis or when a man is returned to full physical activity after a non-accepted accident and suffers deterioration due to a service activity.

61604 At the time of termination of service the assessment of "Agg" cases is determined by Article 9(2)(b)(i) of the SPO 1983. This states we assess the total disablement existing at the date of termination ie disablement present before service, disablement due to service aggravation and any disablement due to natural worsening which may have occurred during service.

61605 On reviewing the case after termination of service we are bound by Article 9(2)(b)(ii). We must first decide whether or not aggravation by service still remains. If the man is considered to be no worse at this point than he would have been if he had not served it is considered that "agg no longer remains" ie APA. If service aggravation is still present it must be decided whether service is responsible for the present condition in its entirety or for only a proportion of it. If it is responsible for only a proportion the assessment should be limited at that degree which is due to service aggravation.

61606 The process of limitation is often difficult in practice and we must have some basic principles to follow. A convenient method is to try to answer the following questions:

- What was the condition like before service?
- What did service do to the condition?
- What has happened to the condition since service?
- What is the condition like now?
- Under what Article was the initial entitlement decision taken?

61607 Several other questions and ideas help to clarify the situation.

- Is the pre-service history precise or vague eg "ear trouble as a child" or "recurrent bilateral otitis media from the age of 6 to 16".
- Is there evidence in the entry medical documents of disablement before service eg hearing loss, perforations etc.
- Were there exacerbations in service, if so, frequency and duration.
- Were surgical procedures carried out and if so was the condition improved.
- Was the condition at release different to that at entry.
- Does the post service history of the condition show improvement, worsening or no change? If worsening, when did it occur? Did the post-service occupation or any other post-service factor play a role?
- Is the condition one which will worsen naturally like bronchitis, or run a course of remissions and exacerbations like psoriasis?

61608 It is usually easier to make a decision where there is a pre-service history than when the condition develops during service.

61609 Once deterioration is accepted following release from service it is very difficult to limit the assessment, subsequently.

Review of Assessment

61610 Policy and legal advice has been received in respect of the correct lawful approach to the review of assessment in War Pensions cases where there are:

1 existing accepted disablements and a deterioration claim is lodged in respect of only one of these

2 existing accepted disablements and a claim is made for a further disablement.

61611 The advice is that review of an assessment decision means review of all its components. It is not lawful to restrict the review to the triggering condition.

61612 Further advice is that there is no need to go into each individual existing accepted condition from first principles and in minute detail.

61613 It is appropriate that MAs "cast an eye" and use medical judgement to decide in which of the components there might be a change in the degree of disablement. Where such a judgement is made, appropriate evidence should be obtained.

61614 You must have this advice in mind when requesting evidence at the first MA submission stage. In practical terms, we should not need additional pieces of evidence in that many cases. More than often, the commonly requested War Pensions Medical Examination and/or GP report should provide the necessary evidence for all the accepted disablements. In certifying, we should not record "AD1, AD2 etc not reviewed."

61615 The same principles apply where there are existing accepted disablements and a claim for further disablement made.

61616-61699

Assessment appeal advice

61700 The WPA363 certificate has a box for the provision of assessment appeal advice. It is important to give the correct advice as the administrative staff rely heavily upon this during the appeals process.

61701 The following is a summary of the procedures which should be followed:

Assessment appeal advice box - NON NISHL cases

61702 **An OMD is required if any of the following apply:**

- Greater Disablement
- Paired organs/limbs
- Limitation of aggravation
- Finality (other than in a "new rules" NISHL case)
- Reduced assessment
- Multiple periods under appeal
- Medically complex cases, eg where there are closely related ADs and non ADs and we need to explain how the disablement has been apportioned.

EXAMPLE

A War Pensioner is severely psychiatrically disabled, and overall, would merit 80%. However, we have rejected Personality Disorder, which accounts for most of his psychiatric disablement and accepted PTSD, attrib 6-14%.

We would need to explain to the appellant and the PAT how we arrived at the assessment of 6-14% for PTSD. An OMD is required in this situation.

Assessment appeal advice box - NISHL cases

61703 **An OMD is required in the following situations:**

- All cases where the assessment is based on clinical findings at release, the pensioner's own statement or an ERA.

  NB: It is planned that standard paragraphs will be prepared to enable the SoS reasons for decision to cover these cases in the future.

- All cases where the NISHL assessment forms part of a composite assessment.
- Finality in an old legislation case.
- All cases where disablement arising from other hearing injurious processes such as otitis media and otosclerosis needs to be dissociated from the NISHL assessment under appeal.
- Any complexity which requires an explanation, eg, an assessment which has been reduced because of new evidence or previous error.

61704 **An OMD is not required if:**

- None of the above criteria applies

  AND

- The NISHL assessment under appeal is based on an audiogram
- As above, where there has been further deterioration due to presbyacusis or post service noise (ie, we are not taking all current sensorineural hearing loss).

61705-61799

All cases

61800 If you are still in doubt as to whether an OMD is required in a particular case, imagine that you are sitting on a PAT. You have in front of you the documents on which the assessment is based. As a PAT member, would you be able to arrive at the same assessment easily? If the answer is no, and an explanation would be needed, then an OMD is required.

MA advice required box

61801 You may need to indicate that MA advice will be required at the appeals stage. It is appropriate to tick this box in the following circumstances:

- **When further evidence may be required in the event of an appeal.**

(61801) **EXAMPLE**

When making the decision on a claim, you may be aware that treatment for the AD is anticipated and that it is likely that HCNs, X-rays, etc, may be available by the time an appeal is made, eg: When cases are being stockpiled.

This could be relevant when we are awaiting legal, policy or medical guidance which would have a bearing on the processing of appeals. You will normally be given advice on how to proceed, if this situation occurs.

61802-69999

Contents

Supplementary Allowances

General information

70000 The Supplementary Allowances include

- War Pensioner's Mobility Supplement (WPMS)
- Constant Attendance Allowance (CAA)
- Unemployability Supplement (UNSUPP)
- Allowance for Lowered Standard of Occupation (ALSO)
- Clothing Allowance

70001 In deafness cases, for the purposes of entitlement to Supplementary Allowances claimed before 22 10 96 it is the assessment which is used for payment purposes which is relevant (eg true assessment 30%, award remains in payment at 40%, the 40% rate is used for the purpose of determining entitlement to supplementary allowances)

70002 The Ministerial promise is that no pension should be reduced or taken away if the claim to a pension (and this includes claims for supplementary allowances) was made before 22.10 96. However, any claim for a supplementary allowance on a case which involves NISHL made on or after 22.10.96, must be determined on the basis of the "true" assessment

70003-70019

War Pensioner's Mobility Supplement

70020 This is a cash payment for War Pensioners whose Accepted Disablement (AD) restricts their mobility significantly. There is also a private scheme called Motability which allows them to put this cash towards buying or leasing a car

70021 The combined assessment must be at least 40% before WPMS can be considered This includes any addition for Greater Disablement (GD) or Paired Organs

Note: Prior to 7 April 1997, WPMS could be considered once the combined assessment had reached 20%, though it was uncommon for the allowance to be advised at this assessment

70022 The Accepted Disablement must be "wholly or mainly responsible" for the walking difficulty This has been interpreted legally to mean that the Accepted Disablement must account for at least 50% of the restricted mobility for the pensioner to qualify Any disablement which has been included in respect of GD/Paired Organs should be taken into account when advising eligibility for WPMS.

70023 The restricted mobility must be considered to be likely to last for at least 6 months

70024 Certain pensioners with the following AD are automatically entitled to WPMS:

- double lower limb amputees at the level of the ankle or above
- both at least 80% deaf and over 80% blind and where the pensioner requires the assistance of another person in order to arrive at a destination

Note This means that the certified assessments must be 80% or more for deafness and 90% or 100% for blindness

70025 Eligibility for WPMS for other war pensioners depends on the AD being wholly or mainly responsible for

- rendering him unable to walk, or
- restricting leg movements to such an extent that his ability to walk without severe discomfort is of little or no practical use to him or
- restricting by physical pain or breathlessness his ability to walk to such an extent that it is of little or no practical use to him, or
- rendering the exertion required to walk a danger to his life or a likely cause of serious deterioration in his health

70026 The decision on a WPMS claim is a lay decision. Since 26 October 1992, this has often been based upon self report by the pensioner, with an attached short report by their usual medical attendant. The pensioner has the option to request a medical examination In cases of difficulty, the lay officer will ask for medical advice This means that cases submitted to MAs are often complex If in doubt, do not hesitate to seek advice

70027 We must consider the distance that the pensioner can walk, the speed, the length of time taken, the manner of walking, balance, whether guidance is required, and whether any walking aids are used.

Note. A normal, healthy person should be able to walk 100 yards (90 metres) in 1 minute.

70028 If he is not able to walk using both feet or artificial legs, eg swinging through crutches or is a lower limb amputee unable to wear his prosthesis, then he is not able to walk

70029 If we advise that WPMS is appropriate, we usually advise that it is merited UFI. However, there are circumstances where we may advise that the award is merited for a specific time period, eg, 1 or 2 years if we think that improvement may occur, if operative treatment is planned, for example

Note The Motability Scheme comes into play when WPMS is merited for at least three years.

Intermediate Rate CAA

70352 Attendance is required most of the daytime and at least twice at night

or

Attendance is required during part of the daytime and frequently at night

Exceptional Rate CAA

70353 The pensioner is completely, or almost completely, helpless

Attendance is required constantly day and night

or

The pensioner is terminally ill, and the AD is the cause of the terminal illness.

Note The Social Security Act 1990 introduced special provisions for the terminally ill in respect of Attendance Allowance ("Special Rules" cases) and these provisions also apply to CAA. "Terminally ill" in this context means a life expectancy of 6 months or less. Such cases are usually walked in and should be dealt with immediately. There is a proforma for completion which will be found in the left hand side of the file. You will be asked to confirm that the terminal illness is due to the Accepted Condition.

70354 When disablement due to service and disablement which is not due to service both contribute to the need for attendance, the following applies

70355 If the Accepted Disablement is the main factor in the overall need for attendance CAA can be awarded at the rate appropriate to the overall need If the AD is not the main factor in the overall need, CAA can be awarded at a lower rate if the AD is the main factor at that lower rate

70356 CAA rates for certain specified conditions are recommended and are shown in Section B of this chapter. These conditions include blindness, renal failure, paraplegia, quadriplegia, severe respiratory disablement, severe mental illness and loss of more than one limb.

70357 As with WPMS, the decision on CAA is a lay decision based on self report by the pensioner with a short report by the usual medical attendant The pensioner may opt for a medical examination. Medical examinations are normally domiciliary The lay officer will ask for medical advice in the more complex cases

70358 When a pensioner who has been in receipt of CAA dies, his widow is automatically entitled to a war widow's pension This should be borne in mind when you are giving CAA advice, as incorrect advice will have long term repercussions

70359-70399

Unemployability Supplement

70400 This allowance is awarded to a pensioner whose AD prevents him working The criteria for awarding UNSUPP are as follows:

- The combined assessment, including GD or Paired Organs, must be 60% or more (20% prior to 7/4/97)
- The pensioner must be unemployable for a prolonged period (generally a minimum of 2 years)
- The AD must be a serious factor in his unemployability
- Awards are restricted to pensioners aged less than 65 at the date of claim (from 7/4/97)

Note. For claims made before 7/4/97, if the pensioner was over retiring age (65 for men, 60 for women) at date of claim for UNSUPP, to qualify, he or she should have been unemployable on the "relevant day" The "relevant day" is the day before the 65th or 60th birthday respectively, or on the day after the final day when he (she) received earnings

70401 In UNSUPP cases, we need to decide firstly whether the pensioner is (or was) unfit to work on the appropriate date If he is unfit, is he merely unfit to do his normal job or is he unfit for any remunerative employment. If unfit to do his normal job, what alternative employment can he follow. In all cases, is the AD a serious factor in his unemployability

70402 Bear in mind that a pensioner may be in receipt of IB (or IVB in the past) but may not qualify for UNSUPP IB decisions are made by a lay DSS adjudication officer on a "points" basis Minor disabilities can quickly add up to qualify for IB If in doubt, obtain a copy of the IB medical report. It may be entirely appropriate to reject UNSUPP when the pensioner is in receipt of IB In these circumstances, it is important to give clear reasons for your decision, based on reliable evidence.

70403 Where ADs and non ADs both contribute to restriction in working ability, a number of situations may arise

- The AD is the sole cause of the unemployability
  UNSUPP should be awarded
- The AD is only a trivial factor in the unemployability
  UNSUPP should be rejected.
- When there is accepted and non-accepted disablement and the pensioner would be unemployable, even if the Non AD was not present
  UNSUPP should be awarded
- If the AD and Non AD together make the pensioner unemployable, but the Non AD on its own would not be sufficient to do so
  UNSUPP should be awarded

70404-70449

70030 We may advise WPMS on the evidence already on file. However, if necessary, evidence may be obtained, for example, a War Pensions examination report with the addition of a WPA332, a GP report or HCNs. A posthumous GP report may be obtained on form WPA902. In very rare cases, it may be necessary to obtain a Specialist report.

70031-70099

Adaptations

70100 WPA may provide financial help towards the cost of adapting cars for use by War Pensioners. The pensioner must satisfy all the following criteria:

- be in receipt of WPMS, and
- buy or hire a car through the Motability scheme, and
- be unable to use a non-adapted car either as a driver or as a passenger. This restriction does not have to be due to the AD(s).

70101 The MA will usually be asked the following question:

"Taking into account the overall condition of the pensioner (ADs and non-ADs), are the following adaptations medically essential?"

70102 In answering this question, it is helpful to construct a mental picture of the pensioner, using the evidence on file. Application of medical knowledge and common sense is then required. It may be necessary occasionally to ask the administrative officer to enquire of the pensioner exactly why a particular adaptation has been requested

70103 If the pensioner himself is not the driver, adaptations to enable another person, eg his wife, to drive the vehicle cannot be approved. You may be alerted to this type of situation if adaptations are requested, and it is perfectly plain that the pensioner is incapable of driving. In such a case, ask the administrative staff to make further enquiries.

70104-70199

Fitness to Drive

70200 ***Instructions will be included as soon as possible.***

70201-70299

Constant Attendance Allowance

70300 A War Pensioner with a combined assessment of 80% or more may be considered for this allowance. The assessment may include GD or Paired Organs

70301 He must be so severely handicapped, mainly by the AD, that he has to depend to a greater or lesser extent on the attendance of another person or for supervision The attendance must not be solely of a domestic nature, such as housekeeping, shopping etc, but must involve assistance with bodily needs such as dressing, undressing, help in or out of bed, washing or bathing, and toileting.

70302 Supervision must be required to prevent danger to the pensioner or others It must be a danger which is likely to occur, rather than a remote possibility, and the pensioner must be unable to avoid that danger.

70303 The degree of attendance/supervision required, rather the amount that is already being given is the important criterion.

70304 Three conditions must be met for CAA:

1. The AD must be assessed at 80% or more (with or without GD)
2. Constant Attendance from another person must be necessary
3. The need for attendance must be wholly or mainly due to the AD

70305 There are 4 rates of CAA:

- Part day rate
- Full day rate
- Intermediate rate
- Exceptional rate

Note: When the need is for supervision, rather than for attendance for bodily needs, the same 4 rates still apply.

70306-70349

Part Day Rate CAA

70350 Attendance must be required at certain predictable times of the day for routine attendance but the pensioner is capable of being left for other periods. Attendance should be required for 4-8 hours daily, ie, at least one quarter and not more than half of the daytime.

Full Day Rate CAA

70351 Attendance is required for between half and all of the daytime (8-16 hours)

or

Minimal attendance is required during the day (less than 8 hours) but is required at least twice every night.

What evidence do we need when considering UNSUPP?

70450 There may be sufficient evidence on file such as War Pensions Medical Examination reports, HCNs, consultant reports, GP reports and NI records, IVB or IB medical reports.

70451 If not on file, we may need to obtain one or more of the above.

70452 If the War Pensioner is under retirement age, we may obtain an UNSUPP/ALSO report (WPA333) asking the examining doctor

1 to record the relevant clinical findings

AND

2 whether he considers that:

- the pensioner is capable of following his regular occupation

OR, if not,

- whether the pensioner is fit for any other employment and, if so, its nature eg light, sedentary etc
- whether the pensioner is unemployable

3 whether any restriction in employment is due mainly to the AD or non ADs

4 whether any restriction in employment will last for the next 2 years.

70453 Retrospective consideration of UNSUPP, where the pensioner is already past retiring age, may be difficult. NI records may be helpful and show he was on Sickness, Invalidity or Incapacity Benefit for a while before the "relevant day". Generally, NI records should be regarded as a reasonable assessment of his employability. There are occasions, however where the NI records show no SB, IVB or IB has been claimed. This may happen if the man took early retirement or sometimes, in psychiatric cases. If you cannot make a decision in such a case, one option is to write to the GP and ask him the type of questions detailed at part 3 above, in relation to the day before the pensioner's normal retiring date. It is wise to explain to the GP why this information is required.

70454 The widow of a pensioner in receipt of payment of UNSUPP and assessed at 80% or more at the time of death will automatically receive a War Widows' Pension (WWP). An award can be made when the death of the pensioner occurred at any time before, on or after 7/4/97. If death occurred prior to 1/4/97 and the criteria for an award are satisfied, payment of WWP will not commence until 7/4/97.

70455 There will be automatic entitlement to funeral expenses if the pensioner was in receipt of UNSUPP and assessed at 80% or more at the time of death An award can be made only when the pensioner's death occurred on or after 7/4/97

70456-70499

Allowance for Lowered Standard of Occupation (ALSO)

70500 This is an allowance payable to a pensioner whose AD renders him incapable, and likely to remain permanently incapable of following his regular occupation or one of equivalent earning power.

70501 If you are asked to advise on a case where there is a prospect that the AD is potentially remediable, eg if surgery is planned, give your advice based on the current state of the AD If an improvement does occur in the future, for whatever reason, and the assessment is reviewed and revised, this will automatically trigger a lay initiated review of ALSO.

70502 The legislation indicates that the AD should be assessed at 40% or more, but less than 100%. The pensioned disablement, including GD or Paired Organs additions, should be mainly responsible for the loss of earning capacity.

Note: Prior to 7/4/97, ALSO could be paid at any assessment below 100% except when the period of award was TLTY or TMTY

The Regular Occupation

70503 ALSO was originally introduced at a time of conscription into the services However, post World War II and National Service, the situation changed to one where career service personnel were entering service directly from school or college and did not have a regular pre-service occupation. As a result, for those who served after 31. 7.73, the legislation was amended, identifying the material occupation as the regular service occupation. (See Article 21, SPO 1983).

70504 The legislation defines in detail what is meant by the "regular occupation" Where the pensioned disablement arose during service after 31/7/73, the regular occupation is "serviceman". If the AD arose before 1/8/73 and was aggravated by service after that date, then the regular occupation is "serviceman".

70505 If the AD was not worsened by service after 31/7/73, then the regular occupation will be the regular pre-service occupation. The administrative officer is responsible for identifying the regular occupation. However, they may ask you a specific question, eg, "Was the AD aggravated by service after 31/7/73?"

70506 Once the regular occupation has been established, the commonest question to be asked is whether the pensioned disablement prevents the pensioner from working in this occupation.

70507 In many cases, the type of work involved in the regular occupation will be obvious. Where it is not, we can ask the administrative officer to obtain a job description from the pensioner There is a standard form for these enquiries. However, it is rather simplistic, and in some cases, it may be advisable to formulate specific questions for the administrative officer to put directly to the pensioner.

70508 In addition, for cases where the regular occupation is the service occupation, ie, infantryman, gunner, or the like, the Agency holds a library of job descriptions supplied by the MOD. The administrative officer will obtain the relevant job description at your request.

70509 Another common question put to the MA is, given the man's disablements, what occupation would be suitable for him? It may be that advising "sedentary" or "light manual work" will suffice. However, sometimes, a more specific answer may be needed, and in this situation, medical common sense should be applied.

70510 In ALSO cases we may need to obtain an UNSUPP/ALSO report as in UNSUPP cases (WPA333).

70511-70599

Common Situations

70600 There are basically 3 main types of ALSO file:

- All service was between 3 September 1939 and 1 August 1973.

  The regular occupation is the pre-service occupation (unless the man was a student, unemployed or only a casual worker, in which case, the regular occupation is the service occupation). The regular (pre-service) occupation will be identified by the administrative staff.

  These cases will be referred to you with the following question:-

  eg Question:

  "Does the pensioned disablement (PD) prevent the man from following his pre-service occupation of shepherd?"

  A straightforward yes or no answer is required, and medical knowledge and common sense should be applied. It is advisable to give brief reasons for your answer.

- Service straddles 31 July 1973

  In these cases, the administrative staff need to decide if the regular occupation is the regular service occupation. However, you may be asked to provide medical input. These cases will be referred to you with the following question:-

  eg Question:

  "Was the PD caused or made worse by service after 31 July 1973?"

  Again, a yes or no answer is required, with reasons.

  The question of causation is not usually a problem. However, it may be difficult to decide whether service post 31 July 1973 worsened a particular condition. You should be able to construct a sensible medical argument to sustain your position. Factors which you should consider are.

  - Whether the man had any problems or consulted with the condition after 31 July 1973. If he did not, then this would favour the view that the condition was not worsened by service after 31 July 1973
  - The natural history and progress of the condition under consideration. It may be difficult to argue medically that a condition was not made worse by service after 31 July 1973
    Brief reasons for your advice should be given.

- All service after 31 July 1973.

  The regular occupation in these cases is the regular service occupation, ie the principal occupation during service - "electrician" rather than "soldier". This occupation will be specified by the administrative staff.

(70600) eg Question:

"Does the PD prevent the man from following his regular (service) occupation of electrician?"

Here we are being asked to advise on the effect of the PD at its present level on the permanent capacity to carry out the stipulated regular service occupation. In effect, what we are determining is whether a man who was an electrician in service can be an electrician in civilian life.

Some service occupations do not have a civilian counterpart. In such cases, an MOD job description will help to understand exactly what duties the man was expected to perform.

Brief reason for your advice should be given.

70601 The decision on ALSO is a lay decision. There are no appeal rights, but an unsuccessful claimant has the right to approach a War Pensions Committee (WPC). At this stage, the administrative staff will need an explanation of any medical advice which has been given. As mentioned above, when giving medical advice you should always justify it in writing. Policy has agreed that in cases which are finely balanced, that the benefit of the doubt should be given to the claimant

70602-70699

Clothing Allowance

70700 This allowance was introduced initially to compensate pensioners with a service related limb amputation for excessive wear and tear to their clothing. The legislation stipulates that a pension must be in payment.

70701 From 7/4/97, a standard rate of clothing allowance was introduced.

70702 Prior to 7/4/97, there were two rates:

1 Lower rate, where there was one artificial limb, other than a "tilting table" limb.

2 Higher rate, where there was more than one artificial limb, or a "tilting table" limb.

70703 Awards of Clothing Allowance may be UFI or non-UFI (12 months).

70704-70749

Amputees

70750 The legislation specifies that an amputee must wear an artificial limb regularly. However, this provision was heavily criticised and was dropped in 1949. The legislation was not amended, to encourage amputees to persevere with wearing their prostheses.

70751 For many years, arm amputees have been given automatic entitlement, but the position of leg amputees has been less clear. The old War Pensions Manual states that they qualify only if they walk with a prosthesis, or crutches. In practice, this does not appear to have been adhered to strictly, and advice from Policy Division to WPA (15/9/94) was given to the effect that amputees should automatically be awarded Clothing Allowance on production of a stump certificate, whether or not they wear a prosthesis.

Pensioners other than amputees

70752 The allowance also extends to pensioners other than amputees whose AD causes excessive wear and tear of clothing. This includes pensioners with leg calipers, splints, colostomies, spinal supports, urinals and trusses

70753 The allowance may also be awarded to pensioners whose AD itself, rather than an appliance results in excessive wear and tear to clothing, eg, incontinence.

70754 Where clothing allowance is claimed and the condition does not fall into one of the above mentioned categories, it may be necessary to have the pensioner examined (WPA357) in order to determine whether there is excessive wear and tear of clothing and if so, whether this is due to the AD.

Footwear

70755 Clothing Allowance may be claimed in respect of footwear. It may be necessary for the pensioner to be examined to determine the following.

- Is special footwear required because of the AD?
- Is there exceptional wear and tear to footwear directly as a result of the AD?
- What is the extent of the exceptional wear and tear?

70756 If you advise that special footwear is required, then the file should be referred to Treatment Group, who will arrange for its provision via the Disablement Services Centre (DSC). If special footwear is not required, but there is exceptional wear and tear, due to the AD, then Clothing Allowance may be merited. Exceptional wear and tear usually equates to the purchase of three pairs of shoes in 12 months, or sole and heel repairs every three months.

Alterations

70757 There is a provision for the cost of alterations to clothing to be met if the need for the alterations is due to the AD.

70758-70799

War Pensions Committees

70800 There are no statutory rights of appeal against the rejection of a claim for supplementary allowances (though unsuccessful claimants may ask for a review of the WPA decision, for example, if they think that the AD has deteriorated). War Pensioners have the right to approach a War Pensions Committee (WPC) if they are dissatisfied. The Committee may then make a recommendation to WPA in respect of the case.

70801 This should be scrutinised carefully, as the Committee may elicit information previously unknown to us which could lead to a different decision. However, it should be remembered that WPCs do not have the statutory power to overturn our decisions, and whatever information has been elicited by the Committee must be considered in conjunction with the evidence already held. If you maintain rejection following WPC involvement, you must give your reasons in full so that the administrative officer will be able to communicate the reasons for the Agency's decision to the WPC. This assists the WPC to discharge its obligation to discuss the Agency's decision with the pensioner.

70802 Prior to a WPC hearing, the administrative staff will submit the case to the MA to confirm that the original decision was appropriate. The next stage is the preparation of a Statement of Case (SOC). This SOC is very different from the SOC prepared for a statutory appeal, in that only the relevant and most basic facts are included. It has been agreed that when requested by our administrative colleagues, we will provide reasons for decision, which will be included in the SOC

70803-70849

Medical examinations

70850 Sometimes, you may need to request a War Pensions Medical Examination in order to come to a decision in respect of a supplementary allowance. A WPA851 should be completed in every case

70851 The relevant forms are:

- WPMS WPA332
- WPMS (posthumous) WPA902
- CAA WPA335
- CAA (posthumous) WPA384
- UNSUPP/ALSO WPA333
- Clothing WPA357

70852 Remember, on its return, the completed form is usually filed in the Awards file rather than the Supplementary Allowance file.

70852-79999

Contents

Treatment Allowances

Criteria

80000 Treatment must be for the AD

This will include treatment for the accepted part of an Agg condition, but not treatment for the natural progress of a limited Agg condition. It may also include treatment for a non-AD where GD has been given

80001 Treatment must be

- treatment as an inpatient in a hospital or similar institution,or
- a course of remedial treatment

80002 Treatment must cause interruption in the pensioner's normal employment and financial loss

80003 In practice, treatment allowances are not paid unless treatment lasts for more than 7 days.

80004-80049

Types of treatment allowance

80050 There are 4 types of treatment allowances:

1 Inpatient treatment allowances (IPTAs)

2. Outpatient treatment allowances (OPTAs)

3. Special treatment allowances (STAs)

4 Home treatment allowances (HTAs)

80051 If treatment allowance is awarded, then the pensioner's disablement pension is increased to 100% during the course of treatment

80052-80099

Inpatient treatment allowance

80100 Where a pensioner receives inpatient treatment for an AD, IPTAs are payable for the whole of the period of admission to hospital, if the AD was the main reason for admission.

80101 Where a pensioner is admitted to hospital with a non AD, and while in hospital receives treatment for the AD, IPTAs can be paid from the date the AD was treated, provided it can be advised that hospital admission would have been necessary for treatment of the AD A report can be obtained from the hospital on a WPA312 if clarification is required

Outpatient treatment allowance

80102 Treatment must be for the AD and must involve regular attendance at hospital. As a guideline, treatment should be for not less than 3 days per week. (Any less is considered not generally to be interfering with work). However lengthy treatment sessions twice per week might be considered for OPTAs.

80103 It should be a course of curative treatment On occasion, it can be difficult, with eg physiotherapy, to decide whether treatment is aimed at cure, but we would usually accept a course of treatment for up to 13 weeks as remedial.

80104 When we are initially asked to advise on OPTAs, and treatment has not been completed, we would advise OPTAs for an initial period, perhaps 4-8 weeks, depending upon the nature of the treatment We can then request further evidence on a WPA343

80105-80149

Special treatment allowances

80150 These may be applicable when a period of rest or recuperation is required prior to return to work following hospital treatment such as surgery. STAs are usually given for a period of 4 to 8 weeks but each case should be judged on its merits, bearing in mind the nature of the procedure performed.

80151 Sometimes, the pensioner may need a period of rest at home in preparation for treatment such as surgery STAs may be approved in these circumstances.

80152-80199

Home treatment allowances

80200 These are applicable when treatment at home for the AD prevents work. This is usually treatment arranged by the GP. In this context, rest can be a treatment

80201 Remember, it must be the **treatment** of the AD, and not the AD itself which prevents work If this is unclear, clarification may be sought from the GP using form WPA318. If it is clear that the AD itself prevents work, it may be appropriate to review the assessment, rather than continue to approve HTAs, which should be regarded as a short-term allowance. **NB this also applies to STAs.**

80202-80249

Hospital travelling expenses

80250 These are applicable to pensioners whose attendance at hospital for the AD is infrequent. This includes those who are attending outpatient clinics regarding the ADs from time to time, as well as those attending hospital for treatment such as physiotherapy, not more than twice per week

80251 HTEs normally exclude travelling expenses other than to hospital, eg to a GP's surgery. However, cases are increasingly seen where a hospital may hold clinics in surgery or other non-hospital premises and you are asked to make a decision Each case should be judged on its merits.

80252 If a pensioner claims HTEs to a private facility which he is attending as a matter of choice, WPA will pay expenses which equate to the cost of a journey to the nearest NHS hospital. However, if the pensioner has been sent to the private facility funded by the Health Authority, WPA will pay the cost of the whole journey.

80253 Approval for HTEs is normally given for no more than 2 years

80254-80299

Remedial treatment

80300 If the AD is a psychiatric condition and there is a medical need for a short period of psychiatric treatment arising wholly or mainly from that condition, we may be able to sanction "Remedial Treatment" in respect of that condition at one of the Ex Services Mental Welfare Society's (ESMWS) homes - Hollybush House, Ayrshire, Tyrwhitt House, Surrey and Audley Court, Shropshire This is normally granted up to a maximum of 6 weeks per year

80301 Each case must be considered individually. Medical approval should be given only where there is a medical need, ie, treatment of the kind provided by ESMWS is considered likely to be beneficial in managing or preventing a deterioration in the pensioner's condition. Approval is not normally given where there is a minor degree of service related psychiatric disablement. The Policy Statement states that special attention should be paid to an application where the degree of disablement is less than 30%.

80302 There is an agreement with the ESMWS that they will obtain a report from the pensioner's GP or Psychiatrist (if he is under active treatment) and submit the report to WPA, along with their request for the pensioner to be admitted. This is to ensure that the GP's or Psychiatrist's management of the case is not disrupted and they agree that the admission can go ahead. If the necessary reports have not been submitted, then the case should be returned to the administrative staff to contact ESMWS.

80303 Necessary travelling expenses may be paid, together with the expenses of an escort where required. The ESMWS may ask for approval to use one of their "Volunteer Drivers" who will transport the pensioner door to door by car. The administrative staff may ask you to advise whether this is necessary Medical common sense should be used and your decision should be based on the medical evidence.

80304 The pensioner will see the Society's psychiatrist during his stay. It has been agreed that a confidential report from the Society's psychiatrist will be forwarded to WPA on completion of the remedial treatment

80305-80349

Skilled nursing care

80350 The criteria for Skilled Nursing Care (formerly Permanent Maintenance) are as follows:

- Prolonged or permanent palliative treatment must be required from trained nursing staff in a nursing home or hospital, and
- The need must arise wholly or mainly from the AD.

80351 Nursing care which can be provided by auxiliary nurses or care assistants does not qualify the pensioner for Skilled Nursing Care. It must be skilled nursing care of the type that only a trained nurse can provide

80352 In order to consider this allowance, it may be necessary to obtain a medical report on form WPA358 asking:

- what regular nursing care is needed
- whether this care is of the type provided only by skilled and trained nursing staff
- whether the need is wholly or mainly related to the AD.

80353 You should complete a WPA851 in the usual way, requesting the supplementary forms WPA358(SNC) and WPA335(CAA). It is standard procedure to obtain a CAA report as well as the SNC report. Obtaining the CAA report provides more detailed information and is useful for advising the rate of CAA if we are asked and when there is a concurrent CAA claim

80354 As a general rule, a pensioner eligible for Skilled Nursing Care will merit CAA at Intermediate rate or more.

80355-80399

Chiropody

80400 Until 1996, WPA paid for chiropody for certain pensioners.

80401 Chiropody was automatically approved for the remaining foot in pensioners whose AD was a lower limb amputation.

80402 In other cases, chiropody was approved if the foot condition requiring chiropody was directly related to the AD.

80403 If the pensioner could not care for his own feet because his AD prevented him from doing so, eg AD of lumbar spondylosis prevented him bending down to reach his feet or the AD was an upper limb amputation, he was not eligible for chiropody at the War Pension Agency's expense. However, at various times, certain voluntary organisations, initially the British Red Cross and the Order of St John, then latterly BLESMA, agreed to meet the cost of chiropody in such cases

80404 From 1996, it was decided that the WPA should no longer accept new claims for chiropody in the UK, as responsibility for provision of this treatment rests with the NHS. However, responsibility has been retained for cases already in payment. Approval may be given in Overseas cases.

80405 When chiropody was accepted, it was usual to advise approval of the treatment up to once every 4 weeks However, if the chiropodist writes and explains that the pensioner requires treatment more frequently, we would generally approve an increased frequency of treatment

80406 The pensioner may request domiciliary chiropody, because he is housebound. Even if the main reason for his immobility is a non-AD, domiciliary chiropody may be approved, provided the need for chiropody is related to the AD, as explained above.

> Example: AD is hallux valgus which requires chiropody but the man has had a CVA which is unrelated to service and which renders him housebound.
>
> Domiciliary chiropody should be approved.

80407 It should not be necessary now to have the pensioner examined in chiropody cases and the facility for a specific chiropody examination no longer exists. In an exceptional circumstance, an examination may be obtained using the WPA851.

80408-80499

Convalescence

80500 A convalescent holiday may be approved for a pensioner whose AD prevents him from taking a holiday in a boarding house or hotel, accompanied by his usual carer. This could be because of the practical difficulties engendered by the AD, or because the AD renders the pensioner "socially unacceptable".

80501 This convalescent holiday can be taken at a suitable convalescent home, nursing home or hospital.

80502 If the attendant requires a rest from caring for the pensioner, convalescence may also be approved to give the carer a respite break, and the pensioner admitted to a convalescent home, nursing home or hospital.

80503 It is often possible to make the decision on convalescence using the evidence on file. However, if it is not clear whether convalescence is necessary, due to the AD, a report on form WPA334 should be obtained.

80504 Care should be taken when considering applications in respect of pensioners in receipt of CAA. Such pensioners will be significantly disabled, requiring assistance with personal care.

80505 Convalescence is normally awarded for a maximum of 4 weeks per year. This may be made UFI, if appropriate. If the pensioner has already taken a 4 week break, an extension of the period or a further period may be considered if the carer is ill or is admitted to hospital.

80506-80549

Priority treatment

80550 In 1953, the Government agreed that War Pensioners would be given priority for examination or treatment of their AD in NHS hospitals.

80551 Administrative staff issue the pensioner with a standard letter WPA 352 (*see appendix twenty three*) if he requests priority treatment. The letter sets out the current provisions and is suitable for the pensioner to show to his GP or Consultant.

80552 There is no MA input required.

80552-80599

Spectacles

80600 Spectacles may be approved where an AD leads to reduced visual acuity. For example, if the AD is corneal abrasion (1942), attrib Nil, one would not generally approve spectacles. On the other hand, where there was reduced visual acuity because of an attributable traumatic cataract, we would approve spectacles, even when the main reason for their need was a refractive error

80601 Sometimes, you may be asked to approve special lenses If you are unclear as to why these are required, the Optician can be asked to provide an explanation.

80602 Special frames may be approved when required to conceal facial deformities due to the AD.

80603-80649

Dental treatment

80650 WPA may assist with the cost of dental treatment if the need for this treatment is related to the AD. Normally, the full cost of NHS treatment is reimbursed. Exceptionally, private treatment costs may be met when necessary treatment is not available on the NHS.

80651 Arm amputees are automatically entitled to dental treatment.

80652 In the past, pensioners with an AD of peptic ulcer were automatically allowed dental treatment at Departmental expense. However, medical opinion does not support a link between peptic ulcer and defective dentition.

80653 If a pensioner with an AD of peptic ulcer submits a first claim for dental treatment, our administrative colleagues should be advised that the claim should be rejected. If such a claim has been allowed previously, it is then up to our administrative colleagues to decide whether to allow the current claim.

80654 If the accepted condition is rheumatic fever, we will not normally pay for dental treatment but we will pay for the necessary antibiotic cover.

80655 In cases of difficulty, reports may be obtained from the Regional Dental Officer. Administrative staff will obtain the report on a standard form WPA323 You may need to advise the administrative staff of any special questions on a minute

80656-80699

Hearing aids

80700 From 1996, WPA ceased to fund the purchase of hearing aids in the UK.

80701 Pensioners overseas may apply for funding to purchase a hearing aid. The evidence should be scrutinised carefully to ascertain whether a hearing aid is necessary for service related hearing loss. In general, if the AD is progressive, eg, otitis media, approval is straight-forward.

80702 When advising in NISHL cases you must bear in mind that hearing loss due to noise is not progressive. You should determine whether the need for the hearing aid is wholly or mainly due to service related hearing loss. Factors to bear in mind are whether hearing was normal at release and whether the need for the hearing aid arose many years after service had ended. In such a case, the need for the hearing aid is most likely due to the normal ageing process. Scrutiny of the Awards File will generally provide the evidence for the decision

80703 Sometimes, in old cases, the accepted hearing loss may be due to blast, but this has not been recognised in the label. In such cases, it may be necessary to return the file to the end to end team for clarification of the entitlement

80704 Hearing aids are normally approved for Overseas FEPOWS with the label "bilateral sensorineural hearing loss". This label is used to recognise that in this group, noise is not the sole aetiological factor in their deafness.

80705-80749

Private treatment

UK

80750 Free medical treatment is generally available in the UK under the National Health Service (remember that war pensioners should get priority treatment).

80751 Where treatment for the AD is provided under the NHS, we would not sanction private treatment.

80752 Article 26(SPO) allows Secretary of State discretion to fund private treatment, aids, appliances etc only where not otherwise provided under UK legislation.

80753 It will therefore be only in wholly exceptional circumstances that WPA will agree to pay for private treatment. If you are asked to consider such a case, you will need to be sure that the administrative staff have indicated the correct channels for obtaining treatment to the pensioner. This is normally done using a series of letters, WPA354 and WPA354A

80754 If the pensioner persists, you may need to communicate with the GP using a standard letter, WPA356 This spells out the NHS responsibility for treatment

80755 It also asks the GP whether:

- he has recommended the treatment
- the treatment is for the AD
- the treatment is essential
- the treatment or suitable alternative is not available under NHS provisions, and if not, why not

(80755) • without the treatment there will be serious and permanent worsening of the AD

80756 It can be seen from the above that approval of private treatment for UK pensioners will be rare. However, the SOS has discretion which must remain unfettered in dealing with individual cases each of which must be handled on its own merits. It is not intended that War Pensions funding be used where the reason for failure of NHS treatment delivery is financial.

80757-80799

Overseas

80800 As there is no NHS overseas, private treatment for the AD may be sanctioned for pensioners living abroad. This may include surgery, dental treatment, hearing aids, cost of drugs and appliances, etc

80801 Recurring treatments, for example physiotherapy, are normally approved as a discrete circumscribed course following the initial injury or during exacerbations.

80802 Once the initial course has been completed, the pensioner is expected to continue at home with exercises taught by the physiotherapist. Repeated courses should not be approved without review.

80803 Chiropractic treatment may be approved for a limited number of treatments. Ten treatments would be a reasonable number We can ask for a treatment plan to be submitted before approving.

80804-89999

Contents

Current Invalidings

Definition

90000 Discharge from service on medical grounds due to injury or illness is termed "invaliding".

Discharge paragraphs

90001 The relevant discharge paragraph of the King's or Queen's Regulations (Army and RAF) is usually noted on the invaliding boarding document. This may be helpful in older cases where it may not be clear if the member was actually invalided Details of these discharge paragraphs may be found in the Library (Library & Information Services - LIASE).

90002 The Royal Navy does not use discharge paragraphs Either the reason for discharge will be stated or the acronyms PUNS or PURMS will be used (Permanently Unfit Naval/Royal Marine Service).

90003 The term "Defect on Enlistment" has no special significance from the War Pension's point of view, other than indicating that the condition may have been present pre-service. It is seen only in Army cases and refers to the paragraph of the Queen's Regulations under which the member has been invalided.

90004-90049

Legislation

90050 Article 4(1) lays down the conditions which are to be satisfied, stating that disablement will be accepted as being due to service, providing that it is certified that the claimed disablement is due to an injury which is attributable to, or aggravated by, service.

90051 Article 4(2) applies to all Current Invaliding cases. This Article removes the onus on the claimant to prove the fulfilment of Article 4(1). The Secretary of State has to prove **beyond reasonable doubt** that the conditions of Article 4(1) are not satisfied

90052 Article 4(3) applies in addition to Article 4(2) when the invaliding condition was not noted at entry Article 4(3) provides that in such circumstances, there is a **compelling presumption** that the requirements of Article 4(1) are satisfied. There is no onus on the claimant.

90053 Article 4(4) applies to claims made in respect of Reserve or Auxiliary service. This Article removes the benefits of Articles 4(2) and 4(3) when the disablement is due to a disease, other than a disease caused or aggravated by an accident accepted by the Secretary of State. However, a certificate may be given if a reasonable doubt is raised by reliable evidence that the conditions of Article 4(1) are fulfilled.

90054-90099

Procedure

90100 When a member of the Armed Forces is invalided, their case is automatically referred to WPA for consideration. (Sometimes, this procedure breaks down - see below) It is important that these cases are dealt with promptly, and WPAMS has undertaken to give a "same day" service. In the majority of cases, it should be possible to make a decision using the service medical documents If a defensible decision cannot be made on the first submission to WPAMS, then further evidence must be sought in the usual way

Entitlement issues

90101 In CI cases, it is the MA who identifies the claims for consideration. All conditions giving rise to disablement at the invaliding board must be considered. In addition, the member may complete a Personal Statement which should accompany the invaliding board. He may also send in a Claim Form All conditions claimed must be answered in the usual way, in addition to the invaliding condition(s). It is not necessary to consider every condition mentioned in the service medical documents.

90102 It is important to follow a standard pattern of working, ie,

- identify and clarify the claim(s)
- select accurate labels
- note what is accepted (or not) by the SoS
- decide whether the condition is attributable to service
- decide whether the condition is aggravated by service.

90103 Despite the heavy onus of Article 4, it is possible that in some cases, you will decline to issue a certificate. If you are in doubt, discuss the case with your ECW or the Training Officer.

90104 Reasons should always be given in respect of your entitlement decisions.

90105-90129

Date of entry

90130 The date of attestation is the legal date of entry into service Problems may arise when a pre-service medical is performed, where no disablement is present, and a condition is subsequently identified at the initial medical It is important to realise that the member may commence training at some point between the pre-service and initial medicals. In such cases, it may be necessary to ask the administrative staff to make detailed enquiries to ascertain whether the member actually did any training or performed any military duties.

90131-90139

Assessment issues

90140 The disablement present at the time of invaliding must be assessed This assessment must reflect the disablement expected during the advised period of award (see below) Usually, the invaliding board is used. Other suitable up to date evidence may be present in the service medical documents. Sometimes, there is a considerable time lapse between the date of the invaliding board and the actual date of termination of service. It is important to check, to ensure that the evidence is not out of date If it is dated more than 3 months before the date of invaliding, you may need to obtain fresh evidence. eg, a WP medical examination, unless the invaliding condition is clearly very stable Remember, the assessment must be defensible.

90141-90159

Advice on time periods

Less than 20% assessments

90160 When entitlement and assessment have been certified following invaliding, the MA must advise a time period for the award It is important to get this advice correct, as the time period advised will determine the size of the gratuity which is paid In effect, you are using your medical knowledge to give a prognosis.

Temporary, less than a year (TLTY)

90161 TLTY is advised when you are **confident** that the disablement will cease to exist within a year of removal from service factors. When considering TLTY, look back at the history of the accepted condition, in particular the length of time for which it has been giving rise to symptoms and functional impairment. You should note the course of the condition - is it getting better or worse? What is the nature of the condition? Is it a trivial, self limiting condition of short duration, or is it a significant, well-established pathology?

90162 For example, a minor muscular problem, present for a few weeks only, and which is showing an improvement, is almost certain to resolve when the individual is removed from service. TLTY is appropriate in such a case.

90163 On the other hand, an internal derangement of the knee which has persisted for a couple of years, with several arthroscopies and unsuccessful courses of rehabilitation, is highly unlikely to resolve in the near future, if ever. TLTY is inappropriate in this case.

90164-90199

Temporary more than a year (TMTY)

90200 TMTY is advised when you are **confident** that the disablement will cease to exist within 2 years of removal from service factors. It is exceedingly difficult to predict this with any certainty, and for this reason, it is advisable to use TMTY very sparingly, if ever If you are considering advising TMTY, the same factors should be examined as for TLTY.

Indeterminate Duration (ID)

90201 ID is advised when it is considered that the assessment of the AD will not improve to the point where it is less than the current assessment.

90202 In a case where the condition may deteriorate in the future, the assessment will be an **INTERIM** assessment and will be considered suitable for Long Term Assessment, **LTA**. We will not review these cases routinely and it is up to the pensioner to approach WPA in the future, should his condition worsen.

90203 If the condition is stable and will never change, ID **FINAL** should be advised.

90204-90229

When to review (conditional list reviews)

90230 In the past, when either TLTY or TMTY was advised, the assessment was made final However, this caused problems if an assessment appeal was lodged at a later stage, as it was usually impossible to produce evidence to confirm that the original TLTY or TMTY advice was correct. To pre-empt this situation, it was decided that when TLTY was advised, a review should be carried out towards the end of the notional year, in practice at 9/12, to ensure that the disablement had resolved, and to confirm that the original TLTY advice was correct. Similarly, with TMTY, a review should be carried out at 24/12.

90231 If on review, the original advice is proved to be correct, then a NIL assessment should be certified for an attributable condition. If the entitlement is aggravated, then aggravation can be said to have passed away, and entitlement can be revoked.

90232-90249

Assessments of 20% and over

90250 If an assessment of 20% or above is certified in a current invaliding case, and the assessment remains at 20% or above at 12 months from the date of invaliding, then an MOD Retirement Pension will be payable to the individual for the rest of his life This should be borne in mind at the initial certification stage when advising on the time period for the award. If there is any reasonable prospect that the assessment is going to fall below 20% within 12 months, then review should be carried out towards the end of the year, in practice, at 9/12

90251 As with TLTY and TMTY, the nature of the condition and its history to date should be carefully considered

90252 For example, it would not be reasonable to review a young man rendered tetraplegic by a high cervical cord lesion at the 9 months stage. It is perfectly plain in such a case, using medical common sense, that he will never improve and in the present state of medical knowledge, he will be 100% disabled for life. **(Long Term Assessment - Interim LTA - should be advised in this case)**. A review at 9/12 will merely serve to confirm this assessment. There is no prospect of reducing it to below 20%.

Practical aspects

90253 In cases for review at 9 months (both < 20% and 20% plus), a file movement to WPAMS is saved if, at the initial certification stage, an WPA851 is completed in advance. Annotate the top of the form, in red, "CLR 9/12" and write "HOLD" across the front in pencil. The WPA851 should be left undated. (The date will be inserted by the AA when the review date is reached). Tag the WPA851 to the inside front cover of the Awards File (WPA947A).

90254 If you require any other evidence before carrying out the review, please indicate the evidence to be gathered on the reverse of the WPA361 as normal, making it clear that the evidence is to be gathered immediately prior to the nine month's review.

90255-90299

Post CLR action

90300 In an attributable condition, if the evidence shows no remaining disablement at the end of 9 months, the original assessment can be confirmed as TLTY FINAL from the date of invaliding.

90301 In the case of an aggravated condition, if there is no remaining disablement at the end of 9 months, then aggravation no longer remains. (Agg passed away - APA). This means that entitlement can no longer be certified and should be revoked. The EO should be minuted to this effect.

90302 If the evidence at review shows that the accepted disablement has improved (eg from 6-14% to 1-5%) then the lower assessment should be certified and ID INTERIM LTA advised.

90303 If the evidence shows that there has been no improvement in the accepted disablement, the original assessment should be made ID INTERIM LTA, eg, 6-14% TLTY 9/12 at invaliding would become 6-14% ID INTERIM LTA.

90304-90349

Belated article 4 cases

90350 These cases include White Paper Reviews (the date of the White Paper was 16/8/43), "PA-no claim" cases, Category C discharges, cases where the MOD have erred in not sending CI cases to WPA, etc. A brief account is given in the *War Pensions Eligibility and Entitlement Guide, Vol 1,* (available from LIAISE).

90351 If you certify entitlement now in a belated Article 4 case, the SoS must consider backdating and payment of arrears. In order to calculate the arrears, assessments will be needed from the appropriate date to the present. Some cases will be very simple, in that a gratuity only is involved. Others will be complex and may involve a stepped award over many years.

90352 The EO may well need to discuss the case with you, but it is important to remember that awarding is a SoS matter. It is the EO's responsibility to identify the date from which any award is payable, and they have specific instructions as to how to proceed. If you are in any doubt, ensure that the appropriate War Pensions Guide is consulted *(Eligibility and Entitlement Guide, Vol 1)* or seek advice from your ECW or Training Officer.

90353-99999

Contents

Amputation Cases

Measurement of amputation stumps

100000 Measurements are taken by using the shoemaker's instrument known as a size-stick. The **first** points of measurement are:-

- Upper arm - The tip of the acromion, with the stump hanging down by the side
- Forearm flexed - The tip of the olecranon, which is best found when the forearm or stump is to a right angle.
- Above knee - The tip of the great trochanter
- Below knee - Antero-medial edge of the upper articular surface of the tibia when the knee is flexed.

100001 The **second** point of measurement is, in all cases, the end of the bone as palpated through the skin or scar tissue. In a below-knee case this will be the end of the tibia and not the end of the fibula, and the measurement will be taken on the inner aspect of the stump and not, as in above-knee cases, on the outer aspect.

100002-100099

Loss of body weight of amputees and weight of artificial limbs at various levels

100100

Level of amputation	Percentage loss of total body weight	Weight of the average limb
Hind Quarter amputation	22-24%	5.4kg (12 lbs)
Disarticulation at the hip	18%	4.5-5.4kg (10-12 lbs)
Above knee amputation	14%	No 2 limb 2.9kg (6.5 lbs) Suction limb 3.2kg (7 lbs)
Below knee amputation	8-10%	No 8 limb 2.0-2.3kg (4.5-5 lbs) PTB limb 2.1-2.4kg (4.75-5.25 lbs)
Symes amputation	3-4%	1.8kg (4 lbs)

100101-100199

Amputation consequential disablements

100200 The "ultimate conclusions" of the 1954 Advisory Committee on Cardiovascular Disorders and Mortality Rates in Amputees (Rock Carling Committee) were:

> "Limb amputations and the subsequent wearing of a prosthesis do not, in time, produce effects on the body as a whole which may initiate, or aggravate, cardiovascular disorders to any significant extent".

100201 Discussions, investigations and research continued both in the Department and in other organisations and outside agencies and in 1979, following the Hrubec Ryder report on "Relationship between Amputation of an extremity and the subsequent development of Cardiovascular Disease", the Department agreed to accept that certain lower limb amputees have an increased risk of developing atherosclerotic circulatory disorders From the 15 February 1979 the Department has accepted that.

- Amputation of both lower limbs at or above the ankle, or
- Amputation of either lower limb above the knee, or
- Amputation of either lower limb below the knee with a stump length of 26 cm or less

may aggravate all atherosclerotic circulatory disorders (Entitlement of aggravation can be accepted, as the injurious process is one which predates service - being an "ever-present injurious process" - and so fulfils Articles 4 & 5 SPO 1983). This applies to all manifestations of atherosclerosis and as the aggravation is a continuing one the aggravation cannot be limited. In Widows claims the death should be regarded as (substantially) hastened by the amputation.

100202 *Notes*

1. Hypertension has not been shown to be influenced by lower limb amputations nor have the rheumatic disorders
2. Before 15 February 1979 certain amputees were given awards for cardiovascular conditions. This followed a report on 5 February 1968 by Dr Evan Bedford, an eminent Physician:

   "When a chronic state of heart failure or coronary insufficiency develops and persists for an appreciable period, for example a year or longer, severe enough to demand a restriction of physical activity and the greatest possible economy of effort, in an amputee whose essential locomotion necessary for ordinary existence is severely handicapped by amputation and its consequences, there must result an increased burden on the damaged heart insufficient to cause aggravation or hastening of the progress of the heart disease"

100203 This referred to the effect on the myocardium, not on the atherosclerosis, but from that date until 1979 claims from amputees for cardiovascular conditions were examined under the "Evan Bedford Dictum"

100204 Other conditions may be regarded as consequential to an amputation. The following list is neither exhaustive nor necessarily mandatory:-

(100204)

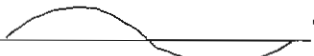
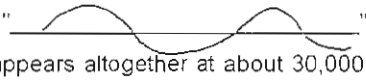
- Injuries:
  - When the artificial limb is quite properly not being used eg at bedtime.
  - Due to a "breakdown" of the artificial limb.
  - When wearing an artificial limb is a cause of an accident (providing the activity is a reasonable one).
  - If wearing an artificial limb prevents the pensioner avoiding an accident.
- Thrombosis of the stump.
- Ulceration or paralysis due to the necessary use of crutches.
- Flat foot or other orthopaedic disablement of the foot or leg when the other leg has been amputated above the knee
- Hernia if caused by strain (inguinal herniae due to strain are unusual in the below knee amputees and specialist opinion may be required).

100205-109999

Contents

Deafness and its investigations

The nature of sound

110000 Sound reaches the ear in the form of waves, which travel from their source at a speed of 760 miles per hour (340 metres per second) These waves cause an alternating increase and decrease of pressure, one full alternation "  " being called a cycle. The number of such cycles per second determines the frequency of the sound and the unit used is the **HERTZ** (Hz) The human ear is unable to perceive sound waves as sound until the number of these alternations of pressure reaches 20 per second or "20 Hz". If a note has one single frequency it is said to be a pure tone and produces a sine wave form "  " eg middle C on the piano is 256 Hz. The sensation of sound disappears altogether at about 30,000 Hz

110001 The intensity of sound gives the sensation of loudness. A tone which is only just audible is known as a threshold sound. The softest sound of human speech which we are normally able to hear is a whisper, and at a distance of 3 feet this is 1,000 times more powerful than threshold sound. Normal conversational voice is about 1 x 10^6 more powerful than threshold sound and a loud shout as much as 1 x 10^9. 1 thousand million Sound which produces discomfort is 1 billion times greater. So enormous is this range of power with which the ear has to deal that power ratios of tenfold have been introduced to express them and the unit is named after Alexander Graham Bell ie "BELS". Threshold is 0 Bels, whisper 3 Bels, conversational voice 6 Bels, shout 9 Bels, discomfort 12 Bels In order to measure differences with greater accuracy the "Bel" is split up into 10 smaller units known as "decibels". Thus. threshold 0 dB, whisper 30 dB, conversational voice 60 dB, shout 90 dB, painful sound 120 dB. One dB roughly equals the smallest perceptible change in loudness over the speech frequencies.

110002 The following shows noise levels which occur in certain situations (Note the gunfire levels)

- Quiet bedroom ..... 35 dB
- Phone ringing at 3 metres ..... 75 dB
- Jumbo Jet at take off from 300 metres ..... 100 dB
- Unsilenced motorcycle 60 cms from exhaust ..... 100 dB
- Riveting of large steel plate at 2 metres ..... 117 dB
- 12 bore shotgun at forward ear ..... 155 dB
- 0 38 calibre pistol ..... 157 dB
- Automatic gun ..... 174 dB
- Anti tank gun ..... 186 dB
- Field cannon ..... 188 dB
- 105 mm Howitzer ..... 190 dB

Anatomy of the human ear

110003 ***Appendix sixteen*** illustrates the 2 tympanic muscles, the tensor tympani attached to the neck of the malleus and the stapedius muscle attached by its tendon to the neck of the stapes. The stapedius is activated reflexly by sounds of intensities of about 90 dB in the normal ear, and increases the stiffness of the middle ear conducting apparatus thus attenuating such loud noises and providing some protection to the inner ear. The tensor tympani is activated reflexly in the "startle response" and will only contract to sound which is loud enough to "startle". This is at a higher sound level than the stapedius reflex. The cochlear anatomy is shown on ***Appendix seventeen*** and it is of note that the oval window with the footplate of the stapes seals the scala vestibula, and the round window with its membrane seals the scala tympani. These spaces are filled with extracellular fluid and joined at the apex of the cochlea. The sense organ of hearing is the "Organ of Corti" shown at ***Appendix eighteen***.

How sound is perceived

110004 When a sound wave enters the external meatus the tympanic membrane moves in response to the changes of pressure in a way determined by the frequency and intensity of the sound. This movement is transmitted to the scala vestibuli via the ossicles, and also to the scala tympani via the air in the middle ear cavity. There is a mechanical advantage of approximately 10:1 for the former, and this results in a displacement of the Organ of Corti and basilar membrane to and fro between the upper and lower perilymph galleries in the form of a travelling wave. This starts at the base of the cochlea and progresses towards the apex with increasing amplitude until it reaches an area of maximum displacement at a position determined by the frequency of the stimulating tone. Beyond this the wave is rapidly dissipated and disappears. For high frequencies the maximum displacement is confined to the base of the cochlea.

As the Organ of Corti moves, there occurs a sliding movement between the hairs of the hair cells and the tectorial membrane. This causes the hairs to be displaced in relation to the bodies of the hair cells and results in impulses being transmitted to the auditory nerve fibres and hence to the auditory cortex in the temporal lobes.

Effect of noise on the ear

110005 Short duration sound of sufficient intensity, eg an explosion, may damage all the structures of the ear giving an immediate severe and permanent loss of hearing. Moderate exposure may initially cause a temporary reduction in cochlear response to auditory stimulation, called a "temporary threshold shift" (TTS). This may or may not be associated with temporary tinnitus. Structural changes associated with TTs have not been fully established, but may include subtle intracellular changes in the hair cells, eg metabolic exhaustion, and swelling of the auditory nerve endings. If the source of noise is removed this temporary phenomenon may fully recover. However, if repeated exposure to noise continues, a permanent hearing loss results. The structural changes then seen are firstly a decrease in the hairs of the hair cells, then a loss of the hair cells themselves. Once destroyed these sensory cells are not replaced, and when a sufficient number are lost in one area, the nerve fibres to that area degenerate, and result in corresponding degeneration within the auditory cortex. NIHL is not progressive in the medical sense. and no further hearing loss occurs on removal from the noise stimulus, apart from normal ageing processes.

110006 The first audiometric sign of NIHL is usually a loss of sensitivity in the higher frequencies from 3000 to 6000 Hz. When we are considering Service noise exposure, about 60% of cases show this initial loss at 4000 Hz. This "notch" may be a sharp depression or a wide trough. The hearing loss is usually bilateral, but not unusually asymmetrical, especially with lateralised noise sources, such as rifles, when the ear closer to the muzzle of the gun shows the greater hearing loss, ie the left ear in a right handed shot. With additional hearing loss from noise or ageing, the threshold at 8000 Hz may worsen and eliminate the "notch" pattern, and subsequently the hearing loss extends to both the lower and higher frequencies. This occurs more rapidly in the early years, and after many years of exposure the high frequency loss levels off but continues to worsen in the lower frequencies.

110007 There is a remarkably broad range of individual differences in sensitivity to any given noise exposure. Thus, both TTS and PTS in response to a given intense noise may differ by as much as 30 to 50 dB from individual to individual. The biological basis of these differences is unknown Some possible influences are the characteristics of the ear canal and middle ear. Thus, any form of conductive hearing loss will protect the cochlear structures, and conversely loss of tympanic muscle function will increase susceptibility to noise.

110008 An important consequence of the hearing loss described, is difficulty in understanding speech. The range of frequencies covered by speech are from about 30 Hz to about 6000 Hz, but whereas a large proportion of the energy in speech is contained within the lower frequencies, much of the information required to differentiate one speech sound from another is contained within the higher frequencies, which are the first to be affected by noise. At ***Appendix nineteen*** the sounds used in English speech have been analysed and superimposed on an audiogram. It has been found experimentally that there is no loss of intelligibility if frequencies below 500 Hz are cut out, and little or nothing is lost by cutting out frequencies above 4000 Hz Other associated effects are recruitment of loudness and frequency distortion. Recruitment is a phenomenon whereby sounds above the threshold are heard more or less normally - we all know the nerve deaf person who says "speak up" and when we do tells us "not to shout!" Frequency distortions also reduce speech intelligibility.

110009-110099

Investigation of hearing loss

110100 The 3 main investigations routinely performed are audiometry, tympanometry and acoustic reflex testing.

110101 In audiometry the patient is tested with pure tones of known and controllable intensity and frequency. Normally earphones are used with high grade moving coil type telephones. The tones are generated by an electrical oscillator circuit capable of providing sine waves at a number of frequencies from which the operator selects one at a time for each threshold deliberation. The operator also controls the electrical output so selecting any desired output. Each tone lasts about 1 second

110102 This procedure is based on the performance of each subject The audiometrician must accept the subject's opinion on whether or not he/she can hear the tone. This is not always an easy decision for the subject as there is an intensity at and above which every test tone elicits a response and the tone is heard 100 per cent of the times it is applied. There is too a somewhat lower intensity at and below which no response is elicited. Between these levels there is a range of intensity where there is uncertainty whether the tone has been heard or not. However, using this method the threshold or lowest appreciable intensity throughout the range of normal hearing, 125 Hz to 6000 or 8000 Hz, may be found both for air conduction (conductive mechanism) and bone conduction (cochlear and retrocochlear function), and characteristic diagnostic patterns obtained. Unsuspected "island" losses may also be found, which could easily be missed by tuning-fork tests.

110103 It is important that the effects of ambient or background noise be remembered - a sterilizer bubbling quietly in the consulting room may decrease the low tone threshold by 20 dB and the traffic in a busy clinic may be heard through fairly adequate sound-proofing.

110104 When testing air conduction in which there is a difference of 40 dB between the good and bad ears, masking to the better ear should be.applied and should always be applied to the opposite ear when testing bone conduction. A safe method is to mask at the difference in threshold between the two ears, plus 15 dB.

110105 Most audiometricians start at 1000 Hz in the better ear reducing intensity by 10 dB steps to threshold then double checking up and down a few steps of 5 dB. This is repeated at 2000 Hz, 4000 Hz, 6000 Hz and then 500 Hz and 250 Hz. The limits of hearing in bone conduction at various frequencies are usually marked on the dial of the machine. The interpretation of the patterns produced is fairly universal. See ANNEX B.

- The presence of a space between the lines that indicate air and bone conduction (air-bone gap) shows conductive deafness. If this is predominantly in the lower tones (Fig 2 Annex B) fluid may be found in the middle ear; if more throughout the range, with a notch (Carhart) at 2000 Hz, ossicular dysfunction, for example otosclerosis, is indicated (Fig 3).
- The presence of no air-bone gap, in which case the lines are more or less superimposed, shows sensorineural loss, and again various patterns are recognised.
  - High tone fade indicates presbyacusis (Fig 4).
  - A sudden drop at 4000 Hz indicates noise trauma deafness (Fig 5).
  - Low tone loss suggests the possibility of Meniere's disease or acoustic neuroma (Fig 6)
  - A saucer-shaped curve with varying or unreliable results is suggestive of psychological or non-organic deafness (Fig 7).

110106 In tympanometry the acoustic compliance of the eardrum and ossicular chain under conditions of changing air pressure is measured. Compliance refers to the mobility of the drum and ossicles and is greatest when the air pressure in the external meatus is equal to that within the middle ear cavity The compliance diminishes as the pressure in the ear canal increases or decreases, thus causing the drumhead to be stretched

110107 The equipment used is an electroacoustic meter with an attached probe (see ***Appendix twenty***). The probe is inserted into the ear canal and a complete air pressure seal is obtained by using different sizes of sealing probe tips. The probe consists of a miniature loudspeaker and microphone and a tube through which air can be introduced to create positive and negative pressure in the ear canal. A pure tone is emitted from the loudspeaker at a constant sound level, and the energy from this tone, which is reflected by the eardrum, is picked up by the microphone The range of pressures tested is usually - 200 to + 200 mm H_2O The units of compliance used to plot the graph are "cubic Centimetres of a volume of air having an equivalent compliance to that of the eardrum". The meter works this out and produces a graph termed a "tympanogram". Different conditions in the middle ear produce characteristic changes in the graph thus obtained, see ***Appendix fifteen.***

110108 Acoustic reflex testing is carried out using the same equipment as that which is used to produce the tympanogram. A pure tone at a high sensation level, usually 70 dB and above, is produced by the probe and a change in the compliance is looked for. With this intensity of sound level, if the sensation reaches the auditory cortex, then the stapedial reflex occurs and the drum will be stiffened, lessening its compliance. Testing is performed at the air pressure level in the external canal that was found at tympanometry to result in the maximum compliance of the system. The intensity of sound is increased until a change of compliance is obtained and the "Acoustic Reflex Threshold (ART)" is the lowest hearing level at which a definite decrease in compliance is noted, and it usually lies about 90 dB (range 70-110 dB) above the subjective threshold

110109 ART is useful in identifying a non-organic hearing loss and because it depends on intact neural pathways, ie 8th and 7th cranial nerves, it is also helpful in indicating an acoustic neuroma.

110110 In cases of non-organic hearing loss the audiogram may indicate a loss at a particular frequency of say 80 dB, and the ART at that frequency is 85 dB. If there was a true loss of 80 dB, then the ART would be expected to occur at 150 dB or above, but because the maximum level of sound intensity level used in the test is 120 dB, the report would show "no result". An ART reading of 85 dB indicates that the true hearing loss is minimal (85 minus 70).

110111 In conductive hearing loss the ART may be increased or unobtainable, and is not in itself very helpful in diagnosis. In otosclerosis, particularly in the higher frequencies, the ART is usually absent. In ossicular discontinuity, although the reflex may occur, contraction of the stapedius will not result in a change in the compliance of the tympanic membrane, and the ART will be recorded as absent.

110112 If the readings of the audiogram are not repeatable during the test, or they are inconsistent with the ART results or clinical findings, **Evoked Response Audiometry (ERA)** will probably be suggested The ARTs alone are not accurate enough to be used for either entitlement or assessment purposes, they can only be used as an indicator of a non organic hearing loss ERA itself is not an absolute investigation, but is accurate enough for our purposes, and the results can be used for assessment of disablement.

110113-110199

Conditions causing hearing loss

110200 Note: ***Appendix twenty four*** for **normal** audiometry, tympanometry and ARTs

Conductive hearing loss

Otitis media

110201 Note: ***Appendices twenty five, twenty six, twenty seven and twenty eight.***

110202 The findings on the tympanogram will depend on the state of the tympanic membrane. Thus if there is a thin scar the tympanogram will show greater compliance than normal, but if the drum has healed with tympanosclerosis the tympanogram will indicate low compliance. If a perforation is present tympanometry shows a flat line at the top of the graph. ARTs may be present depending on the degree of hearing loss.

Otosclerosis

110203 Note: ***Appendix twenty two (fig 3), Appendix twenty nine and Appendix thirty.***

110204 The tympanic membrane appears normal (unless there has been previous otitis media). The audiogram shows a Carhart notch at 2 kHz and the tympanogram shows reduced compliance. ARTs may be present in the early stages and absent later on in the disease.

Ossicular discontinuity

110205 Note: ***Appendix thirty one***

110206 This is an uncommon condition and usually the history is of a sudden hearing loss following a head or ear injury. The tympanogram shows increased compliance and the ARTs are absent.

Eustachian tube dysfunction

110207 Note: ***Appendix thirty two***

110208 A history of symptoms referrable to the nose or sinuses may be obtained, the tympanic membrane may be retracted and fluid may be visible in the middle ear. The compliance is maximal at negative pressure.

110209-110299

Sensorineural Hearing Loss

Virus infection

110300 May cause sudden deafness at any age but rarely does so in adulthood. Again the history may be helpful Those viruses implicated include mumps, herpes zoster (chickenpox or shingles), infectious mononucleosis, polio, measles, adenoviruses and parainfluenza viruses.

Bacterial infection

110301 Brucellosis and Syphilis may also cause a sensorineural hearing loss. Meningitis is a well known cause In Syphilis the sudden deafness probably results from a vasculitis.

Vascular

110302 The history may be of a sudden unilateral hearing loss usually in the older age groups Atherosclerosis, hypertension, vasculitis and vasculopathy associated with hyperlipidaemia, diabetes, hypothyroidism and chronic renal failure are all possible causes

Acoustic neuroma

110303 Note. ***Appendix twenty two (fig 6) and Appendix thirty-four.***

110304 This is a rare condition, one estimate has given an incidence of 0.07% of all unilateral sensorineural hearing losses investigated in a clinical audiology unit It causes a gradually progressive usually unilateral hearing loss and is difficult to diagnose with certainty without the most up-to-date CT scanning tests. The ART can be of help as a screening test, but only when the decay of the reflex is being measured, that is the duration that the reflex lasts (The test carried out for us does not give this reading). It may be associated with tinnitus and unsteady gait. The ART levels may be elevated and ERA may show abnormal responses. The possibility of the condition will be suggested by the presence of a unilateral sensorineural deafness of gradual onset. or a bilateral loss where there is marked difference between one ear and the other.

110305 Indications for further investigation are the absence of another cause for the hearing loss, such as noise, or the presence of symptoms of loss of balance or other neurological symptoms or signs. For War Pension purposes, if an acoustic neuroma is suspected, a Specialist's report could be requested (after discussion with the ECW) The preferred approach, if the claim is clearly for rejection, is to reject R or L SNHL, on the basis that no service factor is involved in the aetiology, and send all the data to the claimant's GP explaining that acoustic neuroma has not been excluded and asking him to refer for further investigation. If an acoustic neuroma is eventually diagnosed, the label could be changed at a later date

110306-110349

Menieres syndrome

110350 Note: ***Appendix twenty two (fig 6).***

110351 The classical history is of attacks of vertigo with deafness and tinnitus It is on the basis of the history that the diagnosis is made, as there is no diagnostic test. Typically the audiogram in the early stages shows predominantly a low tone SNHL and later the loss spreads to all frequencies.

Notes

Congenital

110352 Both conductive and sensorineural hearing losses can be due to congenital causes. These are diagnosed on the history, as usually the hearing loss is severe enough to have been noticed during schooling, and on the audiogram which usually shows a bilateral symmetrical loss. Congenital conductive loss may occur in a number of genetic conditions such as Down's, Marfan's, Pierre Robin, and Apert's Syndromes. It may also occur with cleft palate, cystic fibrosis and osteogenesis imperfecta. Congenital sensorineural loss may be due to intrauterine infection, ototoxic drugs and various metabolic disorders.

Head Injury

110353 Blast Injury, due to explosion, can rupture the tympanic membrane, disrupt the ossicles or cause sensorineural loss. Being struck by lightning can also cause otic blast injury.

110354 Barotrauma may occur in divers and in people flying, particularly at high altitude Divers experience problems when ascending, due to relatively high middle ear pressure, and flyers when descending due to relatively low middle ear pressure. The result may be rupture of the ear drum, haemato-tympanum or rupture of the labarynthine window. In addition, divers may experience sensory loss due to decompression sickness.

110355 Perilymph fistula may result from head trauma, direct ear trauma, barotrauma, acoustic blast, nose blowing and straining It may also occur after ear surgery, particularly stapedectomy. The hearing loss may be associated with tinnitus and/or vestibular disturbance.

110356 Direct Trauma to the ear may cause a conductive loss, from damage to the tympanic membrane or from damage to the ossicular chain. In addition, if often causes a sensorineural loss between 2 and 6 KHz. The hearing loss is severe and sudden with bleeding from the ear and dizziness.

110357 To cause a sensorineural hearing loss the injury is usually of a severity to result in a fracture of the temporal bone, though not all such fractures are demonstrated radiologically. The head injury may result in ossicular disconnection, causing conductive deafness or may damage the vestibulocochlear nerve, causing a sensorineural loss with a 4 or 6 KHz notch similar to acoustic trauma. Severe head injury can also lead to brain stem damage and retrocochlear hearing loss.

Noise Induced Hearing Loss

110358 Note: **Appendix twenty two (fig 5)**

110359 This is really a diagnosis by exclusion. It is suggested by (a) a history of noise exposure (b) absence of any other cause and (c) the classical "ski slope audiogram" ie a notch between 3 and 6 KHz. This notch is not essential and with the onset of presbycusis or the continuation of noise damage the notch may be lost. If it is not present but the degree of hearing is greater than might be expected from presbycusis alone the audiogram can be adjusted for the effects of presbycusis by subtracting from each frequency band the median hearing loss due to age shown in the table at ***Appendix twenty one***. A graph connecting the new points may show the characteristic ski slope form.

Non Organic Hearing Loss

110360 Note: ***Appendix twenty two (fig 7) and Appendix thirty three.***

110361 Often attention is drawn to this by audiometrician/specialist It is suggested by the variable response on audiometry, audiometric findings of a degree of hearing loss in excess of the clinical findings, and ARTs which are incompatible with the degree of hearing loss shown by pure tone audiometry. The diagnosis may be confirmed by ERA.

110361-110499

Deafness - Entitlement and Assessment issues

110500 **This section should be read in conjunction with the War Pensions Policy Statement - Noise Induced Hearing Loss, which was issued to MAs in October 1999.**

Claims to noise induced hearing loss

110501 Noise induced sensorineural hearing loss (NISHL) may be causally associated with service if there is

- A history, due to service, of exposure to potentially harmful noise accepted by the Secretary of State, and
- The presence of sensorineural hearing loss in excess of that expected from presbyacusis and/ or of a type consistent with damage by noise.

110502 Assuming that these criteria are met, noise induced sensorineural hearing loss (service dates) may be accepted as attributable to service.

110503 Noise damages the cochlear hair cells of the inner ear, but when the causative noise is removed, no further loss of hair cells occurs, ie, the process is non-progressive. Once a person leaves service, any subsequent increase in hearing loss must be due to some factor(s) other than service noise. In effect, entitlement of attributability is given to a specific "episode" of cochlear hair cell damage, due to service, which is clearly indicated by including the dates of service in the label.

110504 The audiogram in these cases may show the classical noise trauma pattern of high tone loss, with a notch between 3 and 6 kHz. However, it is important to remember that with the addition of presbyacusis, or if noise damage continues, the notch may be lost. In many cases, the diagnosis is made by exclusion, and the observation that the hearing loss present is significantly (20 dB) greater than that which would be expected from age alone in a person who has been exposed to acoustic trauma.

110505 In some cases, the degree of hearing loss may be commensurate with presbyacusis, but a classical noise trauma pattern is present This raises a reasonable doubt that acoustic trauma has played a part in the aetiology, for War Pensions purposes.

110506 The label to be used when giving entitlement to service related noise induced hearing loss is:

"NOISE INDUCED SENSORINEURAL HEARING LOSS"

110507 This should be preceded by the word bilateral, right or left as appropriate, and followed by the service dates in brackets. Often there is more than one period of regular service, or regular and TA service. In these circumstances each period must be included for which exposure to injurious noise is accepted by the Secretary of State eg Bilateral Noise Induced Sensorineural Hearing Loss (1942-1946, 1948-1950, 1952-1958).

110508-110599

Entitlement issues

110600 The guiding principles in the determination of these claims are:

- each case must be dealt with on its own merits
- Medical Advisers must use their clinical judgement

110601 Noise induced sensorineural hearing loss is not always clinically detectable. A hearing deficit may not have been clinically apparent during service but a service related noise induced hearing loss may be present. In such circumstances the entitlement decision should reflect the damage caused by service factors, and the MA certifies (for example), Bilateral Noise Induced Sensorineural Hearing Loss (service dates), as attributable to service

110602 In cases where "BNISHL (service dates) attributable" has been accepted, and there is evidence of pre and/ or post service NISHL, our lawyers have advised that there is no need to formally reject Bilateral Sensorineural Hearing Loss (pre-service) and/or Bilateral Sensorineural Hearing Loss (post service). When referring to these entities, the term used should be "non-accepted conditions", **not** rejected conditions, as no formal rejection will have been notified to the claimant.

110603 If there is no evidence of a NISHL present, and all the hearing loss is due to another basic injurious process unconnected to service, we should reject both "NOISE INDUCED SENSORINEURAL HEARING LOSS (NOT FOUND)" and the other injurious process NANA. If the other injurious process is presbyacusis, "BILATERAL SENSORINEURAL HEARING LOSS" NANA should be rejected, in addition to NISHL (NOT FOUND). The NISHL should be preceded by the word bilateral, right or left as appropriate followed by the service dates in brackets

For example:

The claim is for "noise induced hearing loss", but the evidence shows that all the hearing disablement is due to otosclerosis There are no features of NISHL present.

REJECT: (1) BILATERAL NOISE INDUCED SENSORINEURAL HEARING LOSS (service dates) (NOT FOUND).

(2) OTOSCLEROSIS NANA.

In the uncommon cases where a NISHL is present but this is considered to be wholly due to a non-service factor, the same system should be adopted.

REJECT: (1) BILATERAL NOISE INDUCED SENSORINEURAL HEARING LOSS (SERVICE DATES) (NOT FOUND)

(2) BILATERAL SENSORINEURAL HEARING LOSS NANA.

110604-110649

110650 The non specific label of Bilateral Sensorineural Hearing Loss would cover the non service NISHL and other causes of sensorineural loss such as presbyacusis

110651 If such cases come to Appeal, then both labels will have to be defended.

110652 Remember that if a claim for "deafness" or "loss of hearing" is made, all the causes of hearing loss present must be identified, considered and answered where appropriate

110653-110699

Tinnitus

110700 Tinnitus, as well as hearing loss, is a symptom of cochlear hair cell damage This may be due to noise or other causative factors such as ageing. If a person has been significantly exposed to noise during his life, it is known that he will be more likely to suffer from tinnitus as he ages, when compared with a similar person without previous significant noise exposure. Therefore, if a pensioner has an accepted service NISHL, and subsequently develops tinnitus, even many years after service has ended, the tinnitus is part and parcel of his accepted condition. If tinnitus has been formally claimed, it must be formally accepted or rejected under the label of the basic injurious process causing it.

Loss of speech discrimination

110701 Loss of speech discrimination is a symptom of cochlear hair cell damage. Unless the evidence indicates that the man has been deaf since service, loss of speech discrimination will normally be part and parcel of the post service, non-accepted condition Bilateral Sensorineural Hearing Loss (post service).

Conductive hearing loss

110702 If a conductive hearing loss is present, entitlement in each case should be decided in the usual way. In some cases, a conductive hearing loss may be present which is not service related, but for which a firm diagnosis has not been established. At the claim stage, where a conductive hearing loss appears to be present, every effort should be made to establish a diagnosis If a diagnosis cannot be reached using the evidence already on file, a GP report, HCNs etc, should be obtained as appropriate. Should the diagnosis still prove elusive, then a specialist report may be obtained. If there is no prospect of elucidating the basic injurious process, and hence obtaining a label, without resorting to invasive investigations, then the symptomatic label BILATERAL/RIGHT/LEFT CONDUCTIVE HEARING LOSS may be used, as a last resort.

For example:

A deafness claim is made in which the audiogram shows an air-bone gap of 30dB on one side. There is no history of otorrhoea, or of any other middle ear pathology. The tympanic membranes are said to appear normal. Tympanometry is not indicative of any particular pathology. The audiogram does not show a Carhart notch. Service documents show no abnormality of the ears and hearing at entry, during service, or at release The GP has not been consulted and no hospital referrals made for any ear condition A specialist cannot reach a diagnosis without invasive investigations, which it would be inappropriate to perform purely for War Pension purposes. In such cases, it is reasonable to reject using the label bilateral/right/left conductive hearing loss, as described above.

110703 In a case where the findings are identical to the above example, but the GP has been consulted, or there has been a hospital referral, this evidence should be obtained before requesting a specialist report.

110704-110749

Air/bone gaps

110750 There are cases which show a negligible air/bone gap, eg of 5-10 dB on the audiogram. In the absence of any obvious pathology, this can be ignored for entitlement purposes at the time of decision. Such gaps are very common, and are a technical occurrence of no significance However, in these cases the assessment should be based on the air curve, rather than the bone curve. The air curve is the threshold at which the man actually hears, and is the true measure of his disablement. If the assessment is made on the bone curve, the gap has to be explained by identifying the basic injurious process and labelling it. This is a nonsense, as the gap is an artefact In some cases, a gap of a few dB can make all the difference between payment and non-payment To be fair to the pensioner, in cases where we are ignoring the minimal air/bone gap for entitlement purposes, we must include all the hearing disablement in the assessment, ie, calculate the assessment on the air curve.

110751 Another problem of this type occurs when unmasked bone conduction plots fall below the air conduction curve. This again is a technical problem. The air curve should be used to calculate the assessment.

110752 By audiometric convention, when unmasked bone conduction is plotted, the triangular symbols are often entered on to the graph for one ear only, showing a significant air bone gap. This may lead to the conclusion that there is a unilateral conductive loss. In such cases, it is important to look at the relative positions of the air curves on both graphs. If they are at about the same level, the probability is that there is actually a bilateral conductive loss present. The unmasked bone plots may then be transposed onto the graph for the other ear to show the extent of the conductive loss

110753-110799

Additional markings on audiograms

110800 Sometimes audiograms are submitted with additional "plots". These may be referred to as M & U markings.

- M or MCL or MCLL - this refers to the most comfortable listening level This is obviously subjective and individually determined.
- U or UCL or ULL or LDL - this refers to the uncomfortable loudness level or the loudness discomfort level. This is the level at which the subject feels the sound is too loud. This is also subjective and individually determined

110801 These levels are used for appropriate selection of a hearing aid for each individual. They are based on measures of auditory dynamic range and are related to SPL (sound pressure level in decibels).

110802 These additional audiometric plots must not influence our entitlement or assessment decisions.

110803-110899

Assessment issues

110900 Disablement due to hearing loss is assessed using the DSS table based on hearing levels obtained by audiometry and averaged over 1, 2 and 3 kHz. This table is used for assessment of both occupational deafness and noise induced hearing loss and was advised by the Industrial Injuries Advisory Council and the British Association of Otolaryngologists To determine the percentage bilateral hearing loss the arithmetical mean of hearing loss at frequencies 1, 2 and 3 kHz is calculated and applied to the table.

110901 NISHL (service dates) is assessed in the light of the medical fact that it is non-progressive, as described above. Remember that once the person leaves service, any increase in hearing loss must be due to some factor other than service noise.

110902 By law, an assessment can only include hearing loss which is due to service. The basis of assessing a NISHL due to service must therefore be the hearing test carried out at release from service. Where there is an audiogram carried out at release, this will provide an accurate record of the hearing at that time, and will be used to calculate the assessment of the NISHL.

110903 This release audiogram will show all hearing loss present at release, with pre service noise and ageing contributing to the sensorineural hearing loss present.

110904 Age related SHL is progressive in all individuals. On enlistment every serviceman will be suffering from that condition to a certain degree and will increasingly suffer from it during his service. At the same time he may have been exposed to service noise. It is not possible, however, to precisely apportion hearing loss between different causes operating at the same time. Where NISHL is accepted, generally no attempt is made to exclude SNHL due to age or any other cause sustained before or during service as this is not measurable. The assessment should, therefore, include all sensorineural hearing loss present at service release irrespective of the cause.

110905 Before the mid 1970s, usually there will be no release audiogram but the release medical will include a clinical assessment of ears and hearing.

110906 In the case where no audiogram was carried out at release, but a clinical test of hearing by conversational voice or forced whisper is recorded, this clinical test will be accepted as reliable evidence. Expert audiological opinion has confirmed that this may be used to assess hearing loss.

110907 The Department is advised by Dr R A Coles (late head of the MRC Institute of Hearing at Nottingham) that a hearing loss of 50 decibels or more, averaged over 1, 2 and 3 kHz in either ear, would result in clinically detectable ie symptomatic hearing loss. It follows that clinically normal hearing in both ears can have a maximum loss of 49 decibels, averaged over 1, 2 & 3 kHz, in each ear which equates to a maximum assessment of 10%.

110908 Reference to the scales of hearing loss shows that the possible assessments for clinically normal hearing must fall into the NIL, 1-5% or 6-14% bands. It is not possible for the assessment of hearing loss at release to fall into the 15-19% band, unless the claimant had a hearing loss in excess of 49 dB in one ear at that time, ie he would have had a clinically detectable hearing loss in one ear at release.

110909 The actual assessment certified in a particular case could be NIL, 1-5% or 6-14%. For example, if the current audiogram shows 0% disablement, calculated using the scales of hearing loss, then a NIL assessment should be certified. Similarly, if the hearing loss calculated from the current audiogram falls into the 1-5% or 6-14% bands, then 1-5% or 6-14% should be certified, as appropriate

110910 In summary:

Current hearing loss from audiogram	Clinical findings at release	Assessment of AD
Nil	Normal	Nil
1-5%	Normal	1-5%
6-14%	Normal	6-14%
15-19%	Normal	6-14%
15-19%	Deafness noted	15-19%
20% or more	Normal	6-14%

110911-110949

110950 It would also be appropriate to take note of when the claimant first began to experience a social problem with his hearing, as indicated on the audiology report or by his claim. As described above, the argument that the hearing loss prior to that date was less than 50 dB can be used, and the assessment would therefore be less than 20%. We could give NIL, 1-5% or 6-14%, depending upon the loss shown on the current audiogram.

110951 Where there is no record of the examination of the hearing at release and there is no history of post service onset of deafness, the assessment should be based on the earliest reliable record of hearing, which was carried out after service. This could be from hospital case notes, a claim for industrial deafness, or a hearing aid clinic or similar source. If the person has never been seen for hearing loss prior to the present claim, the current audiogram may be the earliest record upon which the assessment can be based

110952-110999

Time periods and other advice to administrative colleagues

111000 As already stated, NISHL is non-progressive. Thus, when it comes to the period of the award, it is medically justified to make every award FINAL, as by definition a dated service NISHL cannot ever deteriorate. In new legislation cases, finality does not require an OMD at assessment appeal.

111001 The 1998 Independent Review of Hearing Loss Assessment confirmed that once an individual is removed from harmful noise the hearing loss resulting from that noise injury does not progress

Explanation of assessment in NISHL cases

111002 The administrative staff rely heavily upon the correct completion of the WPA363 certificate when explaining NISHL assessments at both the simple RFD and appeals stages.

111003 In order to help our administrative colleagues and to avoid unnecessary referral to MAs at a later stage, the following procedures should be followed:

- indicate clearly in the reasons for assessment on the WPA363 whether the assessment is based on audiometric or clinical evidence
- where the assessment is based on clinical evidence, the decibel losses box on the front of the WPA363 should **not** be completed and the box should be crossed through
- where the assessment is based on audiometric evidence, specify precisely which audiogram is used in the calculation and complete the decibel values in the box on the front of the WPA363

111004-111049

Change in legislation

111050 On 7 January 1993, Articles 8 and 9 of the SPO 1983 were amended This change in the legislation means that awards in respect of NISHL will not be made, unless at the date of claim the hearing loss (due to service) in **each** ear, averaged over 1, 2 and 3 kHz, equates to at least 50 dB. The amendments also state that any other related conditions or symptoms arising from the exposure of the cochlear hair cells to noise **cannot** be included in the overall assessment of disablement, if the NISHL alone is assessed at less than 20%. This includes tinnitus and loss of speech discrimination.

New cases under pre 7 January 1993 legislation

111051 New Claims in this Category are rare. For a new claim under the old pre 1993 legislation, use the instructions above to decide entitlement issues and the assessment of any accepted condition. Any associated symptoms such as tinnitus will be included in the assessment. The period of the award will be "ID Final" if the assessment is less than 20%, and will be "Final" in the 20% or more assessments Where other ADs are present, the assessment of a service NISHL will be aggregated into the combined assessment. The period of the award will be that which is appropriate for the combined assessment

111052 If a subsequent deterioration claim is made, any worsening of hearing disablement will be due to some cause other than the dated service NISHL. The basic injurious process causing this new hearing loss will not be accepted. Therefore, the assessment of the service NISHL will be maintained at the previous level.

New cases under 7 January 1993 legislation

111053 This will apply to the vast majority of new claims for deafness.

111054 To recap, the legislation states that no award will be made in respect of NISHL unless the hearing loss (due to service) at the date of claim averaged over 1, 2 and 3 kHz equates to 50 dB in each ear. If the NISHL alone is assessed at less than 20%, related conditions and symptoms cannot be allowed for in the assessment. That assessment cannot be added to the assessment of any unrelated ADs present in determining the overall degree of disablement (ie the combined assessment).

111055-111069

Sensorineural hearing loss at date of claim of less than 50 dB under 7 January 1993 legislation

111070 If a hearing claim is made and the CURRENT audiogram shows a sensorineural loss of less than 50 dB in each ear, entitlement and assessment of HEARING LOSS will be decided as already described above. If there is a NISHL due to service, associated symptoms or conditions (eg tinnitus) can be accepted as part and parcel on the reverse of the WPA363 but must NOT be included in the assessment of service NISHL

111071 The AD will be written on the front of the WPA363, in the style as described above, and the assessment of the service NISHL will be inserted in the assessment column. "NO AWARD IN RESPECT OF SENSORINEURAL NOISE INDUCED HEARING LOSS", will be stamped in red ink on the lower part of the front of the WPA363 where reasons are given. All cases should be made final and "ID FINAL" written in the period of award column.

111072 If there are other ADs, in addition to the NISHL, the assessment of the service NISHL must NOT be aggregated with the assessments of these other ADs in the combined assessment. In this situation, a period of award appropriate for the combined assessment should be given in addition to the ID Final for NISHL. The red "NO AWARD...." stamp should be used as above.

111073 When dealing with a first claim where several conditions have been accepted, in order to make it clear that the assessment of the service NISHL is not included in the combined assessment with the other ADs, it is appropriate to make the service NISHL AD 1. The assessments of the other ADs may then be bracketed together.

EXAMPLE	Separate assessment	Combined assessment
AD 1 BNISHL (Service dates)	6-14%	6-14% ID FINAL
AD 2	20%)	
AD 3	6-14%)	40% INTERIM LTA
AD 4	6-14%)	

111074 If there are already other ADs previously accepted, then the service NISHL will be given the next number in sequence.

EXAMPLE		
AD 1) previous ADs	20%)	
AD 2)	6-14%)	30% INTERIM LTA
AD 3 BNISHL (Service dates)	6-14%	6-14% ID FINAL

111075 If subsequent ADs are accepted, they should be given new numbers in sequence after the Service NISHL, whose number should not be changed as this creates confusion for the administrative staff and problems for their computer records.

111076 However we could write our certificate as follows:

Example		
AD 1) previous ADs	20%)	
AD 2)	6-14%)	60% INTERIM LTA
AD 4) new ADs	6-14%)	
AD 5)	20%)	
AD 3 BNISHL (Service dates)	6-14%	6-14% ID FINAL

Sensorineural hearing loss at date of claim of 50 dB or more under 7 January 1993 legislation

111077 If a hearing claim is made and the CURRENT audiogram shows a sensorineural loss of 50 dB or more in each ear, entitlement and assessment of HEARING LOSS will be decided as described above. If there is a service NISHL and that hearing loss alone is assessed at 20% or more, associated symptoms may then be included in the assessment. The WPA363 will be completed in the normal way, and if there are other ADs, the assessment of the NISHL will be included in the combined assessment. The period of the award will be "Final" or "Interim LTA".

111078 If a deterioration claim is made subsequently in a case determined under the new legislation, any deterioration in hearing disablement will be due to some cause other than the dated NISHL. The basic injurious process causing this new hearing loss will not be for acceptance. The AD will be maintained at the previous level

111079-111089

Unilateral NISHL in cases under 7/1/93 legislation

111090 The new legislation is applicable in cases where there is unilateral NISHL. In such a case, entitlement will be given to L/R NISHL (service dates), and the assessment will be based upon the release medical, or other appropriate evidence, as already described As a bilateral NISHL is not present, then the average hearing loss at 1, 2 and 3 kHz cannot be 50 dB or more in each ear. Therefore, an award cannot be payable for the unilateral NISHL in these cases and the red "no award" stamp should be used.

Asymmetrical NISHL in cases under 7/1/93 legislation

111091 In some cases, with an asymmetrical hearing loss, when the table of assessment is used to calculate the total current hearing loss, a figure of 20% or more is produced, but the 50 dB criterion is met in one ear only. However, paragraph 2A of Article 9 states that:

(111091) "Where the average hearing loss at frequencies of 1, 2 and 3 kHz is **not** 50 dB in each ear, then the degree of disablement **shall be assessed at less than 20%**".

111092 In these cases, where the assessment is based on the current audiogram, the correct course of action is to give a maximum assessment of 15-19%, and use the red "no award" stamp. **The legislation specifically precludes an award.**

Use of audiograms without a 3 kHz point

111093 When assessing hearing cases under 7. 1.93 legislation, it is essential that we hold a **current** audiogram bearing points at 1, 2, and 3 kHz, in order to comply with the provisions of Article 9(2A).

111094 While an audiogram without a reading at 3 kHz can be used to support an assessment based on clinical findings at release, it is not suitable for WP assessment purposes on its own An assessment should not be based solely on an audiogram without a reading at 3 kHz.

111095 The instruction not to base assessments on audiograms without readings at 3 kHz is the result of policy advice on the requirements of the 1993 noise induced hearing loss legislation and also feedback from tribunals.

111096 Where an assessment of 6-14% is based on clinical findings at release, history and clinical findings recorded in hospital case notes or based on the pensioner's own statement, an audiogram without a reading at 3 kHz can be used as corroborative evidence. However, in these circumstances an assessment of nil or 1-5% should not be made on readings at 1, 2 and 4 kHz.

111097 Where there is no clinical evidence as noted above, an assessment should be based on the earliest audiogram with a reading at 3 kHz, even if earlier audiograms without a 3 kHz reading are available.

111098-111149

Psychiatric disablement consequential to tinnitus

111150 Expert opinion, both psychiatric and ENT, is that a specific psychiatric injurious process arising due to tinnitus is very rare.

111151 Legal advice is that "related condition or symptom", as defined in article 8(2B) of the SPO, includes psychiatric conditions.

111152 In practical terms, this means that if a psychiatric condition is certified as consequential upon tinnitus which is itself part and parcel of a service related NISHL, **an award in respect of the psychiatric condition cannot be paid, unless an award is payable in respect of the service related NISHL.**

111153 In general, a psychiatric disablement will be certified as consequential to service related NISHL (tinnitus part and parcel) on the strength of a Specialist Psychiatrist's report. The percentage of claims where it is confirmed that a psychiatric disorder is secondary to tinnitus is likely to be small.

Example 1 NISHL (tinnitus part and parcel) assessed at <20%

Specialist Psychiatrist states that a psychiatric illness is present, and tinnitus is the cause:

- certify the psychiatric disorder as consequentially attributable to service
- certify the appropriate assessment
- do not give a combined assessment (Article 9(2B)).
- no award will be payable.

eg:	BNISHL (service dates)	ATT 1-5%}	ID, FINAL: NO AWARD
	Generalised Anxiety Disorder	ATT 30%}	INTERIM LTA: NO AWARD

Example 2 - as above, other accepted disablements present

eg	BNISHL (service dates)	ATT 1-5%}	ID, FINAL: NO AWARD
	Generalised Anxiety Disorder	ATT 30%}	INTERIM LTA: NO AWARD
	Peptic ulcer	ATT 20%}	50% INTERIM LTA AWARD PAYABLE
	Cervical spondylosis	ATT 30%}	

Example 3 - NISHL (tinnitus p & p) assessed at 20% or above

Specialist Psychiatrist states that a psychiatric illness is present, and tinnitus is the cause:

- certify the psychiatric disorder as consequentially attributable to service
- certify the appropriate assessment
- give a combined assessment
- an award will be payable

eg:	BNISHL (service dates)	ATT 20%}	40% INTERIM LTA: AWARD PAYABLE
	Generalised Anxiety Disorder	ATT 20%}	

Requests for evoked response audiometry

111154 Evoked Response Audiometry (ERA) may be used to obtain more accurate readings of hearing loss over the frequencies 1, 2 and 3 kHz, where the readings obtained by routine audiometry are doubtful.

ERA appropriate

111155 When the AD is being assessed on the basis of the current audiogram, ERA is obviously very important in ensuring that exaggerated responses do not result in excessively high assessments. For example, in a case where there is no release medical at the end of service (especially in TA cases) and no evidence until the current audiogram, which is of doubtful accuracy. ERA may be needed to assess the AD, as otherwise, the assessment will have to be based upon the current hearing loss, calculated from an audiogram which is known to be inaccurate.

111156 Another situation where ERA may be required is where the AD is being assessed on the current audiogram and there is a conflict of evidence. Private companies (eg solicitors) who are assisting claimants may commission their own audiograms. If such an audiogram is similar to the audiogram which we have obtained, then there is no problem. However, if the "private" audiogram is very different, then it is appropriate to request ERA to resolve the conflict of evidence.

ERA inappropriate

111157 When there is a release medical or some other evidence of hearing loss (which could, for example, be a post service date of onset of social deafness or an earlier audiogram with a reading of 3 kHz), predating the current audiogram, the current audiogram is of no importance in the assessment of the AD, when the AD is BNISHL (service dates). The current audiogram is, of course, relevant in the diagnosis of the cause of the current hearing disablement.

111158 Where a question of diagnosis is involved, ERA is unhelpful, as essentially, it is useful only for assessment purposes. If the basic injurious process cannot be identified on the evidence available at the first submission, other sources of evidence should be used, eg GP report, HCNs, or a Specialist report.

111159 If a condition is for rejection, for example a BSHL which we know is non-service related, then the absolute readings of present hearing loss are unimportant and ERA should not be requested.

111160-111199

Interpretation of ERA

111200 ERA tends to overstate the true hearing threshold by up to 15 dB, ie hearing may appear worse than it actually is. ERA cannot understate the true hearing threshold, ie, it cannot show that hearing is better than it actually is. The following is a useful summary of the place of ERA in assessment of hearing loss:

- ERA threshold up to 15 dB higher than PTA threshold (hearing appears a little worse than PTA indicates) - confirms that PTA is accurate - PTA can be used for assessment purposes.
- ERA threshold lower than PTA threshold (hearing appears better than PTA indicates) - confirms inaccuracy of PTA - use ERA for assessment.
- ERA threshold much higher (more than 15 dB) than PTA threshold (hearing appears far worse than PTA indicates) - ERA is the more accurate reflection of hearing loss - use ERA for assessment.
- ERA and PTA thresholds coincide - may be slight exaggeration of hearing loss, but this would be difficult to prove Use ERA/PTA threshold for assessment.
- Do not forget the other evidence which may be on file, eg ARTs, War Pensions examinations, HCNs etc. It may provide useful pointers concerning the accuracy of the PTA.
- ERA alone will not provide a label

Hearing claims in respect of blast injury to ears

111201 Blast damage to the ears may arise from an explosive incident The incident is likely to be severe enough to cause damage to other body structures and, if occurring in a confined space, to cause windows to splinter. Damage to the ears occurs as a result of subsequent pressure wave or blast wall and the degree of damage to the ear will depend on the type and amount of explosive, the rate of pressure rise and the peak pressure experienced. Other factors include the distance of the individual from the blast - whether it occurred in or out of doors, the presence of intervening objects and the directional relationship of the blast.

111202 Tympanic membrane perforation results from blast injury in 40% of cases. Clinically there will be pain in the ear (otalgia), tinnitus and hearing loss. The precise audiometric pattern is very variable and most frequently the higher frequencies beyond those important for speech are involved. Recovery of both tinnitus and hearing loss is the rule 50% of tinnitus cases recover in a month and at 6 months maximum improvement in hearing loss, tinnitus and healing of the perforation have taken place.

111203 The standard label to be used in these cases is "blast injury to ears", regardless of the legislative scheme. It is not always easy to decide whether the label of "blast injury" is appropriate. Firstly, it is important to establish whether the Secretary of State (SOS) accepts exposure to blast The lay staff will issue a form WPA68A asking for details of the incident. Secondly, the history should be noted. In this context, we are looking for a specific incident (or incidents). Helpful features are mention of proximity to an explosion, unconsciousness, being knocked over by the force of the blast, etc. There may be recollection of bleeding from one or both ears, pain in the ears, temporary or permanent threshold shift, tinnitus, etc Contemporary physical findings may be recorded, eg haemotympanum, perforated tympanic membranes, superadded otitis media etc. Current findings may be normal/scarred/perforated tympanic membranes. Usually there is recovery of hearing loss. This may be complete or partial. The audiogram may show appearances ranging from a classical NIHL curve, through varying degrees of mixed sensorineural and conductive deafness, to a dead ear. Tympanometry may be helpful, showing the tall, thin peak characteristic of a thin, healed scar or ossicular discontinuity, or a flat tympanogram if the drums are heavily scarred.

111204 The difficult cases are those where there are normal eardrums and a classical NIHL curve, with no conductive loss, and no contemporary evidence. In such cases, the decision of the SOS should be noted, and the question to be asked is whether a reasonable doubt is raised under Article 5 that the cause of the disablement is blast, as claimed.

111205 Where reliable evidence raises a reasonable doubt that blast injury to ears has occurred, then certification will follow in the usual way. In the common circumstance where one ear shows the "classical" features of blast injury eg scarred eardrum and a mixed hearing loss and the other ear has, for example, an unscarred drum and a classical NIHL curve, then "blast injury to both ears" should be certified.

111206 Cases arise where the clinical and audiometric evidence is not consistent with the contention that a blast injury to ear(s) is present or ever has been present. However, the SOS has accepted exposure to blast. In such cases, it is recommended that you discuss the acceptance of exposure to blast with the SOS. If the SOS then reconsiders, it may then be appropriate for the MA to reject "blast injury to both/right/left ear(s), DATED, - NOT FOUND, for example, whilst accepting BNISHL (service dates). It is not logical to use the device "blast injury .. .." attrib, nil.

111207 It should be noted that the hearing level due to blast injury stabilises within a year of removal from the acoustic trauma. Further hearing deterioration occurring more than one year from the blast incident is due to other factors[1].

111208 The effects of blast injury are variable If it is conceded that a blast injury has been sustained, the assessment and type of award will depend on the case specific facts. It may be appropriate to accept all disablement under this label and advise an interim assessment. Deterioration claims can be accepted and on review an increase in assessment may be appropriate. In other cases, it may be possible to apportion only some of the current disablement to the effects of blast and to make the assessment final.

[1]Segal, S et al (1988) Acute acoustic trauma. dynamics of hearing loss following cessation of exposure. Am. J. Otol. 9.293-298.

111209-111299

Review of NISHL claims

111300 Much of the information in this chapter is taken directly from the War Pensions - Noise Induced Sensorineural Hearing Loss (NISHL) Policy Advice issued in June 1997. This discussed the review of cases in which Entitlement to NISHL was established and the same examples are used. This section should be read in conjunction with that policy advice.

111301 Claims for NISHL have not always been actioned in accordance with the Assessment principles outlined above.

111302 Claims for Noise Induced Sensorineural Hearing Loss must be actioned in accordance with the current medical understanding which is as follows:

A **Hearing loss due to a particular noise does not deteriorate once the individual has been removed from that source of noise.**

B **Hearing losses due to noise and age are no more than additive.**

111303 This has been confirmed by the 1998 Independent Review of Hearing Loss Assessment

111304 There are, therefore, some cases where Entitlement for NISHL has been given but the assessment does not reflect current medical understanding If these cases are presented for review, the MA must revise the assessment decision so that it does reflect current medical understanding

111305-111349

NISHL - history of past claims

111350 Until about 1980 the natural history of NISHL was not known Technical advances in microscopy, however, enabled study of the histopathology of NISHL which confirmed that damage did not increase following removal from the injurious noise. This was reflected in Departmental guidance (a medical appendix) produced in 1981. The current view is therefore that hearing loss due to noise and age are no more than additive: in fact the noise related loss acts as a cushion against the subsequent effects of age related hearing loss

111351 The approach to deciding war pension claims did not keep up with these developments:

- until January 1993 assessments were based on the whole of the hearing loss present at the date of claim, however long this was after service. This was unreasonable in the light of the knowledge (1 January 1981) and Departmental guidance that hearing loss due to noise did not deteriorate upon removal from the noise
- from January 1993 NISHL was separately identified and assessed, but additions were made in respect of interaction with other forms of hearing loss, usually age related SHL, using the "greater disablement" principle (GD) Again, this was unreasonable in the light of the knowledge that losses due to noise and age were no more than additive.

111352 Action was taken to bring practice into line with current understanding from 22 October 1996.

Ministerial commitment

111353 The failure to reflect current medical understanding since 1 January 1981 means there are awards in payment for NISHL which, if they are reviewed, will require special action to revise the decision to determine the true level of assessment. Ministers decided that there would be no attempt to seek out cases for review. They would only be considered when they otherwise present themselves (eg because of a claim for a further condition, or an application for the review of the assessment of a condition other than the hearing loss).

111354 Ministers made two commitments to ensure that no pensioner would be unreasonably disadvantaged by the need to revise decisions because of the failure to reflect current medical understanding. These were that:

- no pensioner already in receipt of an award would suffer a reduction in pension or have that pension taken away following the correction of the erroneous decision; and that
- claims (both first claims and applications for review for deterioration) made before 1 March 1996, and still outstanding at the time action was taken to bring practice into line, would be considered on the basis of the practice for handling claims introduced in January 1993.
- special arrangement covering appeals outstanding at the due dates have been made. Handling of these is dealt with in the "NISHL - Guidance on Transitional Cases (June 2000)".

111355 NOTE: **"Correction of an erroneous decision" refers to the acceptance of post service deterioration or GD when this was not in line with contemporary medical understanding or the law. It does not mean that decisions which were wrong (for example because of incorrect calculation) cannot be corrected.**

111356 To comply with Ministerial commitment the MA certifies an assessment which reflects current medical understanding and this is referred to as the "true" assessment. Any appeal will lie against the true assessment. However, the MA also makes an advisory assessment which includes the true assessment and any previous GD or post service hearing loss. The advisory assessment is used to determine the award, that is, the actual money paid to the pensioner. Examples are given in the Annexes at the end of this section.

111357-111399

Categories of claims for revision

111400 Cases divide into three categories:

Category A = Awards for noise induced hearing loss made before 1 January 1981.

111401 These decisions reflected the medical understanding of the time and were not unreasonable The SoS has no power to revise these assessments. ***See Appendix thirteen.***

111402 Single condition NISHL assessments made before 1 January 1981 should be maintained on review and made final. There is no requirement for an advisory assessment. A blue certificate should be used.

111403 Multiple accepted conditions including a NISHL assessment made pre 1 January 1981 should be handled as follows:

(111403) • Maintain the certified NISHL assessment and include in the certified composite assessment.

- Advise a time period appropriate to the certified composite assessment.
- There is no requirement for an advisory assessment.
- A blue entitlement certificate should be used.

Category B = Awards in respect of noise induced hearing loss made on or after 1 January 1981.

111404 Where post service hearing loss or greater disablement was included in the assessment, these decisions were unreasonable as they did not reflect the medical understanding of the time.

111405 On review, the post 1 January 1981 assessment should be revised in line with the current medical understanding, ie, GD or post service hearing loss should be removed from the previously certified assessment. A new "true" assessment should be certified.

111406 An advisory assessment for awarding purposes which includes the post service/GD component removed from the certified assessment should be provided.

111407 The advisory assessment will mark time until exceeded by the certified assessment

111408 The SoS will maintain the award under Article 67(6).

111409 Green entitlement certificates should be used for this category until the certified assessment equals or exceeds the advisory assessment. In the latter situation, the normal blue entitlement certificate should be used.

111410 Any assessment appeal will lie against the certified true assessment, not the advisory assessment **see *Appendix fourteen.***

111410-111449

Category C = New claims to, or applications for review of noise induced hearing loss made before 1 March 1996 but still uncleared on 22 October 1996 (commencement of stockpiling).

111450 The certified assessment should be in accordance with the current medical understanding

111451 An advisory assessment should be provided for awarding purposes This advisory assessment should comprise the total assessment which would have been certified had the case been actioned prior to 1 March 1996.

111452 The advisory assessment will mark time until exceeded by the certified assessment.

111453 Any "new" GD included in the advisory assessment will be paid under the Dispensing Instruments. "Old" GD will be paid under Article 67(6).

111454 These cases should be certified on a yellow entitlement certificate until the certified assessment equals or exceeds the advisory assessment. In the latter situation, the normal blue entitlement certificate should be used.

111455 Any assessment appeal will lie against the "true" certified assessment.

111456 There are very few Category C cases but in order to action them appropriately, it is necessary to understand how GD was applied previously. This is explained in ***Appendix twelve*** and also see ***Appendix fifteen.***

111457-111499

Hybrid cases

111500 Where an award for noise induced hearing loss has been made prior to 1 January 1981 and subsequently increased, the certified assessment should not be revised below the level of the pre 1 January 1981 assessment as this assessment was reasonable when it was made.

111501 Note: (1) In older cases the precise label of BNISHL (service dates) may not have been used Labels such as bilateral perceptive deafness, bilateral sensorineural hearing loss and bilateral sensorineural hearing loss (noise induced) may have been accepted in the past. If the hearing loss due to service is shown to be due only to exposure to injurious service noise, these labels can be treated and the cases can be reviewed in exactly the same way as BNISHL (service dates). Care must be taken to ensure that no other service factor such as a blast incident is responsible for the deafness included in the accepted condition.

111502 Note: (2) True and advisory assessments should be made only when the previous assessment includes an allowance for post service worsening of hearing loss. This may be by assessing all hearing loss present or by the application of the greater disablement principle It is not appropriate to give true and advisory assessments because the previous assessment is now considered generous Examples of this are given in the introductory Annex.

111503-111549

When to review a NISHL assessment

111550 Cases will not be sought out for review, but the NISHL assessment should be reviewed whenever a case presents itself eg:

- the case is presented for review of assessment of NISHL or another condition
- a further condition is accepted
- a post treatment review
- a pre-appeal review.

111551 At all times MAs must certify an assessment based on the facts of the case, the law and contemporary accepted medical understanding Advisory assessments do not strictly speaking form part of a certificate, although they are by convention entered on it That practice should continue.

Appeals advice

111552 Legal advice is that the right of appeal will lie against the current certified **true** assessment, and the notified (advisory) assessment (see NISHL guidance on transitional cases - June 2000). It is planned that ultimately, the majority of cases will be handled by the SOS, by including more comprehensive SOS Reasons for Decision in the Statement of Case. However, significant MA input will be required.

OMD criteria

111553 The "OMD required" criteria for NISHL cases have been redefined as follows:

- All cases where the assessment is based on clinical findings at release, the pensioner's own statement or an ERA.

  NB: It is planned that standard paragraphs will be prepared to enable the SOS Reasons for Decision to cover these cases in the future.

- All cases where the NISHL assessment forms part of a composite assessment.

- All cases where disablement arising from other hearing injurious processes such as otitis media and otosclerosis needs to be dissociated from the NISHL assessment under appeal.

- Any complexity which requires an explanation, eg, an assessment which has been reduced because of new evidence or previous error

111554 Cases where the NISHL assessment is based on an audiogram, including pre and post 7/1/93 cases and category A, B and C cases, do not require an OMD unless they fulfil the above "OMD required" criteria. OMDs are not required in those cases where the assessment is based on an audiogram and there has been further deterioration due to presbyacusis or post service noise.

111555 Note: The OMD criteria for all non NISHL cases remain unchanged. See *Part six - Assessments* for further information.

111556-111599

Supplementary Allowances

111600 The Ministerial promise is that no pension should be reduced or taken away if the claim to a pension (and this includes claims for supplementary allowances) was made before 22.10.96. However, any claim to a supplementary allowance on a case which involves NISHL made **on or after 22.10.96,** must be determined on the basis of the "true" assessment.

Post appeal awards

111601 Shortly after the implementation of the new medical understanding in respect of NISHL, it was realised that there was the possibility of inequitable treatment of appellants whose entitlement appeals involving NISHL had been lodged prior to 1/3/96 and were still outstanding on 22 October 1996.

111602 Representations were made to WII who have advised WPA that these cases should be treated as Category C cases.

111603 In practical terms, this means that if you are certifying a post appeal award in a case where either

- An award for NISHL was already in payment but an appeal had been lodged (before 1/3/96) in respect of the rejection of another condition and was outstanding on, and allowed by the PAT after 22/10/96, or
- An appeal in respect of the rejection of NISHL alone had been lodged (before 1/3/96) and was outstanding on, and allowed by the PAT after 22/10/96,

you must provide a certificate in accordance with the new medical understanding and an advisory assessment for awarding purposes A yellow certificate should be used

111604 The advisory assessment should comprise the total assessment which would have been certified had the appeal been allowed prior to 1 March 1996. "Mark time" will come into operation at the next review, from when the advisory assessment will mark time until exceeded by the certified assessment. (Once this occurs, the normal blue entitlement certificate should be used).

111605 Any "new" GD included in the advisory assessment will be paid under the Dispensing Instruments. "Old" GD will be paid under Article 67(6). Any assessment appeal will be against the "true" certified assessment.

111606-111649

Assessment appeals affected by transitional arrangement

111650 Detailed instructions on handling of these cases is included in NISHL - Guidance on Transitional Cases (June 2000)

111651-111899

Handling claims for noise induced sensorineural hearing loss

111900 Claims are regularly received in respect of impairment of hearing alleged to be caused by noise exposure during service Recorded evidence is often scanty. Hearing at release may be recorded as normal, and the first evidence of any hearing impairment may be long after service.

111901 Nevertheless, the claim may possibly be well-founded, at least to the extent of a reasonable doubt required by Article 5. Noise induced deafness affects the perception of higher frequencies and may cause no detectable disablement on simple testing by voice. Obvious social disablement may occur later because of the addition of impairment through presbycusis.

111902 It is a lay officer's responsibility to decide what factors of service, including noise exposure, can be accepted. When submitting a claim for medical consideration the lay staff should specify as fully as reasonably possible what noise exposure has been accepted. In particular it should be stated whether the particular exposures being claimed are accepted. Noise exposure should be considered for each period of service. If necessary medical advisers should ask for clarification or additional information.

111903 The lay officer will identify the claim and refer it directly to BMI for an Audiology Technician's report. The Form WPA301 will be completed by the Audiology Technician who then arranges an audiogram. If indicated the Audiology Technician will continue with tympanometry and acoustic reflex testing. The main indication for the latter is the presence of a conductive hearing loss. An audiology report will not be arranged if there is a recent release audiogram available, ie within 12 months of the claim.

111904 The completed investigations will then be made available to the medical adviser for a decision and this will be the first sight a medical adviser has of the file These may or may not be accompanied by further evidence obtained in respect of other claims.

111905 Further investigations may have to be considered eg ERA. A specialist report may still be required in a small percentage of cases.

111906 The lay officers will attempt to identify claims for Meniere's Disease which will be referred directly to Medical Branch for consideration of further evidence

111907 This procedure does not apply to Overseas Cases, Channel Islands, Ireland, both Republic and Northern Ireland and Isle of Man A specialist report is often required for claimants living in these areas.

111908-111999

Contents

Joint Applications

Background

120000 PAT entitlement decisions are final and binding both upon the appellant and the Department. However, the PAT Act 1943 provides for appeal against PAT decisions in certain strictly defined circumstances.

120001 Section 6(2) allows for an appeal to the High Court on a point of law, leave to appeal having been given by the President of the PAT, or the nominated judge.

120002 Section 6(2A) allows the Secretary of State and the appellant to make a joint application to the President of the PAT for the original PAT decision to be set aside for the appeal to be re-heard If the PAT President so directs, the Minister has 2 months from the date of the President's direction to review the original decision. (Customarily, WPA works within a 6 week timescale)

12003 In practice, an MA reviews the original decision. The outcome will be either to redefend the original decision before the PAT or to certify entitlement and an assessment. In the latter case, the appeal against the original decision is normally struck out.

120004-120049

Grounds for joint application (JA)

120050 This is:

- On a point of law
- If there is additional evidence

120051 Case will normally be submitted to you to decide whether there is additional evidence. However, it is important to be alert to the possibility of an error in law. For example, it may be apparent from the wording of the PAT decision that the wrong article has been applied If you identify such a case, you should minute the EO, Joint Applications/High Court Section (JA/HC) appropriately.

What constitutes additional evidence?

120052 Additional evidence adds fact or reasoned argument to what was previously before the PAT. For example, a conflict of expert medical opinion may be regarded as a "fact". A change of medical opinion (either a change with a fixed date, or a gradual evolution) may be regarded as a fact.

120053 Mere repetition of a view previously before the PAT does not constitute additional evidence unless that view is supported by fact or reasoned argument not previously before the PAT.

Weighing the evidence

120054 When deciding whether grounds exist for a JA, you must not weigh the evidence. For example, it is wrong to conclude that there are no grounds for JA, just because you think that the additional evidence will not alter the PAT's decision. At a Judicial Review in 1995, Mr Justice MacPherson criticised the Department on this point, emphasising that it must not act as judge and jury.

120055 It is the PAT President who must weigh the evidence, and decide whether to direct that the original PAT decision should be set aside and the appeal reheard.

120056-120099

The process

120100 The man (or his representative) makes contact with the WPA in various ways Once the possibility of a JA is identified, the case is scrutinized by the JA/HC section to see if there are grounds to proceed If it appears that there may be additional evidence, the case will be referred to an appeals MA in the appropriate HEO command. The EO JA/HC will normally contact the MA by telephone just before sending the case Priority - By Hand.

120101 The MA should then scrutinize the case and decide whether there are grounds for a JA (additional evidence or point of law). At this stage, you may decide that there are no grounds for a JA You should minute the EO JA/HC appropriately.

120102 You may decide that there are grounds to proceed to a JA If so, then you should provide a certificate to that effect, and return the file with a covering minute to the EO JA/HC.

120103 Alternatively, you may identify a need for further evidence gathering before coming to a decision. For example, in old psychiatric cases, the label may be "psychoneurosis" and you may suspect that in the light of current medical knowledge. that the condition at issue is actually PTSD, which could be attributable to service. A Regional Consultant report may well be required in such a case.

120104 The man may have pointed to additional evidence eg HCNs which will have to be obtained before you can make a decision.

120105 It may well be that in a "date of change of medical opinion" case, you can anticipate the President's direction, and gather evidence to make an assessment, once the direction is received.

120106 Try to carry out any evidence gathering concurrently with the submission to the President if possible. The man may have to wait some months for the President's direction, and have to wait again while we gather evidence for assessment or redefence. Remember, we have a legal maximum of 8 weeks in which to come to a conclusion.

120107 Following your initial scrutiny/action, the file should be returned to JA/HC, with appropriate minutes.

120108 If there is additional evidence, the man will be invited to make a joint application, which is then submitted to the President of the PAT, with your certificate.

120109 If the original decision is set aside, the case will be submitted to you again for re-defence, or for certification. If you have not been able to gather evidence earlier, it may be done at this stage. If evidence gathering is likely to be lengthy (more than 6 weeks) contact the EO JA/HC, who may be able to negotiate an extension with the PAT President.

Problem cases

120110 These should be referred to the Training Officer, who will seek policy advice, if appropriate. Nuclear Test Veterans, Gulf War Cases and old SMO/PMO cases where JA action has been refused in the past will normally require discussion.

120111-120149

Chief Executive/other priority files

120150 Cases with potential JA action may be identified by Parliamentary Section, eg Chief Executive cases, the Chief Executives'; hotline, etc These cases will be walked over to the MA by JA/HC section staff. A "same day" turnaround is required

Practical aspects

120151 The forms necessary for JA action are available on the customised documents system.

120152 Joint Application No Grounds - includes a minute advising that there are no grounds on which to support a joint application.

120153 Joint Application Grounds and MA Cert - include a certificate and a minute to the EO JA/HC advising that there are grounds for joint application

Additional reading

120154 You may want to read the following:

- Pensions Appeals Tribunals Act 1943 - Article 6.
- MPM57A - paragraphs 164 to 167 inclusive.

120155-129999

Contents

Quality Assurance of Medical Adviser Work

130000 A new war pensions medical QA monitoring process is being developed in connection with Revalidation. Regular update on progress will be provided by the Professional Revalidation Project. When completed the new processes will be incorporated into the Instructions and Procedures.

130001-130199

BMI Quality Assurance

130200 Under the terms of the present contract, WPA is required to undertake monitoring of completed deafness questionnaires (WPA301) returned from BMI.

130201 As the prime users of the WPA301 and because of the technical nature of the material, MAs are best placed to carry out this function

130202 A statistically valid sample has been calculated at 378 WPA301s per annum With all MAs (FTMA and fee paid) participating, individual MAs can expect to see 7-8 cases per annum

130203 Administrative staff of the Audiology Payments Unit will attach a monitoring form WPA816 (please see the example at the end of this chapter) on a random basis You are asked to complete the WPA816 in the course of the normal processing of the file.

130204 Please read the instructions of the reverse of the WPA816 carefully, as filling in the monitoring form will be a rare event When you have completed the monitoring form, detach it from the file and send it in a transit envelope to **Peter Stanway, Room 6319,** extension 62020. Peter is the contact for any queries arising of this procedure.

130205-130299

Return of specialist reports and EMP reports for rework

130300 Commencing 1 September 1998, a private company, the SEMA Group, took on the contract for obtaining Specialist reports and EMP reports on behalf of WPA. SEMA subcontracted the specialist and RC work to DEFINITECH Ltd (The National Medical Examination Network).

130301 As end users of the reports, MAs are well placed to determine whether they are fit for purpose, ie, does the report enable the MA to adjudicate the case? If a report does not meet the required standard, it is important that this information is fed back to the contractor. By doing so, we can help to ensure that the standard of reports is not allowed to fall and that it will improve over time. This will, of course, be beneficial to us in the long term.

130302 Any report returned from SEMA/DEFINITECH which is sufficiently below the required standard to prevent the MA from adjudicating will be classed as REWORK and will be returned for remedial action at no charge toWPA.

130303 The categories for returning reports as rework are as follows:

A. Report is not fair or impartial, or could compromise adjudication or decision making

B. Advice is not legible or concise

D. Advice is not comprehensive and does not clearly explain the medical issues raised

F. Advice given is not complete and information is missing, or some questions are unanswered

Note: The omitted categories C & E apply to Social Security benefits other than War Pensions.

130304 **Reports which cannot be actioned due to any other reason, eg MA not asking for or giving sufficient information, do not count as rework, and WPA will be charged for obtaining the additional information required. Illegible requests will also be returned. It is therefore essential that our referrals are of good quality and legible to avoid cases being delayed, rework by ourselves and additional expense to WPA.**

130305-130399

Action to take

130400 If you receive a completed WPA331 or Specialist report which prevents you from making a decision because of an error falling into one of the above categories, the following action should be taken:

- Complete form WPA1067 (please see the example at the end of this chapter), ticking **one box only** to show why the report is unusable If there is more than one reason for the report being unusable, then tick one box to show the main problems and use the large box on the back of the form to identify the other error(s).

130401 If you are returning an EMP report, please explain the nature of the problems in the box(es) provided. If you are returning a Specialist (Consultant) report, you may write directly to the Specialist. Please attach your letter to the WPA1067 and it will be forwarded to the Specialist by DEFINITECH.

130402 When you have completed the WP1067, please send the file to **Peter Stanway, Contracts and Procurement, Room 6319.** Further copies of the WPA 1067 should be obtained from Peter by ringing him on extension 62020.

130403-139999

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Appeals to Pensions Appeal Tribunal (PAT)

Introduction

140000 An appeal is initiated once a pensioner requests an appeal form or simply writes to WPA intimating a desire to appeal. The lay officer obtains the award file, studies the evidence and decides whether or not there are appeal rights in respect of that condition. If there are, an appeal form is prepared and despatched to the appellant together with other forms to help with the appeal. This appeal form is not a WPA document, it is issued by the PAT office (Lord Chancellor's Department). In this, WPA is acting purely as an agent on behalf of the PAT office. When a form is returned the appeal is said to be "lodged" and the action must continue until:-

- WPA allows the appeal or
- PAT reach a decision following a hearing or
- the appellant withdraws the appeal

Entitlement appeals

140001 Entitlement appeals may be made against complete rejection of the claim, against the rejection of attributability, against the decision that aggravation has passed away or against the date the Secretary of State considers that aggravation passed away The lay officers identify the actual issue under appeal, check appeal rights, check the SPO article under which the case is to be considered, assemble the evidence they identify as relevant, decide whether or not certain statements or claimed incidents are accepted by the Secretary of State, prepare a submission to the medical adviser if this is necessary, prepare the Statement of Case (SoC) and apply Rule 22 where appropriate.

Statement of Case (SoC)

140002 This is a copy of all the evidence to be presented to the PAT and is determined by Rule 5 of the PAT rules. This rule requires the SoC to contain "the relevant facts relating to the appellant's case as known to the Secretary of State, including the relevant medical history of the appellant"

140003 In the past the SoC tended to contain more than the minimum of evidence required. It was also prepared by the lay officers before the case was submitted to the medical adviser. The entire SoC was typed A master copy was prepared and the first copy from this was used as a working document by the EO, MA, and the Departmental Representative at the tribunal.

140004 To improve the handling of appeals cases, changes to the SoC were implemented in April 1998. The aim was to prepare a more focused document which contained evidence **relevant** to the issue under appeal

140005 Much of the evidence in the new style SoC is photocopied. However, certain documents are always typed. These are:

- hospital case notes
- A & T cards

(140005)
- NI records
- Pulheems assessments
- Field Medical Cards
- any documents not suitable for photocopying
- evidence subject to the application of Rule 5, Rule 22.

140006 The SoC is not prepared prior to submission to the MAs.

140007 The MA must identify the relevant medical evidence which is necessary for inclusion in the SoC. This is done concurrently with the preparation of the OMD.

140008 The lay officer will always include the following documents in the SoC.
- entry medical
- release medical
- Pulheems at entry and release
- claim form
- all audiograms in deafness cases
- reasons for appeal (PAT form).

140009 Additionally the following documents may be selected at the discretion of the lay officer:
- those recorded on the WPA362, considered in connection with a specific incident/accident
- those required to answer any new contentions made at appeal
- any forwarded by the appellant in support of the appeal

140010-140099

Rule 22

140100 This PAT rule states that the Secretary of State can exclude from the appellant's SoC any material which in his opinion would be 'undesirable' to disclose to the appellant. In practice a full SoC is prepared and evidence to which Rule 22 is applied is underlined in black. Copies of this are used by the Department, the Tribunal and the appellant's representative. A separate copy, from which the underlined sections have been omitted is sent to the appellant This facility is necessary, since we often use evidence recorded many years ago and cannot go back to the author. Rule 22 is applied to diagnoses such as cancer or multiple sclerosis, if the appellant is unaware of the diagnosis. It is also applied to unfavourable prognoses, and comments of a personal nature, though the President of PAT has recently stressed the need to limit omissions to essential exclusions (MPM57A paragraph 154).

Rehabilitation of Offenders Act

140101 Evidence is also excluded from the SOC under this act. It is an act to rehabilitate offenders who have not been re-convicted of any serious offence for periods of years and to penalize the unauthorised disclosure of their previous convictions. The act covers convictions, but not charges where there was no conviction. When a certain length of time has passed following a conviction, the convicted person is judged to have paid his debt to society and all reference to the conviction must cease. The person is 'rehabilitated' and the conviction is said to be 'spent'. (See MPM57A paragraph 155 et alia for the handling of these cases).

Medical Adviser action

140102 Take the following action:

Step	Action
1	The lay officer will submit the file to the MA using form WPA766. A copy of this form is attached in the Annex at the end of the chapter.
2	The WPA766 give details of the condition(s) under appeal, any accepted disablement and any SoS decisions. It also contains a section in which the EO caseworker will have identified evidence for inclusion in the SoC.
3	The MA should carefully read the lay submission noting the label(s), Article, Incidents accepted/not accepted, any changes since the lay officer dealt with the case. If in any doubt, the MA should clarify the issue.
4	Note the representations by the appellant and any subsequent letters and statements.
5	Consider the label and check that: • it is correct • the claim has been answered in full • the diagnosis is supported by adequate evidence.
6	Consider the MAs original reasons for rejection.
7	Prepare an OMD.
8	Complete form WPA765 indicating what MA action has been taken and the proforma identifying all medical evidence necessary for inclusion in the SoC. A copy is enclosed in the Annex at the end of the chapter.

140103-140199

Overturn of previous decision

140200 If the rejection cannot be defended entitlement must be reconsidered and certification will ensue. If the overturn is due to a change of medical opinion or further evidence which was not before the MA who originally rejected the condition, entitlement can be conceded.

140201 If the previous decision is deemed unreasonable, the case should be discussed with the ECW and wherever possible the MA who made the original decision.

140202 In all cases, where entitlement is conceded, form WPA375 should be completed. This indicates the reasons for the overturn and is helpful for our administrative colleagues in determining the date of award. This form must be countersigned by the ECW if the overturn is on the grounds of a previous decision being unreasonable.

140203 The overturn should also be recorded on the monthly proforma for the Medical Director. Copies of these forms are at Appendix thirty-four.

140204-140249

Further evidence collection

140250 For some time now, it has been understood that all decisions made at the claims stage should be defensible and supported by relevant, reliable evidence.

140251 It should not usually be necessary to obtain further evidence at appeal. However, the appellant or his representatives may cite additional evidence which was not originally considered. In such circumstances, it may be necessary to obtain further evidence at the appeals stage. It is important to ensure that all the evidence PAT will require is available. Remember PAT may require actual films whereas the MA will accept an X-ray report as sufficient evidence.

Claims for further conditions

140252 During the course of the appeal, claims for further conditions may come to light. These may be completely new claims or the MA may consider that further conditions need to be addressed to fully answer the original claim. These further conditions should be accepted or rejected/defended as appropriate.

140252-140299

Assessment appeals

140300 Assessment appeals can be made against the composite assessment, the period or finality.

140301 The assessment PAT has power to uphold, increase or decrease an interim assessment and/or reduce the period. It has no power to increase a period. In final awards PAT can uphold or set aside the final decision, raise or lower the assessment or make a new interim assessment for any period up to 2 years.

140302 When 2 awards are given, one for a SMI, dual rights of appeal exist. The SMI is final, the other condition often interim.

Medical Adviser action

140303 Take the following action:

Step	Action
1	The lay officer will submit the file to the MA using form WPA789 (A copy of this form appears in the Annex).
2	The WPA789 gives details of the accepted conditions including the assessments and the period of award. P&P symptoms should be cited in the appropriate box as should details of greater disablement and rejected conditions The lay officer will have identified some evidence for inclusion in the SoC.
3	Before considering the assessment appeal, it is necessary to go through the case to check that the entitlement decisions are correct. Having ascertained that the claims have been fully answered, the labels are satisfactory and the entitlements are correct, the assessment under appeal can be considered.
4	Note the representations by the appellant and any subsequent letters and statements
5	Consider the MAs original reasons for assessment.
6	Prepare an OMD.
7	Complete form WPA765 indicating what MA action has been taken and the proforma identifying all medical evidence necessary for inclusion in the SoC.

Overturn of previous decision

140304 As with Entitlement appeals, if the assessment cannot be defended, an overturn of decision will follow There is no equivalent to form WPA375 for assessment overturns but it is essential to minute the EO explaining the reasons for the change in assessment. As with Entitlement overturns, any increase due to a previous unreasonable decision must have the authority of the ECW and must be discussed, wherever possible, with the original certifying MA. Increases in assessment due to acceptance of further conditions or the availability of new evidence do not necessitate discussion with the ECW. The monthly proforma for the Medical Director recording assessment overturns should be completed.

Further evidence

140305 It may be necessary to obtain further evidence in certain circumstances eg appellant cites further evidence indicating that his condition has necessitated investigations and treatment since his claim was made. Generally, however, all evidence should have been obtained when making a defensible assessment at the outset

140306 Remember that radiological examination is of limited value in the assessment of disablement for War Pensions purposes

Streamlined assessment appeals/OMD criteria

140307 Streamlined Assessment Appeals were devised in 1991 in an attempt to reduce the length of the appeal period. (Reference A/C 9/91 Med Lib). Certain assessment appeal cases were selected in which a considerably shortened SoC was produced without an OMD.

140308 As discussed earlier in this chapter, the SoC has now been modified for all appeals so that in every case many documents are photocopied and only relevant evidence is included. This has superseded the previous "streamlined" SoC.

140309 However, there are cases in which there is no necessity to produce an OMD in the event of an assessment appeal Such cases must be "in time", there must be no finality (except NISHL cases) or limitation, there must be no question of GD and there must be no other complication which would necessitate the production of an OMD

140310 The documents upon which the assessment is based are simply copied into the SoC and a "lay" comment is inserted to the effect that the Secretary of State relies on that evidence in the maintenance of the assessment.

140311-140399

OMD criteria - all cases

140400 An OMD is required where any of the following apply:

- Greater Disablement
- Paired Organs/Limbs Rule
- Limited assessment
- Reduced assessment
- Medically complex case
- Finality (other than in "new rules" NISHL cases)
- Multiple periods under appeal

OMD criteria - NISHL cases

140401 In NISHL cases, an OMD is required where any of the following apply.

- The assessment is based on the clinical findings at release, the pensioner's own statement or an ERA
- All cases where the NISHL assessment forms part of a composite assessment
- Finality in an old legislation case
- All cases where disablement arising from other hearing injurious processes such as otitis media and otosclerosis needs to be dissociated from the NISHL assessment under appeal
- Any other complexity requiring an explanation.

140402 Note

- An OMD is **NOT** required in a NISHL case where the assessment is based on an audiogram, unless the case fulfils any of the general/NISHL criteria listed above.
- OMDs are **NOT** required in those cases where the assessment is based on an audiogram and there has been further deterioration due to presbyacusis or post service noise exposure.

140403 If the MA considers that an OMD is not necessary in the event of an assessment appeal, this will be clearly marked on the front of the Entitlement certificate WPA363. The evidence upon which the assessment is based should be clearly identified on the reverse of the certificate.

140404 In order for these procedures to work efficiently and effectively, the documents indicated by the MA must contain all the evidence which is necessary to defend the COMPOSITE assessment for the whole of the appealable period. If there is more than one AD it is not sufficient to simply indicate the evidence upon which the assessment of the most recently accepted condition has been founded. The MA must refer to ALL the documents necessary for the defence of the composite assessment ie all the ADs must be covered and for the whole of the period.

140405 Problems can arise in cases where MAs certify a new entitlement but where there are existing ADs. In the past, where a new entitlement was certified and the claimant had made no claim in respect of the state of the extant ADs, there may not have been evidence for the existing ADs appropriate for the period of appeal.

140406 Should an appeal be subsequently lodged against the new composite assessment, the MA should, at that time, obtain all relevant evidence. On receipt of that evidence, the MA will make a judgement, as to whether or not the case needs an OMD. If there are ANY complicating factors, the MA will prepare an OMD in the usual way.

140407-140449

Out of Time appeals

140450 In an out of time assessment appeal the MA may advise an increased assessment for the whole period under appeal. Under Rule9(3) of the PAT Rules this disposes of the appeal which is then struck out. Under Article 65 of the SPO 1983 payment will not normally be made for any period prior to the date of the successful appeal application.

Posthumous assessment appeals

140451 Where a pensioner dies during an assessment appeal the designated person may continue that appeal but cannot lodge a fresh assessment appeal. If in these cases the medical officer advises an increased assessment the designated person may not be satisfied with the increased assessment. The Department would deny the designated person the right to a PAT hearing if the increased assessment was awarded. An "offer" is therefore made to the designated person explaining fully the reason for the proposed increase and the effects of implementing. If the award covers the whole period under appeal prior to death the assessment appeal would be struck out (Rule 9(3) of the PAT Rules). The designated person may accept the offer but if not the relevant correspondence between the Department and the designated person is reproduced in the Statement of Case and the Tribunal asked to decide the assessment.

WPA758

140452 To ensure the quality of the submissions to the Tribunals the Departmental Representative (DR) at the Tribunals has since 1975 completed a form whenever a Tribunal has remarked on an error or other imperfection. This form, previously 33X is now WPA758 and a copy is included in the annex. The DR distinguishes between "minor errors" and ones he regards as "significant" ie ones which have probably affected the Tribunal's decision. These reports are not kept on the awards file but are sent to the BAU. The MA in the BAU sends the whole case back to the appeals MA for comment. The BAU MA completes the relevant section of the WPA758, records the nature of the error and keeps a copy of the WPA758. The information is given to the Medical Director.

140453-140499

Preparation of Opinion of Medical Division in entitlement and assessment appeals

140500 The minute to the lay officer should make clear which conditions will be discussed in the OMD and why any amended/additional label meets the claim in full. Ensure that the changes are indicated on the WPA765 proforma. Our lay colleagues will send an Amended Notice of Decision in lieu of the previous notification clearly showing the conditions which will be presented to the PAT.

140501 Where rejection is purely on the grounds that the Secretary of State does not accept an alleged incident/ condition of service it is not always necessary to provide an OMD. An OMD is required only where a medical question is involved. Matters of acceptance/non-acceptance of incidents are lay matters and should be dealt with fully in the Secretary of State's Reasons for Decision (prepared by the lay officer).

140502 In cases where the appellant makes contentions regarding his/her own personal sphere (eg loss of earnings etc), then the rebuttal of such contentions is the SOS's responsibility. It is not a responsibility of medical services and should not, therefore, be referred to in the OMD. MAs are, thus, reminded that they need no longer concern themselves with such contentions and that the relevant paragraph in the Assessment template is no longer applicable.

140503 When it is decided that a rejection, or an assessment, should be maintained the medical adviser must provide an OMD explaining the medical reasons for the decision Templates have been prepared to assist in this task. These provide the medico-legal framework for the OMD. There are 10 of these, appropriate to each situation. Copies are enclosed in the Annex at the end of the chapter.

140504-140549

Dating of OMDs - assessment and entitlement

140550 The OMD should be routinely dated on the day on which it is signed and prior to its despatch.

140551 Occasionally, an OMD is returned to a Medical Adviser, an error having been identified prior to its despatch to the appellant. In such instances, and providing the MA agrees that an error exists, the original OMD should be destroyed and a new one produced. The date assigned to the revised OMD should be the date on which it is signed.

140552 It sometimes happens that, subsequent to the production of the OMD, but prior to the appellant's answer, further pieces of evidence are received If the EO considers this evidence to be, in any way, relevant to the case, then it is passed to the MA for comment. In the past, it has been the practice for the EO to suggest that, providing the new material necessitates no alteration to the OMD, the OMD should simply be re-dated, in order to signify that the material has been considered by the medical officer. Such re-dating should cease. In such a situation, if the fresh material has any medical content, then an FOMD should be prepared, duly signed and dated. If, in the opinion of the MA, such material has no medical content, then there will be no necessity for an FOMD. The EO should be informed that no medical comment is needed. Such a procedure often occurs at the answer stage and there is no reason not to use it in this type of situation. The EO can insert a suitable annotation into the SoC, making it clear that the fresh material has been seen by the medical adviser but that no further medical comment is considered to be necessary.

140553 Where new conditions related to the condition under appeal are officially rejected or where the labels are changed, in order to more closely answer the original claim, the usual practice is for the MA to produce the OMD at the time of this initial action. This practice is entirely correct and should continue. The official letter notifying rejection will be annotated with the same date as the OMD.

140554 However, when new claims are identified at the time of appeal and additional conditions unrelated to the condition under appeal are rejected on an WPA364 it is not necessary to produce an OMD relating to these new conditions at this stage.

140555-140599

Entitlement (Disablement) appeals

140600 The procedure for preparing an OMD is as follows:-

140601 At all times have in mind the required onus of proof and ensure that the evidence weighs sufficiently strongly in relation to the Article.

(140601)

		Action	Consider
Para 1	i)	Select the appropriate template. Work through the template amending each paragraph in turn.	i) The Article ii) The date of onset of the condition as shown by the evidence or in relation to known aetiology of the condition.
Para 2	i)	Select a suitable label and refer to the relevant appendix (attached as an appendix).	i) Does the label meet the claim?
	ii)	Explain any change in label.	
	iii)	Show what is p&p.	iii) Are any claimed features/symptoms p&p.
	iv)	Point to the evidence which supports the diagnosis. Clearly identify the entries eg HCNs dated ..... . Consultant's reports of ..... date. Indicate undated entries by reference to adjacent entries eg Undated Consultant's report immediately following the GP report of ..... date. DO NOT INSERT PAGE REFERENCES	iv) Which entries most firmly support the diagnosis?
Para 3		Select appropriate paragraph 3 for defence of not attrib. Clearly show relevant references. Identify any causal factors which are present and dissociate these from service	i) Date of onset. ii) Known aetiology. iii) Absence of service related causal factors iv) Incidents not accepted.
Para 4		Select appropriate para 4 for defence of not agg/APA. If relevant to the argument refer to the evidence which shows	

(140601)

	Action	Consider
	i) Date of onset/1st manifestation	i) Cannot be agg if of post-service onset. Remember - in some conditions onset and date of 1st manifestations are not necessarily the same eg atherosclerosis spondylosis.
	ii) No in-service deterioration or no worse than if he had never served	ii) Condition and progress in service and at release.
	iii) Treatment in service prompt and correct at all times.	iii) Was treatment impeded by service compulsions? Was treatment the same as it would have been in the civilian setting?
	iv) Long period of quiescence after release	iv) Post-service progress
	v) Absence/non-acceptance of service incidents.	v) Service incidents/compulsions.
	vi) Natural course (ie appendix)	vi) Natural course of the disease.
	vii) Absence of service risk factors. Non-acceptance of identified risk factors.	vii) Known risk/aggravating factors.
	viii) If there was agg persisting at release cite the evidence which shows this did not persist at the date of claim (Article 5) or did not persist at date of the evidence (Article 4).	viii) Article 5 - agg must not remain at the date of claim. Article 4 - you must be able to show beyond reasonable doubt that agg no longer remained on the specified date.
Para 5	i) Rebut appellant's contentions with evidence/reasons. Negative evidence can be quoted in Article 5 cases.	i) Incidents/service factors not accepted. ii) Efforts made to obtain evidence to support/ refute the allegations. iii) Could the alleged factors cause or influence the progress of the condition?
	ii) Dissociate accepted conditions (and if necessary their treatment). Give evidence in support of your argument.	i) the possibility of consequential disablement. ii) Could the ADs cause or influence the progress of the condition under appeal?

Interaction

140602 Remember that interaction between ADs and non-ADs of post-service onset is a matter of assessment (GD) and not one of entitlement.

Off Duty Incident

140603 Where a condition was caused by a non-accepted (eg off duty) incident and attrib is rebutted the question of aggravation by service factors has to be addressed.

Multiple periods of service

140604 When there were several periods of service, attrib and agg must be discussed in relation to each period, under the relevant article for that period.

Not Found - OMD Template 9

140605 Note: This template and rejection of a condition as NANA - not found, are only suitable for those cases where the claimant does not suffer and has never suffered from the claimed condition.

140606 In those cases where there is disablement due to the claimed condition the rejection defence should be on the basis of NANA - ie the evidence shows the condition is not attributable, was not aggravated by service factors (Article 4), or the appellant has not by reliable evidence raised a reasonable doubt that the condition is attributable to or was aggravated by service and remains aggravated (Article 5).

AGG remaining at date of claim. OMD Template 5 (Post-service, Article 4).

140607 Reference to Aggravation remaining "at the time when the claim was made", is to be found in Article 5(3) of the SPO No reference to 'date of claim' is to be found in the wording of Article 4 Article 4 merely makes reference to the fact that the claimed condition "remains aggravated" by service.

140608 Despite the fact of the words 'date of claim' not being mentioned in Article 4, we have always interpreted the words 'remains aggravated' as meaning that such aggravation must remain at the time that the claim is made In 'Current Invalidings' the date of claim is deemed to be the date of service discharge, thus we have to consider whether any service aggravation was present on the day that the claimant left service. In all other Article 4 cases our considerations are based on date of claim.

140609 Because of the above argument, and in spite of the fact that the actual phrase does not appear in Article 4 of the SPO, Template No 5 contains the words "at the date of claim" at the conclusion of paragraph 1. The inclusion of these words, in this particular template has somewhat disconcerted our administrative colleagues, who are of the opinion that the phraseology should accurately mirror that of the SPO. We have, therefore, agreed that, in future, whenever a Medical Adviser uses template 5, the words "at date of claim" will be deleted. Paragraph 1 will, therefore, conclude "and remains aggravated thereby". The actual criteria, used to consider the merits of the claim/appeal, will, however, remain unaltered, as expounded above.

140610-140619

After the OMD entitlement is prepared

140620 Take the following action:

Step	Action	
1	Refer to check list and amend any errors/omissions	
2	Mark text where R22 is applied and provide both abridged and unabridged copies. (1 abridged and 2 unabridged (blacklined) copies).	
3	If there is no application of R22 print 2 copies. Sign one of these (include your qualifications) Date both copies	
4	Complete form WPA765 - to show	a) certificate prepared - explain b) condition rejected - explain c) OMD(s) prepared - labels d) R22 applied e) Appendices enclosed.
5	If necessary write a brief minute to the lay officer clarifying any points shown on WPA765 and advise on reference to a High Court Case	
6	Enclose appropriate medical appendix.	

Check list for entitlement opinions

140621 Check the following:

- Is the reference number correct?
- Are all the quoted dates correct? (Re-check).
- Are all the paragraph numbers in the correct order?
- Has all the relevant medical evidence been identified for inclusion in the SoC.
- Have the words 'discharge', 'release', or 'invaliding' been used correctly?
- Has the document been proofed? (ie has the 'spell check' been used?)
- Has the correct template been used and does it meet the onus of the article etc?
- Has the disablement template, in widows cases, been suitably modified?
- Is the grammar of the finished OMD correct in all aspects? (Bearing in mind the limitations of the template system).
- Has Rule 22 been applied correctly? If so have three separate OMDs been produced (one with and two without the application of Rule 22)?
- Has the need for any necessary change of label been fully explained?
- Is the overall presentation satisfactory? (Bearing in mind that this is a finished, legal document for presentation to PAT).

(140621) • Has the 'lay side' pro-forma (WPA765) been correctly completed?

140622-140699

Assessment appeals

140700 Once it is decided that the assessment should be defended and that an OMD is necessary the OMD should be prepared by selecting the appropriate template. Form WPA765 should be completed and 2 copies of the OMD (one signed, one unsigned. both dated) provided

Notes

140701 It is often useful to explain what is accepted in an assessment though not specifically mentioned in the label - eg osteoarthritic changes, bronchitis in old Pul Tub etc This may assist the DR.

140702 Where an assessment has been reduced we should give reasons

140703 There are grounds for defending finality

- When the AD is medically final or
- When an agg assessment is limited.

140704 So far as possible the disablement which is accepted should be identified and distinguished from what is not accepted. Say whether GD applies and if so, how much

140705 Individual numerical assessments given to separate ADs may be discussed but the appeal lies against the combined assessment Multiple ADs should be discussed separately, showing where relevant that they have remained static, improved or worsened and whether disablement from them is nil, slight etc.

140706 Rule 9(3) of the PAT Rules provides that where the Department increases the combined assessment during an assessment appeal the increased assessment disposes of the appeal and the appeal will be struck out. There is then a right of appeal against the new assessment for the whole period covered by the struck out appeal and an OMD will be required to explain this action if the pensioner appeals against the new assessment.

140707 In agg cases where we limit liability the reasons for limiting liability must be explained. Attention should be drawn to such relevant factors as:-

- Pre-service history.
- Condition at enlistment.
- Nature and length of service
- What happened in service - eg no acute or severe exacerbation.
- What has happened since service - eg improvement, long period in status quo, worsening due to natural progress or to factors unconnected with service. Where applicable refer to previous PAT decisions.

(140707) Having given the reasons attention is then drawn to Article 9 (which is attached as an appendix) to explain why the increased disablement should be excluded What is said depends on -

- Whether or not disablement already exceeds the assessment.
- Whether potential worsening is "found now or in the future".
- Whether the condition limited is not the only AD.
- (Select the appropriate wording from the template).

140708 At times, MAs are faced with the situation, in which it is necessary to explain why the Department's assessment of a particular disablement differs from that of a Service Invaliding Board. The Invaliding Board's assessment will be from many years in the past, as, at the Department's request, assessments are no longer given in such situations.

When seeking a form of words to explain the discrepancy, it should be borne in mind that the Invaliding board's assessment was based on a different set of criteria to that encompassed in the War Pensions legislation. The form of words noted below may be found helpful in such cases.

'We have noted the assessment suggested by the Invaliding Medical Board, dated ... . However, that assessment was not based on the same set of criteria as those that constrain the Department. Departmental assessments of disablement, in War Pension cases, are certified according to Article 9 of the Service Pensions Order (1983). This Article states that "the degree of disablement due to service of a member of the armed forces shall be assessed by making a comparison between the condition of the member so disabled and the condition of a normal healthy person of the same age and sex, without taking into account the earning capacity of the member in his disabled condition in his own or any other specific trade or occupation, and without taking into account the effect of any individual factors or extraneous circumstances;" Bearing in mind the constraints of Article 9, and for the reasons already outlined above, we remain of the opinion that the present assessment adequately reflects the degree of disablement arising from the Accepted Disablement, for the period under appeal'.

140709-140799

Answers - entitlement and assessment

140800 "Answers will be received to both entitlement and assessment cases, and will vary from simple comments to fairly elaborate reports.

- If they raise no new points, the medical adviser may advise that no further medical comment is needed. A Departmental statement is inserted to say this.
- If they introduce new evidence or ask for additional evidence to be obtained, this must be considered. The War Pensions Agency will usually try to get the additional evidence, or give reasons for not doing so. Because of the answer an award may be advised.
- If an award is not made, points in an Answer may need to be discussed in a Further Opinion of Medical Division (FOMD). Where the answer is a report from a regular contributor the same ground may have been covered before. There is no template for a FOMD. This must be typed freehand.

140801 One signed and dated and one unsigned and dated copy (or 3 copies - one abridged (unsigned) and 2 unabridged (one signed) when R22 is applied) must be produced.

140801-140899

Preparation and use of medical appendices

140900 In an entitlement appeal, attached to the statutory Statement of Case is an Opinion of Medical Division, a reasoned argument explaining the basis for the medical decision. Of those interested in the appeal some may not have adequate medical knowledge of the condition under appeal eg the appellant, his representative, the legal chairman and service member of the Tribunal. To aid their consideration a Medical Appendix is prepared in terms comprehensible to a non-medical person explaining the medical condition, its clinical manifestations and its aetiology.

140901 This appendix is not intended to be an all-embracing document of medical knowledge but rather an easily understood reference explaining the medicine of the condition By its nature it cannot contain all the fine details for such a document would tend to confuse and not assist the Tribunal in coming to a fair and just conclusion. It is not feasible, for example, to include detailed arguments about the various theories about the causation of a particular disease. In describing the aetiology of a condition we attempt to state the current authoritative consensus of opinion rather than to give all the minority views of possible aetiological factors.

140902 In compiling a Medical Appendix the consensus of current authoritative medical opinion is presented in relatively simple, straightforward terms. To prepare the Appendix standard medical textbooks and articles in current medical journals are scrutinised The feedback from those who must read the appendices, in particular the medical members of the Tribunals, is taken into careful consideration.

140903 Should a Medical Adviser consider it imperative that rule 22 be invoked in respect of any part of the chosen Appendix, that Appendix must first be copied and the black lining applied to the copy. A copy of the 'black-lined' Appendix should then be made, from which the black-lined material should be deleted. Both the 'black-lined' and the 'deleted' copies must be sent to the relevant section.

140904 Should the Medical Adviser consider it undesirable for a copy of the medical appendix to be supplied to the appellant (eg in cases of malignancy or serious diseases such as schizophrenia where the appellant is unaware of the true diagnosis), then the Medical Adviser should indicate such in red ink on the WPA765.

140905 If the MA is dealing with some esoteric, unusual subject then the production of an Appendix is unnecessary. A paragraph in the body of the OMD outlining the clinical features and aetiology will be sufficient In such cases, references should be quoted at the end of the OMD after the MA signature.

140906-149999

Appendices

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Appendix eighteen	The Organ of Corti
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War Pensions Agency
Norcross
Blackpool FY5 3WP
England

Monday - Thursday: 8.15am - 5.15 pm
Friday: 8.15am - 4 30pm

Telephone: 01253 858858
Textphone: 01253 859999
Fax: 01253

WAR PENSIONS AGENCY

An executive agency of the Department of Social Security

(A)

If you get in touch with us please tell us this reference number
(B)
Date (C)
Office use

Dear (D)

(E)

I am writing in reply to your (F) the supply of medical records in respect of the above named.

On 8th January 1999 the NHS Executive issued the Health Service Circular - HSC 1999 / 001 which replaces the Financial Directive letter FDL(93)79 and reaffirms the long-standing responsibilities of the NHS Hospitals and Trust Hospitals to supply patient information to the Department of Social Security within 10 working days of request, free of charge. The War Pensions Agency is an executive Agency of the DSS.

We accept that you may not wish to release your original records and we are willing to receive copies of the information we have requested.

We regret, however, that in line with the Health Service Circular, we are unable to make any payments for such copies as the records are required for Benefit Assessment Purposes.

I look forward to your reply in due course

Yours sincerely,

(G)

For Chief Executive
War Pensions Agency

2/99 DL77

Health Service Circular

NHS Executive

Series number: HSC 1999/001
Issue date: 8th January 1999
Review date: 30th September 1999
Category: Finance
Status: Action

sets out a specific action on the part of the recipient with a deadline where appropriate

The Provision of Patient Information by NHS Trusts to the Department of Social Security

Requests for information used for Benefit Assessment Purposes

For action by: NHS Trusts - Chief Executive

For information to: Health Authorities (England) - Chief Executives
NHS Trusts - Directors of Finance
Health Authorities (England) - Directors of Finance

Further details from: Stuart Perry
Room 3W06
Quarry House
Quarry Hill
Leeds
LS2 7UE
0113 254 5429

Additional copies of this document can be obtained from:

Department of Health
PO Box 410
Wetherby
LS23 7LN

Fax 01937 845 381

It is also available on the Department of Health website at
http://www.open.gov.uk/doh/coinh.htm

The Provision of Patient Information by NHS Trusts to the Department of Social Security

Requests for information used for Benefit Assessment Purposes

Summary

This circular describes how NHS Trusts should handle requests for patient information from the DSS, its executive agencies (Benefits Agency and War Pensions Agency) and contractors who will be providing medical services on behalf of the Benefits Agency and the Independent Tribunal Service. These requests for patient information will be sought in order to assess individual claims for a range of social security benefits and war pensions.

Action

With immediate effect all NHS Trusts should apply this guidance and comply with the directions contained in this letter and accompanying Annex In particular, they should note.

- requests from the contractor/DSS for the provision of hospital case notes, X-rays and factual reports in respect of a client's claim for benefit should be supplied without charge;
- for the provision of hospital case notes the contractor/DSS would prefer to receive photocopies of the original documents, unless otherwise specified;
- requests should be met within ten working days of receipt;
- the guidance does not alter the position regarding the charging by practitioners of third parties for the provision of information which is deemed not to be reasonably incidental to their contractual duties relating to the prevention, diagnosis or treatment of illness, which forms part of the services provided by the practitioner's employing authority under Section 3(1) of the NHS Act 1977.
- it is not necessary for patients or their representatives to exercise their rights under the Access to Health Records Act 1990 to obtain information to support a claim for benefit.

Background and Other Information

This guidance has been issued as an update to original guidance contained in FDL(93)79 which has now expired. Detailed background information is contained in the accompanying annex.

WAR PENSIONS AGENCY

An executive agency of the Department of Social Security

War Pensions Agency
Norcross
Blackpool FY5 3WP
England

Freeline (UK only): 0800 169 22 77
Textphone: 0800 169 34 58
Fax: 01253
Tel (Overseas): + 44 1253 866043

Mon - Thurs: 8.15am - 5.15pm
Friday: 8.15 - 4.30 pm
Post Ref Number:

WAR PENSIONS MEDICAL REPORT

To:- Atomic Weapons Establishment
Room 105
Building A6:1
Aldermaston
READING
Berkshire RG7 4PR

re:

Re: Name:
NINO:
DoB

Date: 28 March 2001

The above named claims to have been present at a UK atmospheric nuclear test site. As a result of this service he claims a war pension for ~ . In order to decide the claim we need a report of his service related ionising radiation exposure.

We would be grateful if such a report could be provided with particular attention to the following:-

1. What participation, if any, did the claimant have in the UK atmospheric nuclear weapon test and experimental programmes?
2. What were the nature of his duties?
3. Was he issued with film badge dosimeters, and if so, what exposures were recorded?
4. What is his assessed total equivalent effective dose from participation?
5. Conclusions

Thank you for you help in this matter.

Medical Adviser

e-mail: warpensions@gtnet.gov.uk
Internet. www.dss.gov.uk/wpa/index/htm

The Ionising Radiation (Medical Exposure) Regulations 2000

(Together with notes on good practice)

1 Introduction

1.1 This document provides guidance on the Ionising Radiation (Medical Exposure) Regulations 2000 (the Regulations) and notes on good practice. The guidance is not intended to be binding and cannot take the place of legal advice. It sets out the Department's view of how certain provisions of the Regulations should be interpreted but the ultimate arbiter in any case of doubt would be the court. Only it could make a definitive ruling.

1.2 The Regulations implement for Great Britain the majority of the provisions of Council Directive 97/43 Euratom of 30 June 1997 (the "Medical Exposures Directive") laying down the basic measures for the radiation protection of persons undergoing medical exposures. The remainder is implemented in the Ionising Radiations Regulations 1999 ("IRR 199"). The Directive reflects the 1990 Recommendations of the International Commission on Radiological Protection.

1.3 The Regulations revoke and replace the Ionising Radiation (Protection of Persons Undergoing Medical Examination or Treatment) Regulations 1988.

2 Justification

2.1 The Medical Exposures Directive requires that all medical exposures to ionising radiation must be justified prior to the exposure being made. The Directive refers to two levels of justification; justification of types of practice and justification of individual medical exposures.

2.2 The Regulations apply only to individual medical exposures. Hence, justification of types of practice is not addressed within Regulations.

2.3 It is intended that justification of types of practice involving medical exposures will be covered by amendment to IRR 1999.

3 The Private Sector

3.1 Practice involving the use of ionising radiation in the NHS and in the private sector of healthcare is broadly consistent. Whilst this guidance is drafted with specific reference to the NHS, the Regulations and guidance apply to both the NHS and the private sector.

4 Application - Regulation 3

4.1 This regulation lists the medical exposures to which the Regulations apply. Compared to the 1988 Regulations, these Regulations cover an increased range of exposures to ionising radiation, and in particular include exposures for the purpose of medical or biomedical research.

4.2 The Directive covers "exposure of individuals knowingly and willingly helping (other than as part of their occupation) in the support and comfort of individuals undergoing medical exposure." Such exposures are not covered by these Regulations but are covered by IRR 1999.

5 Interpretation - Regulation 2

5.1 This regulation defines a number of terms used in the Regulations. Certain key definitions are discussed below.

5.2 **"appropriate authority"**

5.2.1 Since the Regulations apply to England, Scotland and Wales, it was necessary to provide for different authorities in each of these areas for enforcement and reporting purposes. The definition accordingly states the relevant entity for each of England, Scotland and Wales.

5.3 **"diagnostic reference level"**

5.3.1 The Regulations require the employer to set diagnostic reference levels and provide procedures on how they are to be used. A diagnostic reference level should be set for each standard radiological investigation. They should also be set for interventional procedures, nuclear medicine investigations and radiotherapy planning procedures.

5.3.2 Diagnostic reference levels should be expressed in quantities which are directly applicable and relevant to the examination in question to enable the resulting patient dose to be calculated eg dose area product, screening time, etc. Diagnostic reference levels can be decided on by an employer after considering local exposures or administered activities of standard radiological examinations. Records of exposures or activities used previously can be used for this purpose. However, regard must be had to European data where available when setting local diagnostic reference levels (see also regulation 4(3)(c)).

5.4 **"employer"**

5.4.1 This definition is not as used conventionally in employment law. In most circumstances within the NHS, a Trust will be considered to be the employer.

5.4.2 If an employer, eg an NHS Trust, contracts a third party to provide services (including the provision of operators) then the Trust will be the employer as regards the operators for the purposes of the Regulations, but the third party is the employer of the operators for employment law purposes.

5.4.3 Equipment ownership has no impact on the employer responsibilities under these Regulations.

5.5 **"equipment"**

5.5.1 Equipment as referred to in these Regulations, includes that equipment used for nuclear medicine procedures, such as gamma cameras etc. In diagnostic radiology auxiliary equipment that can indirectly affect the exposure such as grids, cassettes, tables, cameras, monitors and imaging software is included.

5.6 **"medico-legal procedure"**

5.6.1 This category of exposure will include those required for legal purposes of any kind eg those required in connection with legal proceedings or those required prior to emigration.

5.7 "medical physics expert"

5.7.1 The science degree or its equivalent referred to in this definition should be relevant to the use of ionising radiation as applied to medical exposures. The medical physics expert (MPE) is required to have been adequately trained (as defined in the Regulations) for his involvement in medical exposures under the Regulations. The MPE is expected to undertake tasks such as giving advice on patient dosimetry, development and use of new and/or complex techniques, as well as other matters related to radiation protection concerning medical exposures.

5.7.2 The MPE should not be confused with the Radiation Protection Adviser as identified under the IRR 1999. The functions are different although, in practice, it is possible that the same person may undertake both roles.

5 8 "operator"

5.8.1 An operator is anyone who carries out a practical aspect. The range of functions covered by the term 'practical aspects' is broad. It is unlikely that a single operator will carry out all these functions for any individual medical exposure.

5.8.2 Nevertheless, an operator usually will carry out a variety of functions and therefore it is essential that the functions and responsibilities of individual operators are clearly defined within standard operating procedures. The operators who can undertake certain tasks may be identified in a variety of ways in the employer's procedures, for example, by profession, grade, or individual name. In some cases, detailed job descriptions may help.

5.8.3 In some cases, the practitioner may also undertake practical aspects of an exposure eg fluoroscopic screening. In these circumstances, the practitioner becomes an operator with regard to these specific functions.

5.8.4 Examples of operators include doctors, medical physicists, medical physics technicians, nurses, radiographers and radiopharmacists. Third party service engineers would not normally be considered as operators. Where significant changes to equipment have been made, these should be checked where practicable by an operator (eg an employee of the NHS Trust) before equipment is brought into clinical use.

5.9 "practical aspects"

5.9.1 The range of functions covered by this term is extensive and includes the supporting functions prior to the exposure taking place eg the calibration of equipment that emits ionising radiation, the preparation of radioactive medicinal products, computer planning and calculation of monitor units to be delivered in radiotherapy etc, as well as of performing the exposure itself.

5 10 "practitioner"

5 10.1 Decisions on who is entitled to act as a practitioner should be taken at local level by agreement between the employer and the healthcare professionals involved in medical exposures. Such decisions should be based on the type of medical exposure and on specific circumstances and may be restricted eg it may be appropriate to agree that certain health professionals can act as a practitioner for radiographic procedures for extremities, but not for complex interventional examinations.

5.10.2 The primary responsibility of the practitioner is to justify medical exposures. This requires the practitioner to have a full knowledge of the potential benefit and detriment associated with the procedure under consideration. Clearly all practitioners need to be adequately trained to undertake this function.

5.11 **"radiological"**

5.11.1 By stating that the term 'radiological' applies to planning and guiding radiology, activities such as those associated with radiotherapy simulation, the planning of radiotherapy treatments etc are included as well as those associated with interventional radiology.

5.12 **"referrer"**

5.12.1 As with practitioners, decisions on who is entitled to act as a referrer should be taken at local level by agreement between the employer and the healthcare professionals involved in medical exposures. Such decisions should be based on the type of medical exposure and on specific circumstances and entitlement to act as a referrer may be restricted eg it may be agreed for example, that certain health professionals can act as a referrer for radiographic procedures for extremities, but not for complex CT examinations. Further examples, where agreed locally, might include certain requesting of specific planning procedures involving ionising radiation for patients on whom it has already been agreed that radiotherapy is appropriate.

5.12.2 The range of procedures that can be requested by a referrer should be agreed locally between the referrer and the employer of the radiological installation. It is intended that the healthcare professionals involved in imaging and/or therapy as appropriate at that site will advise that employer.

5.12.3 In situations where an individual, following an invitation, undergoes an exposure as part of a national screening programme, there is no requirement in practice for a named referrer.

6 **Duties of the Employer - Regulation 4**

6.1 **Regulation 4(1)**

6.1.1 This regulation requires the employer to establish written standard operating procedures. These procedures are intended to provide a framework under which professionals can practice. It is recommended that the employer seek advice from professional colleagues from the fields of radiology, radiotherapy and nuclear medicine in establishing the procedures.

6.1.2 In practice, the employer may ask a practitioner or operator to produce a written procedure. However, it is important to note that while the task may be delegated, the responsibility remains with the employer eg the task of producing a patient identification procedure can be delegated by the employer, but if the procedure is not produced in fact then the employer remains responsible under the Regulations. Procedures should be specific where necessary but allow freedom for professional judgment where appropriate. Examples are given in guidance to Schedule 1. However the matters listed in Schedule 1 are not exhaustive and may be considered a minimum requirement. As a matter of good practice, the procedures should be reviewed at regular intervals and be signed and dated accordingly.

6.1.3 In some cases, the employer is the same person as the practitioner and/or the operator (for example, some dental practitioners). Such an individual is still required to establish the procedures required by this regulation and to comply with them.

6.2 **Regulation 4(2)**

6.2.1 The protocols required under this regulation should not be confused with employer's procedures required by regulation 4(1). Protocols cannot be absolute or totally comprehensive as it is not possible to produce detailed and rigid protocols for every examination. However, they should be specific to each examination and machine as appropriate, eg in diagnostic practice, for a particular x-ray room, x-ray exposure factors for a specific examination (PA chest: 120k V 2mAs). They must be written down and their status clear. Protocols should allow latitude for professional judgement but where the latitude provided is exceeded and exposure factors varied, it would be advisable to record the changes made. Where, on commissioning, exposure values are programmed via the console into the x-ray generator, it is recommended that a record of the values be kept in the department together with any changes to these values, whether for individual patients, or as a result of agreed protocol changes.

6.2.2 In radiotherapy, the protocols might refer to standard dose regimes, energies and beam projections and may be specific to each consultant if necessary. Such protocols would not negate the need for individual planning to produce the intended therapeutic effect.

6.3 **Regulation 4(3)(a)**

6.3.1 In establishing the referral for medical exposures required under this regulation, it will be appropriate to consult and agree with those professionals involved in medical exposures. It is expected that most departments already have criteria in place for many procedures. For example, the Royal College of Radiologists have produced recommendations for diagnostic practice and these would be an acceptable foundation on which to base local criteria.

6.3.2 The locally agreed criteria must be made available to all referrers to that department. There is an obligation to produce these criteria regardless of the size or type of the department, types of examinations performed, or whether the employer, referrer, practitioner and operator are the same person.

6.4 **Regulation 4(3)(b)**

6.4.1 The quality assurance programmes required are for standard operating procedures, not equipment, which is dealt with under IRR 1999. All procedures should be regularly reviewed to ensure that they are effective and appropriate and to identify any necessary amendments.

6.5 **Regulation 4(3)(c)**

6.5.1 This regulation requires the employer to establish diagnostic reference levels for standard radiodiagnostic examinations. National reference levels may be taken into account in doing so, for example, in nuclear medicine procedures, data produced by ARSAC (Administration of Radioactive Substances Advisory Committee) will be relevant. The Regulations require that regard be had to European levels, where available.

6.6 **Regulation 4(3)(d)**

6.6.1 The dose constraints to be established by the employer under this regulation should be applied to research protocols involving standard radiodiagnostic procedures. Such research should be subject to a dose constraint based on the total dose from all radiodiagnostic procedures included in the protocol.

6.7 **Regulation 4(4)**

6.7.1 This regulation requires the employer to ensure that practitioners and operators are both adequately trained and undertake continuing education and training. With regard to the latter, it is to be noted that the duty is not on the employer to provide continuing education and training himself. The obligation will be satisfied if he takes steps to ensure that the practitioner and operator seek out and attend such education and training. Where the employer is also the practioner and/or operator, he must himself ensure that he undertakes appropriate continuing education and training.

6.7.2 In cases where the employer engages sub-contractors, the obligation to ensure compliance with this regulation will be satisfied by the employer if he includes a clause in the contract stipulating that the practitioner or operator to be engaged by him must have been adequately trained and undertake continuing education and training. Records of previous and continuing education and training must be kept by the sub-contracted company (or in the case of the self-employed, themselves) eg for agency staff, the agency employer is responsible for keeping up-to-date training records on the staff supplied by the agency. These records also must be made available to the employer, upon request. See also regulation 11.

6.7.3 Requirements for continuing education are integral to the functions of health professionals and employers should make provisions for such training.

6.8 **Regulation 4(5)**

6.8.1 This regulation requires the employer to carry out investigations of incidents and appropriate reviews. In most cases, the term 'much greater than intended' as used in this regulation should be interpreted as for IRR 1999 HSE has published specific guidance on doses which are likely to be much greater than intended for particular types of medical exposure. While this guidance was not developed for this purpose, application of this guidance is appropriate. Incidents which occur as a result of equipment malfunction or breakdown must still be reported to the HSE under IRR 1999.

6.8.2 Patients who undergo a procedure that was not intended, as a result of mistaken identification or other procedural failure, and consequently have not been exposed to an ionising radiation dose, should be considered as having received an unintended dose of radiation.

6.8.3 The detailed investigated required by the Regulations should be aimed at:

- establishing what happened
- identifying the failure
- deciding on remedial action to minimise the chance of a similar failure
- estimating the doses involved.

6.8.4 The notification is required to be made directly to the appropriate authority appointed for these Regulations.

6.8.5 As a matter of good practice, patients who have been exposed to a dose of ionising radiation much greater than intended, should be informed of the incident, unless there is a good reason for them not to be. It should be a local decision on how, when and by whom the patient is notified, but the practitioner and referring clinician should be involved. When the patient is unable to understand the information given, it may be more appropriate to inform the patient's representative or parent/guardian. It would be advisable to record decisions not to inform the patient or the patient's representative or parent/guardian in the patient's case notes. Further, whilst the Regulations refer to those incidents resulting in exposures much greater than intended, it is recognised that in certain situations eg radiotherapy, exposures much lower than intended can also have serious consequences. Whilst not notifiable under these Regulations, as a matter of good practice, the employer may wish to carry out his own investigations in such circumstances.

6.9 **Regulations 4(6)**

6.9.1 The review required by this regulation is intended to provide an opportunity to provide at a local level to evaluate the reasons why diagnostic reference levels have been exceeded. Corrective action might include setting new values for diagnostic reference levels (see regulation 4(3)(c) and notes thereon). Corrective action may also include retraining an individual. This might not be restricted to techniques directly involving ionising radiation.

6.9.2 It is not intended that this regulation should replace or diminish the need for regular reviews of diagnostic reference levels.

7 **Duties of the Practitioner, Operative and Referrer - Regulation 5**

7.1 Regulation 5 sets out the respective responsibilities of practitioner, operators and referrers and makes clear that where the employer also acts in one or more of these roles concurrently, he is responsible accordingly. Points to note are as follows:

7.2 **Regulation 5(1)**

7.2.1 The practitioner and the operator must comply with the employer's procedures and where these include detailed standard operating procedures, they must be followed explicitly eg patient identification and checking procedures. All those matters required by the Regulations to be in employers' procedures (Schedule 1) are binding.

7.3 **Regulation 5(3)**

7.3.1 This regulation deals with the allocation of responsibility for practical aspects of a medical exposure to specific individuals. The employer must set out in his procedures who will be entitled to act in this capacity. In doing so he should have due regard to professional roles and appropriate training. The person to whom a practical aspect has been allocated is responsible for that aspect (regulation 5(4)).

7.4 Regulation 5(4)

7.4 1 Those persons undertaking practical aspects (operators) are responsible under the Regulations for their functions. No overarching responsibility is held by another person.

8 **Justification of Individual Medical Exposures - Regulation 6**

8.1 This regulation deals with the justification and authorisation of individual medical exposures and provides that no one may carry out a medical exposure unless the matters set out in regulation 4(1)(a)-(e), where applicable, have been complied with. Points to draw attention to under this regulation are as follows:

8.2 **Regulation 6(1)**

8.2 1 In this regulation, the phrase "carry out a medical exposure" refers to the actual process of exposure to ionising radiation itself, and not to other practical aspects of the exposure, such as calibration, which can be carried out irrespectively of the justification of individual exposures.

8.3 **Regulation 6(1)(a)**

8.3.1 The practitioner is responsible for the justification of each individual medical exposure. This should be based on his knowledge of the hazard associated with the exposure and the clinical information supplied by the referrer. Authorisation is a separate process and is the means by which it can be demonstrated that justification has been carried out. The method of authorisation may depend on local circumstances and may include a signature on the request card, addition of an electronic signature etc. It is recommended that the employer specify a method of authorisation to be used locally to ensure a consistent approach.

8.3.2 In cases where the referrer is the same person as the practitioner and/or the operator (eg some dental practitioners), justification and authorisation still must be carried out, but this may be done by the same person.

8.3.3 In nuclear medicine, the ARSAC certificate holder will be the practitioner, although the authorisation of the procedure may be undertaken by an operator under guidelines (see regulation 6(5)).

8.4 **Regulation 6(1)(c)**

8.4.1 Guidance on the establishment, composition and functions of Local Research Ethics Committees (LRECs) is provided by the Health Departments. The guidance states that all research in the UK should be approved by a LREC, whether or not it has been submitted also to a Multi-centre Research Ethics Committee (MREC). The LREC can recommend that research is undertaken with a proviso that a certain dose is not exceeded.

8.5 **Regulation 6(2)**

8.5.1 The process of justification must give appropriate weight to the factors specified in regulation 6(2) and in doing so pay special attention to the matters set out in regulation 6(3).

8.5 2 The criteria referred to a regulation 6(2)(d) highlight the need, where practicable, to chose techniques involving the minimum necessary amount of exposure to ionising radiation. These are to be preferred where they have the same objective. In practice, use of such techniques will be influenced by availability. The implications of delaying diagnosis or treatment in order to provide the preferred method should be weighed against the potential detriment associated with an increased radiation dose of other techniques.

8.6 **Regulation 6(4)**

8.6.1 Regulation 5(5) requires the referrer to supply the practitioner with sufficient medical data relevant to the medical exposure requested to enable the practitioner to decide whether the exposure can be justified. Regulation 6(4) requires the practitioner to consider the data provided by the referrer before justifying a medical exposure. In order for the data to be sufficient for the purposes of justification it may need to include previous diagnostic information or medical records. However, the Regulations do not require the Medical records to be provided for every procedure.

8 7 **Regulation 6(5)**

8.7.1 The Regulations recognise that it may not be practicable for a practitioner to consider every request for a medical exposure. Regulation 6(5) requires practitioners to produce guidelines which must be followed by operators when it falls to them to authorise an individual exposure. It must be borne in mind that any person who authorises an exposure becomes an operator by virtue of doing so. The guidelines may be written to allow flexibility eg in radiology an agreed range of projections which may be taken to provide the necessary clinical information. This will allow the operator the appropriate freedom to exercise professional judgement.

8.7.2 If the operator authorises an exposure which does not accord with the guidelines, he will be in breach of the regulation and will be responsible accordingly. In these circumstances, the operator's actions in themselves do not change the status of the operator to one of as practitioner in respect of that exposure.

9 **Optimisation - Regulation 7**

9.1 Regulation 7 provides for the optimisation process which involves ensuring that doses arising from exposures are kept as low as reasonably practicable. Optimisation is a process which relies on professional competence and skill. While employer's standard operating procedures can provide framework within which the health professional is to work, they will not generally prescribe the manner in which functions specified therein are to be carried out This is left to the health professionals to effect in a manner commensurate with their professional status.

9.2 Points to highlight in relation to optimisation are as follows:

9.3 **Regulation 7(2)**

9.3.1 This regulation requires individual planning of target volumes for all radiotherapeutic exposures. It also applies to therapeutic research exposures therefore.

9.3.2 In complying with this regulation, the practitioner should use the best means available to him. However, in order to comply with the regulation it will not be necessary, for example, in external beam radiotherapy, that all patients be planned for treatments using therapy machines equipped with multi-leaf collimators. In practice, decisions on the use of such devices will rest with the practitioner and may depend on availability, clinical circumstance etc. Equally, for therapy with unsealed sources, the requirement for individual planning will be satisfied by carrying out an assessment of the individual patient. However, recommended standard activities of radiopharmaceuticals can still be used.

9.4 **Regulation 7(4)**

9.4.1 This regulation requires the employer's procedures to provide safeguards for medical and biomedical research programmes and to specify how and by whom these shall be effected. The research co-ordinator may be the person best placed to carry out some of these tasks and, where he does so, he will be the operator for those purposes.

9.4.2 All research programmes should be submitted to a Local Research Ethics Committee for approval before commencing.

9.5 **Regulation 7(4)(c)**

9.5.1 This regulation requires dose constraints to be applied where no direct medical benefit for the individual is expected from the exposure. The constraint must be set by the employer in his procedures and must not be exceeded. The constraint should be set at a level to facilitate the research, and be deemed appropriate by the practitioner and agreed by the LREC.

9.6 **Regulation 7(4)(d)**

9.6.1 This regulation requires the planning of individual target levels of doses for patients who voluntarily undergo experimental diagnostic or therapeutic practices in cases where some benefit to the patient is expected. The practitioner is identified as the person who is most able to set target levels, due to his knowledge of ionising radiation and its potential risks. The practitioner may seek advice from others to clarify the doses involved.

9.6.2 In separating these cases from the situation in (c) above, the Regulations recognise that where there is potential benefit for patients from exposures as part of research, setting a constraint is inappropriate. However, regulations 7(4)(d) requires that some target level of dose is set before the exposure begins, for which the benefit still outweighs the detriment. In this way, excessive doses should be avoided. For example, in routine interventional techniques, the radiation dose from screening should not be so great as to produce unacceptable levels of skin damage and a target level should ensure that this will not happen.

9.7 **Regulation 7(5)**

9.7.1 This regulation requires the employer's procedures to provide for the giving of instructions and information in appropriate cases where radioactive medicinal products are administered. The regulation sets out the persons to whom such information should be given.

9.7.2 Regulation 7(5)(a) refers to the patients themselves where they are adults or children who have capacity to consent to the treatment or diagnostic procedure. A child is a person under the age of 18 in England and Wales or 16 in Scotland. The regulation recognises that many "children" are mature enough to consent to treatment etc and to understand what is involved and that such children should be given the information/ advice themselves. However, in such cases, it will usually be appropriate to give the information/advice to be person(s) with parental responsibility (generally the parent or parents) as well.

9.7.3 Regulation 7(5)(b) deals with where the patient is a child who lacks capacity to consent The regulation requires that the information be given to the person(s) with parental responsibility.

9.7.4 Regulation 7(5)(c) deals with mentally incapable adults. In some cases there may be a court appointed receiver (or, in Scotland, a tutor dative or curator) or person with an enduring power of attorney who can deal with their affairs. However, such persons do not necessarily have any rights in relation to the individual's health care. Therefore the most appropriate person to whom to give the information in practice is likely to be a relative taking care of the patient or, for example, the manager of a care home. The position in Scotland will change when the adults with Incapacity (Scotland) act is implemented. This is expected to be from the summer of 2001 onwards.

9.8 **Regulation 7(6)**

9.8.1 This regulation sets out some of the matters to be addressed in the information/instructions to be provided pursuant to regulation 7(5) and when they should be given. In practice, the level of administered activity and resulting dose to others will determine what, if any, advice needs to be given. For example, it will usually be appropriate to give advice in most therapy exposures. A small number of diagnostic exposures also may be of sufficient activity to receive advice etc to be given eg scanning for metastases after thyroid ablation.

9.9 **Regulation 7(7)**

9.9.1 This regulation requires the practitioner/and the operator to pay special attention to certain factors in the optimisation process. One such factor is high doses to the patient. This will be relevant to procedures, such as interventional radiology, radiotherapy and some CT scanning, which deliver an increased radiation dose compared to most routine diagnostic examinations.

9.9.2 Another factor is potential pregnancy in particular if abdominal and pelvic regions are involved. In practice, the dose to the uterus, and, where pregnancy is confirmed, to the unborn child, is likely to vary with the anatomical site and magnitude of the exposure in radiology and with the administered activity and radiopharmaceutical in nuclear medicine. Where practicable, the scheduling of the exposure should be influenced by the date of the last menstrual period.

9.9 3 In nuclear medicine, females who are breast feeding must also be paid special attention. In practice, depending on the administered activity and radiopharmaceutical used, it may be necessary to advise the patient temporarily to cease breast feeding.

9 10 **Regulation 7(8)**

9.10.1 This regulation requires the employer to ensure that a clinical evaluation of the outcome of each medical exposure is recorded and set out in his procedures how and when this is to be done. This evaluation should detail the resulting diagnostic findings or therapeutic implications. If it is known prior to the exposure taking place that no clinical evaluation will occur, then the exposure would not be justified and could not lawfully take place.

9 10.2 Where the employer is concurrently the practitioner/operator, he must still make the appropriate record. Where the evaluation of a medical exposure is not done by an operator engaged by the employer, that employer must take steps to ensure that it is carried out by a third party in accordance with the employer's procedures.

9.10.3 Factors relevant to the patient dose should be included in the record where appropriate, in order that, if necessary, at a later date an estimation of the effective dose to the patient can be made.

9.11 **Regulation 7(9)(a)**

9.11 1 This regulation requires the operator to ensure that, in fluoroscopy, examinations without devices to control the dose rate are limited to justified circumstances. An example of when such justification may exist is in paediatric radiology where devices designed to control the dose rate can result in doses greater than necessary.

10 **Clinical Audit - Regulation 8**

10.1 This regulation requires the employer's procedures to provide for the carrying out of clinical audit as appropriate. In doing so, the employer may wish to take account of existing guidance, for example in England and Wales: "Clinical Governance: Quality in the new NHS" (March 1999). Similar Guidance exists in Scotland.

11 **Expert Advice - Regulation 9**

11.1 This regulation requires the employer to ensure that a medical physics expert (MPE) is involved, to varying degrees, in every medical exposure. In practice, the level of involvement of the MPE should be determined by the level of hazard and risk associated with the exposure and the amount of benefit expected from their advice. For most radiotherapy, MPEs are likely to be full-time contracted members of staff and will be available on site. For nuclear medicine imaging, the number of sessions per week that the MPE will be on site is likely to vary with the complexity of the service offered.

11.2 In all other radiological practices it is recommended that a MPEs availability be secured under contract although, depending on the rate of introduction of new techniques, the amount of time spent on site in fact may be limited (although for dental radiology it is unlikely that a MPE will need to be contacted on a permanent basis). In practice, it may be appropriate only to seek advice as and when new techniques are introduced.

12 **Equipment - Regulation 10**

12.1 Regulation 10 sets out some requirements in respect of equipment. However, most of the requirements of the Directive are addressed in IRR 1999 and reference to those Regulations should be made accordingly.

12 2 The regulation requires the employer to keep and make available for inspection an inventry of equipment and specifies what information the inventry must contain.

12.3 The inventry should be preserved for periods consistent with Health Departments' guidance on retention of records.

12.4 The inventry must be made available, on request, to officials acting on behalf of the appropriate authority, normally inspectors appointed for the purposes of the Regulations.

13 **Training - Regulation 11**

13.1 This regulation prohibits any practitioner or operator from carrying out a medical exposure or any practical aspect without having been adequately trained. An exception is made for trainees where they participate in practical aspects under the supervision of someone who is adequately trained. Adequate training is training that satisfies the requirement of Schedule 2.

13.2 The regulation also requires the employer to keep and have available for inspection an up-to-date record of all practitioners and operators engaged by him showing the date on which training was completed and the nature of the training. Where the employer is concurrently practitioner or operator, he must keep a record of his own training.

13.3 Training records should be available separately from general personal records and preserved for periods consistent with Health Departments' guidance on retention of records.

13.4 Regulation 11(5) makes clear that, where an employer engages individuals to act as practitioners or operators but those individuals remain employed by another body, eg agency staff, then the second party ie the agency are responsible for keeping and maintaining the training records. These must be made available to the first employer upon request so that he can make them available to officials acting on behalf of the appropriate authority as the Regulations require.

14 **Enforcement and Offences - Regulation 12**

14.1 This regulation provides for the Regulations to be enforced as if they were made under section 15 of the Health and Safety at Work etc Act 1974 save that the enforcing authority is the appropriate authority. As explained in the definitions (see notes in section 2) the enforcing authority is specific to each of the Home Countries The provisions of the 1974 Act regarding offences also apply.

15 **Employer's procedures - Schedule 1**

15.1 Schedule 1 sets out a list of matters that must be covered in the employer's procedures. The list is not exhaustive but all those matters identified in Schedule 1 will be binding as a result of having to be included in the procedures. Employers are recommended to take care in wording the procedures as any additional matters which the employer wishes to provide for but intends not to be binding must take a different form and be easily identified as such.

15.2 Some of the matters listed in Schedule 1 require further comment. These are as follows:

15.3 **"Procedures to currently identify individuals to be exposed to ionising radiation"**

15.3.1 The patient identification procedure must specify how a patient is to be identified before a medical exposure is made. The procedure should be positive and active eg "What is your name?" etc.

15.3.2 The procedure should state by whom the patient should be identified eg by the operator carrying out the exposure. The person with responsibility for identifying the patient will be considered as an operator by this function, and as such subject to the Regulations.

15.4 **"Procedures for making enquiries of females of child-bearing age to establish whether the individual is or may be pregnant or breastfeeding"**

15.4.1 It is recommended that such procedures include the age range of individuals who should be asked about pregnancy or breast feeding. In setting this age range, consideration should be given to the increased period of reproductive capacity due to earlier maturity and advances in technology.

15.5 **"Procedures to ensure that the probability and magnitude of accidental or unintended doses to patients from radiological practices are reduced so far as reasonable"**

15.5.1 The employer should include within standard operating procedures a requirement that all practical aspects should be conducted with due regard to minimising unintended doses to patients. This particularly relevant in radiotherapy eg treatment plans should be produced with due regard to the most effective treatment delivery and the potential for error.

16 **Adequate Training - Schedule 2**

16.1 Schedule 2 sets out details of the training which a practitioner or operator must have successfully completed in order to be permitted to carry out medical exposures or practical aspects under the Regulations. The Schedule is divided into two sections. Section A sets out subjects relevant to an individual's functions as practitioner or operator. Section B details subjects relevant to specific areas of practice. Not all the subjects listed in Schedule 2 have to be covered. The subjects of Schedule 2 that would need to be covered will depend on the range of exposures the practitioner or operator intends carrying out.

To

War Pensions Agency
Norcross
Blackpool FY5 3WP
England

Tel 01253 858858
Fax: 01253

WAR PENSIONS AGENCY

An executive agency of the Department of Social Security

Reason for rejection of medical advice

Customer details

NI number

Surname

Other names

■ **Advice rejected because** (tick one box only)

		Tick box	Nature of error/comments
A	Advice given is not fair and impartial or could compromise adjudication or decision making		
B	Advice given is not legible and concise		
C	Advice given is not in accordance with relevant legislation	**Not for WPA use**	
D	Advice given is not comprehensive, does not clearly explain the medical issues raised		

Please turn over >

8/98 WPA1067

■**Advice rejected because** (tick one box only)

		Tick box	Nature of error/comments
E	Advice given is not plain English and is not free of medical jargon	**Not for WPA use**	
F	Advice given is not complete and information is missing or some questions unanswered		

■**Additional supporting information**

Signature

Date

Section **Room** **Ext**

Alcohol paragraph for Specialist or Regional Consultant Reports

Departmental policy - supported by case law - has long been that disablement due to the effects of tobacco or alcohol cannot normally be accepted as service-related because the decision to use these substances is a matter of personal choice. In 1994, this provision was included in War Pensions legislation. To protect any individual whose disablement is truly caused by service, the amendment provides a specific exception. For disablement due to alcohol or tobacco to be accepted the following policy applies: a) the pensioner must suffer from an accepted mental condition assessed at 50% or more, and b) he must have started or continued to use tobacco or alcohol as a result of removal of his free will by that condition.

War Pensions Agency
Norcross
Blackpool FY5 3WP
England

Monday - Thursday: 8.15am - 5.15pm
Friday: 8.15am - 4.30pm

Tel 01253 858858
Fax: 01253

WAR PENSIONS AGENCY

An executive agency of the Department of Social Security

If you get in touch with us please tell us this reference number

Date

Office use

Dental treatment

Surname

Other names

Address

Accepted disablements

Our Medical Advisors require more information so that they can look at this pensioner's claim for

Please turn over >

12/96 **WPA 323**

What we want you to do

Please examine the pensioner and then complete the reply part of this form.

Please send this form and your report back to us as soon as you can, using the envelope we have sent you as it does not need a stamp.

For Chief Executive
War Pensions Agency

Your reply

1 Does this person need any dental treatment because of their accepted disablements?

Yes ☐ Please go to question 2

No ☐ Please tell us why

2 Is special dental treatment necessary?

Yes ☐ Please tell us why

No ☐ Please tell us why

3 Can they get the treatment on the NHS?

Yes ☐

No ☐

4 Where can the pensioner get the treatment?
eg own dentist, dental hospital

■ What you should tell the pensioner

We will pay back the cost of the National Health Service (NHS) charges for the treatment.

If private treatment is required, an estimate of the cost must be sent to us before treatment starts.

Please sign and date here

Signature

Date

/ /

Official stamp

To EO
Team
Room
Norcross

War Disablement Pension - Reduced Assessment

NI number

Surname

Other names

Please see the certificate dated / / .

I have ticked the appropriate box(es) to indicate the reason(s) for reducing the certified (composite) assessment in this case. I have provided an explanation on the reverse of this form.

☐ The previous assessment was made in consequence of ignorance of, or a mistake as to, a material fact or of a mistake as to the law.

☐ The previous assessment was calculated correctly on evidence which was thought to be reliable at the time, but current reliable evidence conflicts with the previous evidence.

☐ On current reliable evidence, there is an improvement in the level of disablement.

☐ Some other reason.

Please turn over >

■ Explanation/any other comments

Signature and name stamp

Date

Section

Room

Ext

Constant Attendance Allowance - guide to rates for specified conditions without additional features

Blindness

Blindness with "guiding vision" ie where pensioner is not totally blind but is unable to read print or get about in unfamiliar places without assistance ..... Part-day

Blindness with "guiding vision" accompanied by any single limb amputation ..... Full-day

Total blindness without any added complication ..... Full-day

Total blindness accompanied by any single-leg amputation ..... Intermediate

Total blindness with (at least) 60% deafness ..... Intermediate

Loss of three limbs

The minimum rate in these cases is ..... Intermediate

Both arms amputated at any level and amputation of leg (or serious injury to leg for which he cannot use crutches) ..... Exceptional

Loss of both arms

Both stumps from 11 5 centimetres (4.5 inches) below elbow* ..... Full-day

Both stumps from 20.5 centimetres (8 inches) below shoulder to less than 11.5 centimetres (4.5 inches) below elbow ..... Intermediate

Both above elbow with stumps of less than 20 5 centimetres (8 inches) ..... Exceptional

Loss of both legs

Both below knee≠ ..... Part-day

One through knee or higher (at any point) and one below knee≠ ..... Part-day

All other double amputations through or above knee ..... Full-day

Loss of one arm and one leg

The Full-day rate is appropriate unless both amputations involve only the lower half of the limb, ie below elbow* and below knee≠, in which event the Part-day rate is appropriate.

Mental conditions

Severe mental condition, including epilepsy, but where there is a large measure of physical control of actions ..... Full-day

Severe mental disablement but able to do a few things such as feeding. ..... Intermediate

Severe mental disablement resulting in complete helplessness. ..... Exceptional

Paraplegia

Partial paraplegia without incontinence ..... Part-day
(Sometimes no award)

Paraplegia

with incontinence largely controlled by aid of appliances and considerable independence both within and outside the house (ie not practically house-bound) ..... Full-day

other cases where the pensioner is confined to bed or a wheel-chair, but has good use of upper limbs and there is no incontinence ..... Full-day

with material incontinence where, although not bedridden, the pensioner needs a considerable amount of attendance both during the day and night (eg needs assistance from bed to chair and from chair to motorised vehicle so that he is almost house-bound without help). Bed sores repeated urinary infections, considerable preventative skin care, nursing, will also tend to place case in this category ..... Intermediate

almost completely bedridden with little use in upper limbs and severe incontinence leading to regular and considerable attendance both during day and night, eg tidal drainage, excessive laundry, persistent bed sores ..... Exceptional

Quadriplegia

with little or no use in the hands ..... Exceptional

Renal failure

on haemodialysis at home (see MPM 200, Desk Card) .... Full-day (not UFI)

on haemodialysis in hospital .. No award

on CAPD .... on evidence (uncomplicated CAPD - No award)

after transplant (see MPM 200, Desk Card) . on evidence

Respiratory conditions

Severe respiratory disablement necessitating frequent attendance throughout the day and occasional night attendance ..... Full-day

Severe respiratory disablement necessitating frequent attendance throughout the day and regular night attendance but not all night ... Intermediate

Severe respiratory cripple with intense dyspnoea and severe coughing bouts necessitating attendance day and night ..... Exceptional

*This implies amputation through the wrist or higher.

≠This implies amputation above the ankle joint, or at the ankle joint with a stump incapable of end-bearing. CAA is not payable if there is an end-bearing stump

Terminally ill

The Social Security Act 1990 introduced special provisions for Attendance Allowance for the terminally ill These apply to Constant Attendance Allowance. All that is required is a certificate from the family doctor stating that the terminal illness is due to the Accepted Condition Reference N5 Note 376 Medical Library.

To Medical Adviser
BAMS

War Pension Allowances

Office use

Surname

Other names

NI number

War Pension reference number

We are looking at whether a Supplementary Allowance may be payable to this person.

Please tell us in the **BAMS reply** part on page 2 whether we need to look at paying a Supplementary Allowance to them. Then send this form back to us as soon as you can.

Signature and name stamp

Room

Section

Date / /

Ext

Please turn over >

5/95 WPA 381

■ BAMS reply

These Supplementary Allowances should be looked at.

Please tick the boxes that apply

- ☐ WPMS
- ☐ CAA
- ☐ Unsupp
- ☐ ALSO
- ☐ Clothing Allowance
- ☐ No action needed

An award is not to be made on the above advice.

Medical Adviser Signature

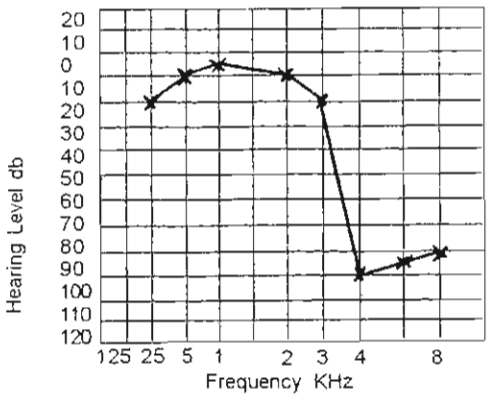
Date / /

NISHL - previous methods of assessment

Assessment of NISHL prior to 7.1.93 and after 1.1.81

Example 1

Present Audiogram:



Hearing Loss using 1, 2, 3 = "NIL"

Although the hearing loss merits NIL, a higher assessment was often given because of the significant losses in the frequencies 4, 6 and 8. 6-14% would have been a likely assessment. This might currently be viewed as "generous". In such cases, on review, it is not appropriate to reduce the assessment and give a true assessment of NIL and an advisory of 6-14%. The original assessment was merely on the high side. It did not obviously include an allowance for post service worsening or GD.

Example 2

(a) Audiogram shows pattern consistent with noise induced sensorineural hearing loss.

(b) Audiogram merits a 40% assessment.

(c) 40% assessment certified

This applied even in the presence of a normal release medical examination, a post service onset of deafness or any earlier audiograms showing a smaller hearing loss. The assessment was based on current audiometric evidence

As the assessment obviously includes post service worsening, on review it is appropriate to make true and advisory assessments

Assessment of NISHL from 7.1.93

The hearing loss due to the AD was assessed using the earliest reliable evidence, for example, a release medical examination showing clinical details of hearing or an audiogram. The MA used clinical judgement to decide whether Greater Disablement was appropriate - Greater Disablement was generally not considered appropriate where:

- the AD was assessed at NIL or 1-5%
- the AD was assessed at 6-14% and the current hearing loss was low ie 20-24%
- there was minimal in-service noise exposure and significant pre and post service noise exposure.

Based on clinical judgement GD was generally considered where:-

- the AD was assessed at 6-14% + the current hearing loss was 26% or more
- the AD was assessed at 20% or more + the application of Greater Disablement did not result in the inclusion of the whole of the current disablement in the assessment.

In Summary

Assessment of AD	Current Hearing Loss	Greater Disablement
NIL	Not relevant	Not appropriate
1-5%	Not relevant	Not appropriate
6-14%	20-24%	Not appropriate
6-14%	26% or more	Consider
20%	40% or more	Consider

Calculation of Greater Disablement:

(a) The hearing loss due to the AD was assessed using the earliest reliable evidence, for example, release medical examination showing clinical details of hearing loss or an audiogram.

(b) The total current hearing loss was calculated in the usual way from the current audiogram.

(c) The assessment of hearing loss due to the AD was subtracted from the total current hearing loss and halve this figure to calculate GD. If the GD factor ended in 5 or above, the figure was rounded up to the next assessment band.

(d) Any addition for tinnitus was made to the AD.

(e) Combined assessment was the total of the assessment of the AD and GD.

Examples

1 AD HL assessed at 6-14%

Total current HL assessed at 54%

Total HL - AD = 54 - (6-14%) = 44%

GD - 44 ÷ 2 = 22%

GD = 20%

No tinnitus

Combined assessment = AD + GD = 6-14 + 20 = 30%

2. AD HL assessed at 6-14%

   Total HL assessed at 60%

   Total HL - AD HL = 60 - (6-14%) = 50%

   GD = 50 ÷ 2 = 25% which rounds up to 30%

Tinnitus present meriting 6-14%

AD = 6-14% + 6-14% = 20%

Combined assessment = AD 20% + GD 30% = 50%.

NB: When GD was included, the combined assessment became at least 20%. Hence, related conditions and symptoms were included in the assessment and the hearing assessment formed part of a composite assessment with any other Accepted conditions

Category A - pre 1.1.1981 cases

Certificates and awards made prior to 1 January 1981 were reasonable at the time that they were made. Therefore, the SoS cannot review and revise the assessment or the award to the detriment of the claimant.

If on review another new condition is accepted as due to service or it is accepted that a condition other than NISHL has deteriorated, the new or revised assessment should simply be added to the original assessment.

EXAMPLE

(a)	Pre-1.1.1981 assessment for hearing loss (including service related NISHL)	60%
(b)	assessment of new condition other than NISHL or application for a review of a condition other than NISHL	10%
(c)	New overall composite assessment (a + b)	70%
(d)	**Award increased to reflect new assessment:**	**70%**

The usual blue WPA363 certificate should be used

Category B - 1.1.1981 and later awards

Claim for a new condition or application for review in respect of deterioration of an existing condition other than NISHL - no increase in the award

An assessment for a new condition or for deterioration of a condition other than NISHL must be added to the "true" assessment for NISHL not the previous "unreasonable" assessment protected under Article 67(6) Thus there may be instances where:

(i) a pensioner who is already receiving a pension for NISHL will claim for a new condition or apply for the review of a condition other than NISHL; and

(ii) that claim or review is accepted; but

(iii) at the same time, as part of the review of the case, the NISHL assessment is revised to produce a "true" assessment; and

(iv) the addition of the assessment for the new condition, or the revised assessment for a condition other than NISHL, to the "true" assessment for NISHL means that the award cannot be increased; because

(v) the new composite assessment is the same or less than the "previous unreasonable" assessment for NISHL used to maintain the level of the award under Article 67(6)

In some cases the revision of the NISHL assessment may produce a "true" NISHL assessment of under 20%. The treatment of this will depend on when the claim was originally made ie before or on or after 7 January 1993

EXAMPLES

The following examples illustrate the effect on NISHL claims, of successful new claims/applications for reviews in respect of conditions other than NISHL.

EXAMPLE 1 Award made on or after 1.1.81 - successful new claim/application for deterioration review in respect of a condition other than NISHL - "previous unreasonable" NISHL assessment 40% - "true" NISHL assessment 20% - No increase in award payable

(a)	"True" assessment for service related NISHL alone	20%
(b)	Further condition accepted	10%
(c)	"True" composite assessment (a + b)	30%
(d)	"Unreasonable" assessment for hearing loss (including service related NISHL) made on or after 1.1.81	40%
(e)	Award maintained, using SoS power under Article 67(6),	40%

The green WPA 363 certificate should be used.

Note:	(i)	The true composite assessment (30%) should be certified by the MA
	(ii)	the assessment for payment purposes (40%) should be specified and SoS should confirm his decision to exercise his discretion under Article 67(6) to maintain the level of payment.

EXAMPLE2 Award made on or after 1.1.81 - NISHL claim made before 7 January 1993 - successful new claim/application or review in respect of a condition other than NISHL - "previous unreasonable" NISHL assessment 40% - "True" NISHL assessment 6-14% - No increase in award payable

(a)	**"True" assessment for service related NISHL alone 6-14% =**	**10%***
(b)	Further condition accepted - assessment	20%
(c)	"True" composite assessment (a + b)	30%
(d)	Original assessment for hearing loss including service related NISHL made on or after 1.1 81	40%
(e)	**Award maintained, using SoS power under Article 67(6)**	**40%**

The green WPA 363 certificate should be used.

Note:	(i)	*although assessment for NISHL is less than 20%, it can be included in a "true" combined assessment because of transitional powers applying to claims made before 7 January 1993 (Article 4 of SI 1992 No 3208)
	(ii)	The true composite assessment of 30% should be certified by the MA
	(iii)	the assessment for payment purposes (40%) should be specified and SoS should confirm his decision to exercise his discretion under Article 67(6) to maintain the level of payment.

EXAMPLE3 NISHL claim made on or after 7 January 1993 - successful new claim/application for review in respect of a condition other than NISHL - "Original" NISHL assessment 40% - "True" NISHL assessment 6-14% - No increase in award payable

(a)	**"True" assessment for service related NISHL alone 6-14% ie**	**(10%) but no award***
(b)	Further condition accepted - assessment	20%
(c)	"True" composite assessment (b)	20% **see note 1**
(d)	Assessment for hearing loss including service related NISHL/GD	40%
(e)	**Award maintained, using SoS power under Article 67(6), at**	**40%**

The green WPA 363 certificate should be used

Note:	(i)	*as the claim/application for review in respect of NISHL was made on or after 7 January 1993 the NISHL assessment for less than 20% cannot be combined in any "true" composite assessment
	(ii)	The service related NISHL assessment and the true composite 20% assessment should be certified by the MA
	(iii)	the assessment for payment purpose (40%) should be specified and the SoS should confirm his decision to exercise this discretion under Article 67(6) to maintain the level of payment.

EXAMPLE4 Award made on or after 1.1.81 - NISHL claim made before 7 January 1993 - successful new claim/application for review in respect of a condition other than NISHL - "Previous unreasonable" NISHL assessment 40% - "True" NISHL assessment 6-14% - Increase in award payable

(a)	**"True" assessment for service related NISHL alone 6-14% =**	**10%***
(b)	Further condition accepted	50%
(c)	"True" composite assessment (a + b)	60%
(d)	Original assessment for hearing loss including service related NISHL made on or after 1 1.81	40%
(e)	**Award payable at**	**60%**

The blue WPA 363 certificate should be used.

Note.	(i)	*although assessment for NISHL is less than 20%, it cannot be excluded from the "true" composite assessment because of transitional powers applying to claims made before 7 January 1993 (Article 4 of SI 1992 No 3208) ie before the introduction of the 20% assessment threshold cut off.
	(ii)	The true composite 60% assessment should be certified by the MA
	(iii)	in this case Article 67(6) does not apply because the less than 20% NISHL assessment is protected by the transitional powers.

EXAMPLE5 NISHL claim made on or after 7 January 1993 successful new claim/application for review in respect of a condition other than NISHL - "previous unreasonable" NISHL assessment 40% - "True" NISHL assessment 6-14% - Increase in award payable

(a)	**"True" assessment for service related NISHL alone 6-14% =**	**(10%) but no award***
(b)	Further condition accepted	50%
(c)	"True" composite assessment (b)	50% see note 1

(d)	Original 7.1.93 or later assessment for hearing loss including service related NISHL/GD	40%
(e)	**Award payable at**	**50%**

The blue WPA 363 certificate should be used.

Note. (i) *as the claim/application for review in respect of NISHL was made on or after 7 January 1993 the NISHL assessment of less than 20% cannot be combined in any "true" composite assessment

(ii) The service related NISHL assessment and the true composite 20% assessment should be certified by the MA

(ii) in this case Article 67(6) does not apply

Category C

New claims to, or applications for review of, NISHL made before 1 March 1996 but still uncleared on 22.10.96.

Category C cases are therefore a tightly defined and limited group. This category only applies to claims/ applications for review made before 1 March 1996 and still uncleared when action was suspended on 22 October 1996.

EXAMPLE 1 Outstanding claim is a new claim solely in respect of service related NISHL no other hearing loss involved - eg man invalided from service on the basis of NISHL

Where there is a new claim solely in respect of service related NISHL an assessment can be made of that condition in the normal way. If the assessment is less than 20% no award can be made. The question of interaction with another type of hearing loss does not arise so there is no need to apply the DIs because the award (if any) is fully covered by the SPO.

(a)	**"True" assessment of NISHL**	**20%**
(b)	Service related NISHL assessment	20%
(c)	**Award under the SPO**	**20%**

A blue WPA 363 certificate should be used.

EXAMPLE 2 Outstanding claim is a new claim in respect of service related NISHL, other post-service hearing loss present

Where there is a new claim in respect of service related NISHL, but overall hearing loss includes other post-service hearing loss eg due to age. A **"true"** assessment must be made of the service related NISHL which must be certified by the MA. If overall hearing loss is greater than the **"true"** NISHL assessment, the DIs should be used to give an increase in the award equivalent to that which would have been given under the approach in place before 1 March 1996 (ie by application of the GD principle).

The basis under which payment is made will depend on the **"true"** assessment for NISHL. If the "true" assessment is 20% or more, part of the payment will be under the SPO, and part under the DIs:

(a)	**Service related NISHL - "true" assessment (award under the SPO)**	**20%**
(b)	Non service related hearing loss [GD] (award under the Dispensing Instruments)	20%
(c)	**Award (a + b)**	**40%**

A yellow WPA 363 certificate should be used.

If the **"true"** assessment is under 20%, no award can be made under the SPO, and the whole of the payment (40% pension) will be under the DIs eg.-

(a)	**Service related NISHL "true" assessment 6-14% (award under Dispensing Instruments)**	**10%**
(b)	Non service related hearing loss [GD] (award under Dispensing Instruments)	20%
(c)	**Award (a + b ie all under DIs)**	**30%**

A Yellow WPA 363 certificate should be used.

EXAMPLE 3 Outstanding application for a review of an award in respect of service related NISHL - initial award made and implemented before 1.1.1981

The application for a review in respect of deterioration of service related NISHL should be accepted. The SoS cannot revise the original assessment in respect of service and non-service related NISHL because he has no power to reduce an assessment to the detriment of the pensioner under Article 67(3) unless it is wrong in fact or law (ie to this extent it is a Category A case). If overall hearing loss has deteriorated since the previous assessment, the DIs should be used to give an increase in award equivalent of that which would have been given under the approach in place before 1 March 1996

(a)	Assessment of service related NISHL made before 1.1.81 (award under the SPO)	30%
(b)	Award for deterioration under the DIs	20%
(c)	**Award (a + b)**	**50%**

A Yellow WPA 363 certificate should be used.

EXAMPLE 4 Outstanding application for a review of an award in respect of service related NISHL - initial award made on or after 1 January 1981

The application for a review in respect of deterioration of service related NISHL should be accepted. The existing assessment for hearing loss may be subject of revision (ie as in a category B case). The medical adviser should give an assessment of disablement according to current medical understanding, including in respect of NISHL. Because the original decision was unreasonable at the time it was made Article 67(3) of the SPO requires the SoS to reduce the existing assessment to produce a new **"true"** assessment in line with the MAs new opinion The existing award, however, will be protected using Article 67(6).

If overall hearing loss has deteriorated since the previous assessment, the Dispensing Instruments should be used to give an increase in award equivalent to that which would have been given under the approach in place before 1 March 1996 (ie by the application of GD) The award in respect of non-service related hearing loss allowed under Article 67(6) should be noted separately together with that allowed under the Dispensing Instruments.

(a)	**"True" assessment in respect of service related NISHL 6-14%=**	**10%**
(b)	1.1.81 or later award for NISHL	30%

(c)	Assessment in respect of non service related hearing loss (under the authority of Article 67(6)) (b - a)	20%
(d)	Assessment in respect of non-service related hearing loss [GD] (under the authority of the Dispensing Instruments)	
(e)	**Award (a + c + d)**	**40%**

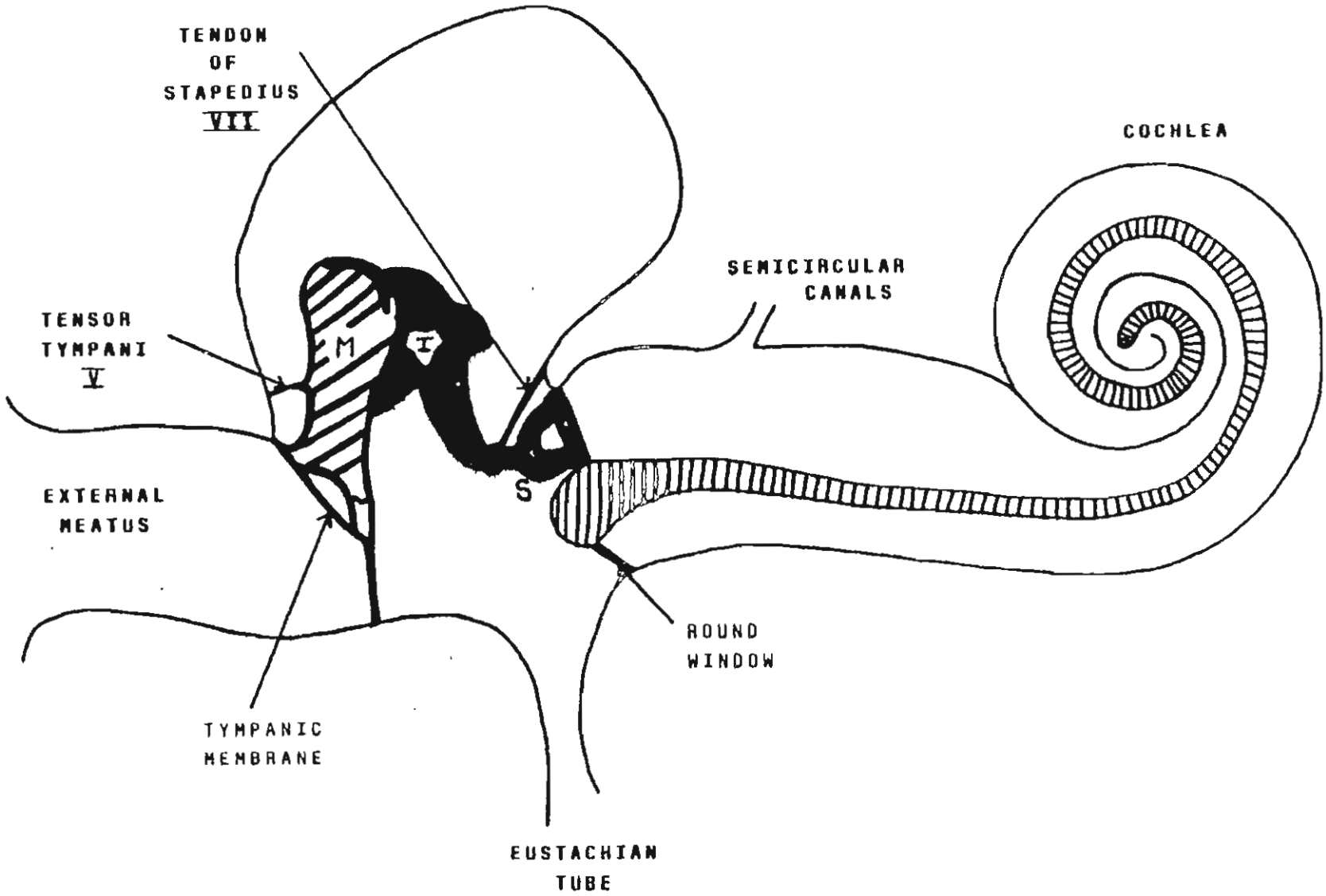
A yellow WPA 363 certificate should be used.

EXAMPLE 5 Outstanding application for a review of an award in respect of service related NISHL - initial award made and implemented before 1.1.1981 - subsequently reviewed and increased on or after 1.1.1981

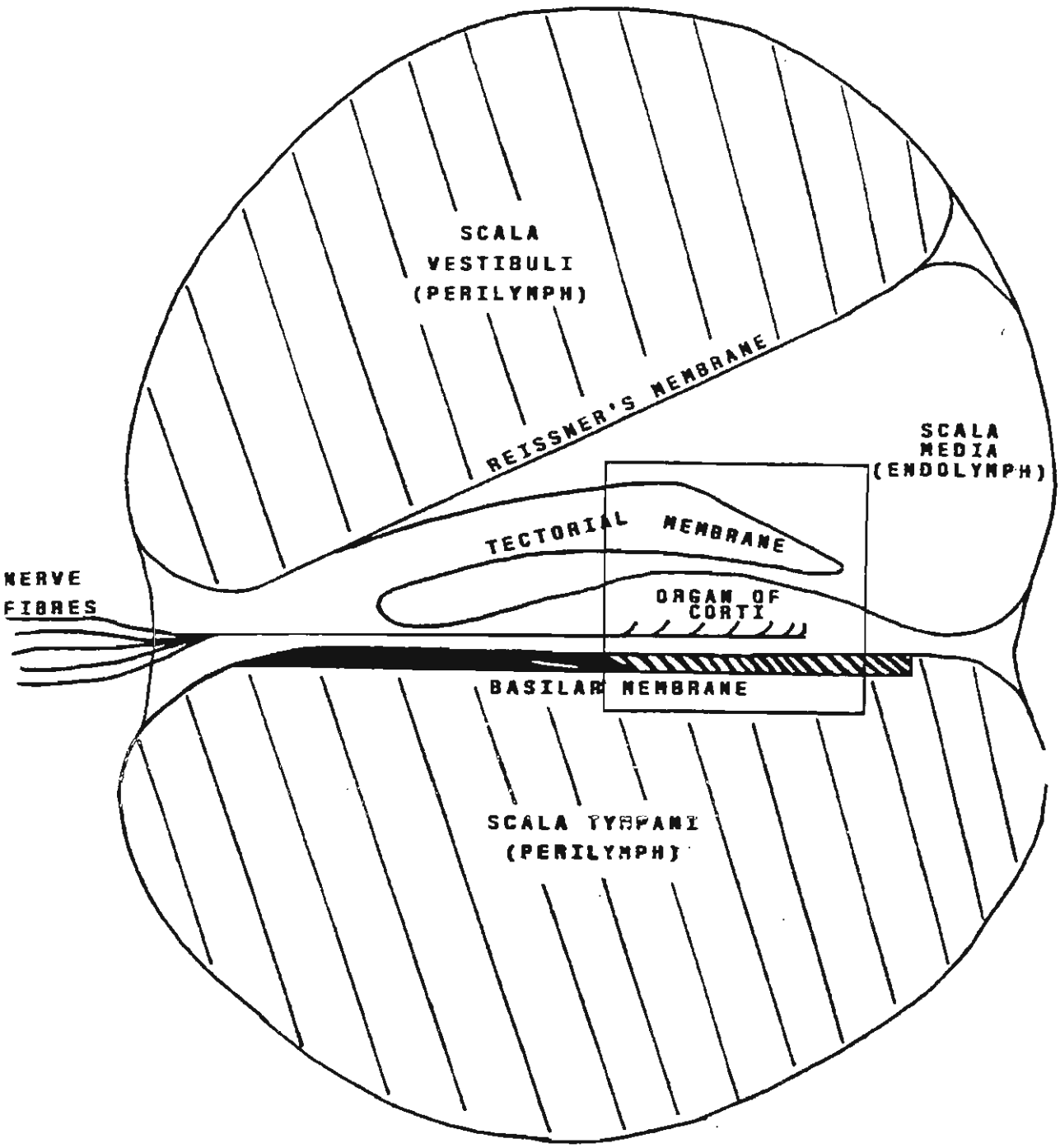
(a)	Pre 1.1.1981 assessment in respect of service related NISHL. This is the **"true"** assessment	30%
(b)	Increase in assessment in respect of non service related hearing loss made on or after 1.1.81 Article 67(6)	10%
(c)	Award, on review, in respect of service NISHL and non-service related hearing loss (a + b)	40%
(d)	Assessment of further increase in respect of non-service related hearing loss [GD] (under the authority of the Dispensing Instruments)	10%
(e)	**Award (a + b (now under Art 67(6)) + d under DIs)**	**50%**

A yellow WPA 363 certificate should be used

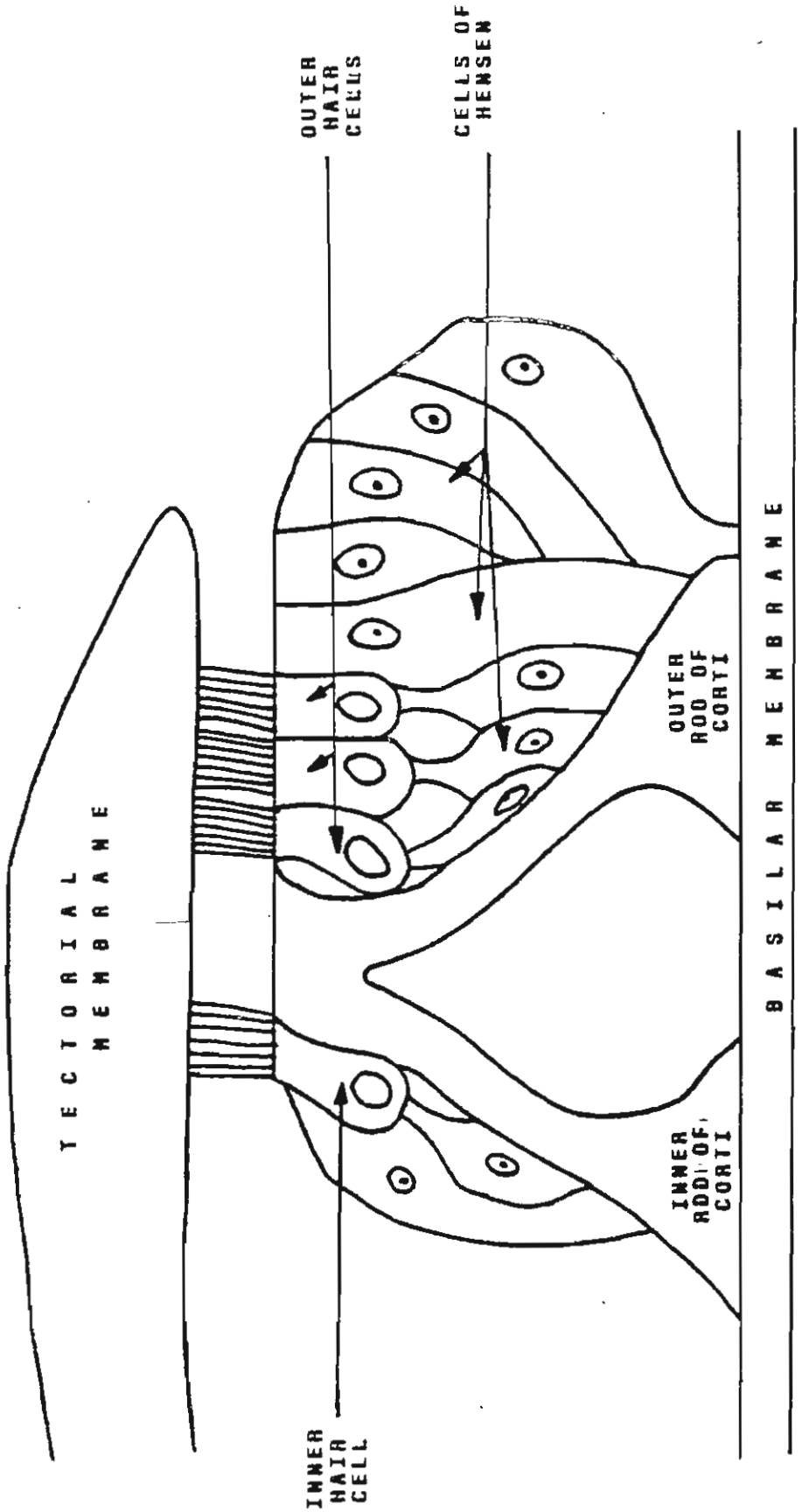
Diagram of the Anatomy of the Ear



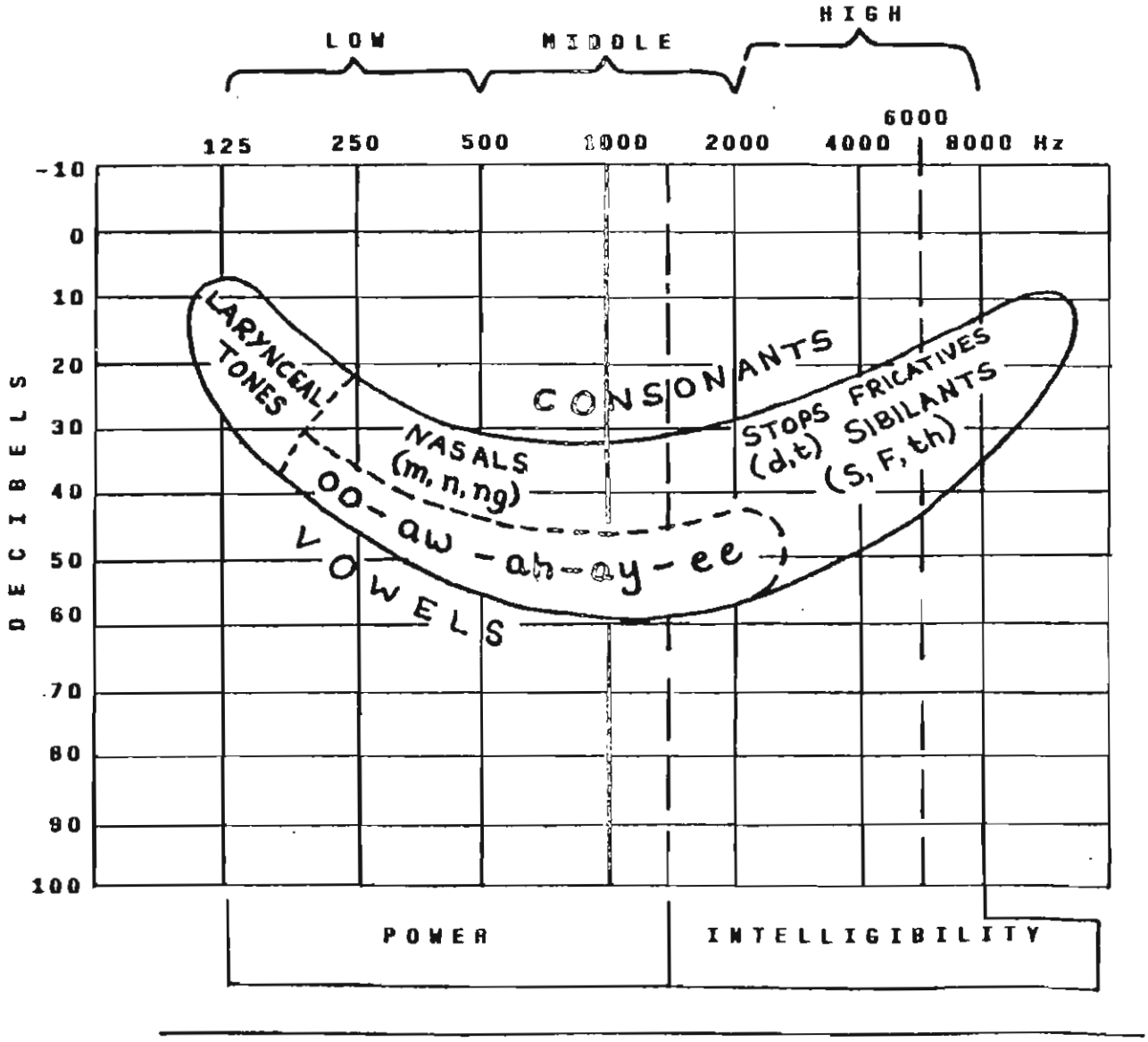
Section through the Cochlea



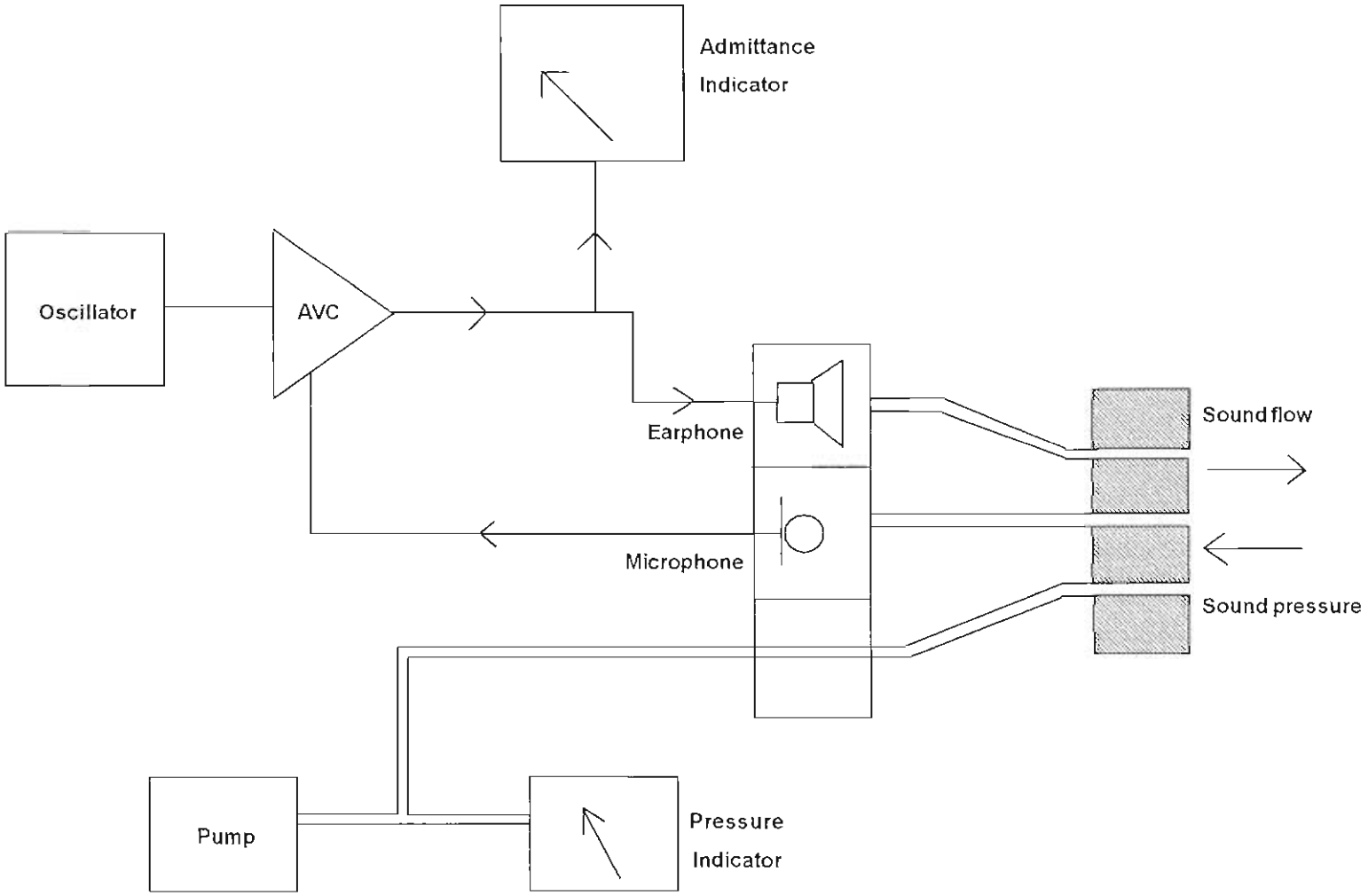
The Organ of Corti



Audiogram showing the sounds used in English speech



Block Diagram of an Acoustic Admittance Meter



AVC = Automatic Volume Control

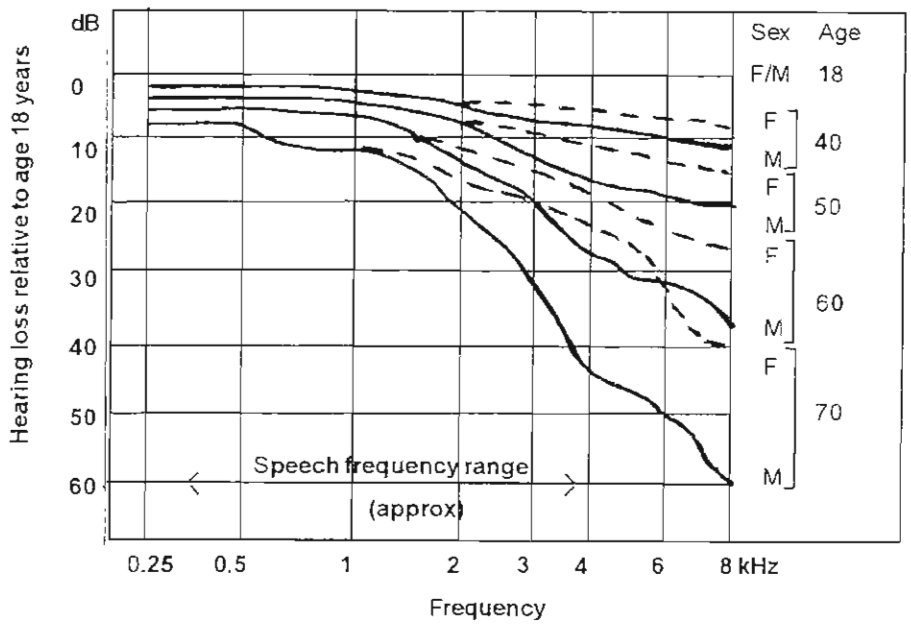
Hearing Threshold Levels, in Decibels of 50th Percentile of Otologically Normal Individuals

♂

AGE(YRS)	500	1000	2000	3000	4000	6000	8000
30	1	1	1	2	2	3	5
40	2	2	3	6	8	9	10
50	4	4	7	12	16	18	20
60	6	7	12	20	28	32	38
70	9	12	20	32	43	49	60

♀

30	1	1	1	1	1	2	3
40	2	2	3	4	4	6	8
50	4	4	6	8	9	12	14
60	6	7	11	13	16	21	27
70	9	12	16	20	24	33	40



Pure Tone Audiograms

The International Standards Organisation (ISO) setting for the audiometer was used.

Key: air conduction, 0 = right ear, x = left ear; bone conduction, B = unmasked ear, (= right ear,) = left ear.

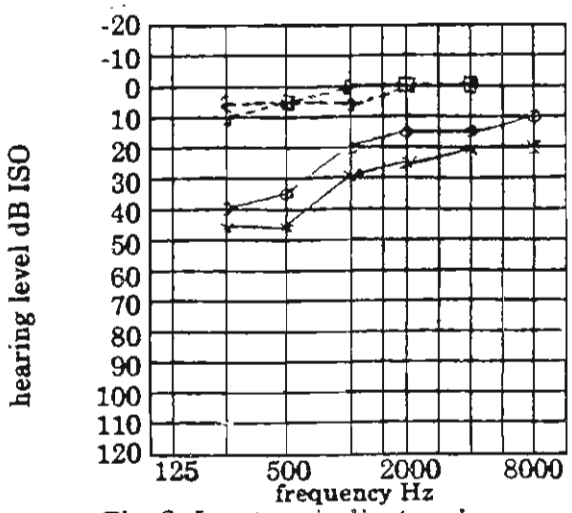


Fig. 2 *Low tone indicates glue ear.*

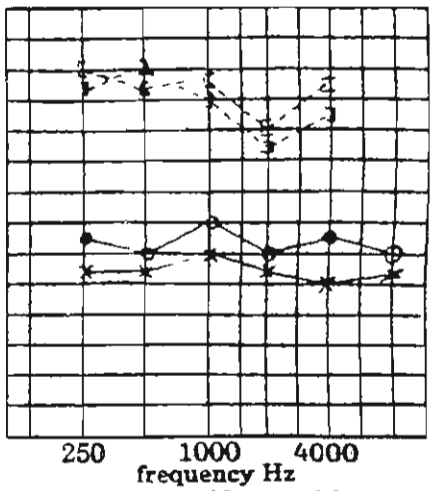


Fig. 3 *Hearing uniform with notch.*

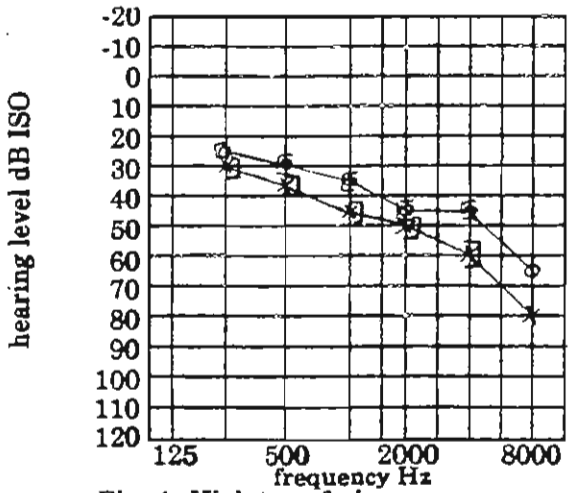


Fig. 4 *High tone fade.*

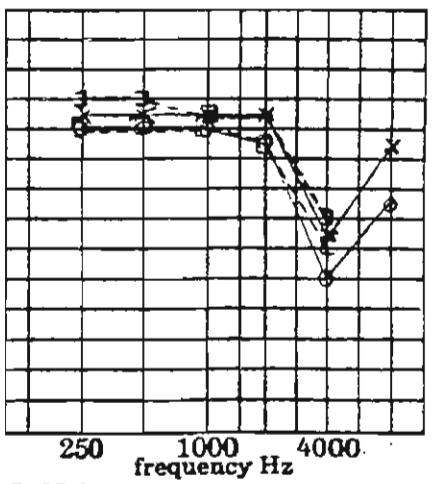


Fig. 5 *Noise trauma.*

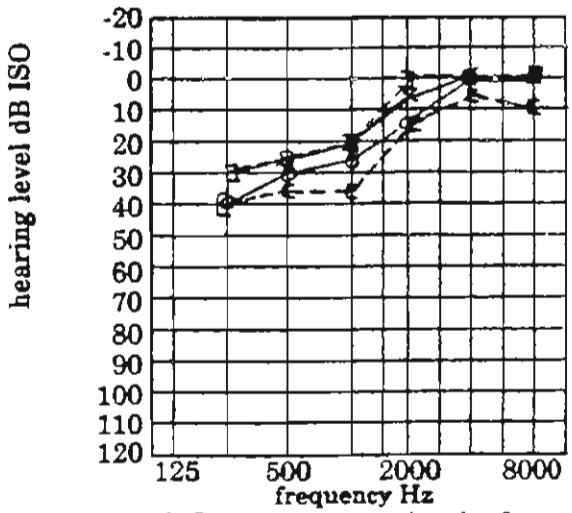


Fig. 6 *Low tone perceptive deafness.*

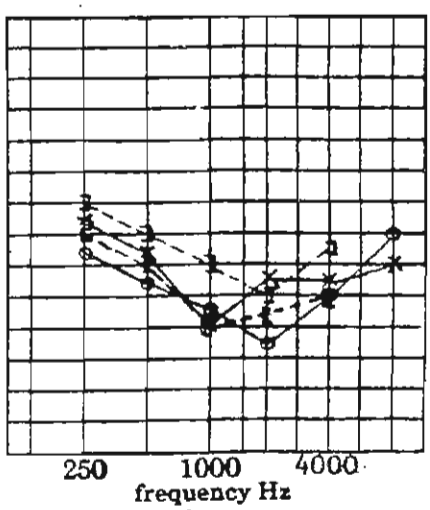
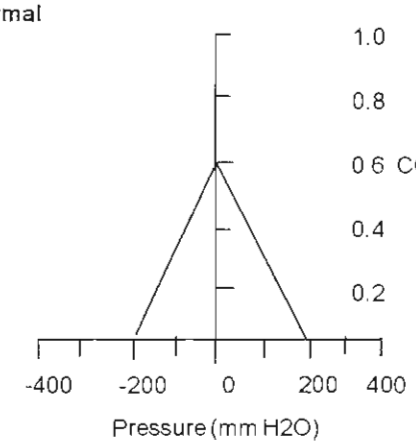


Fig. 7 *Non-organic saucer.*

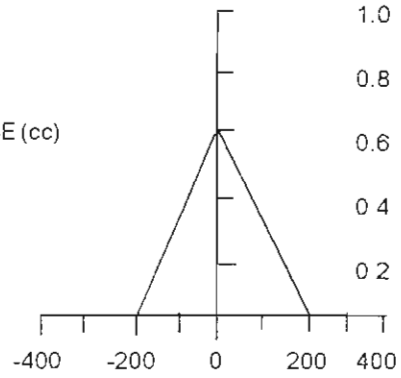
Tympanograms

1. Normal



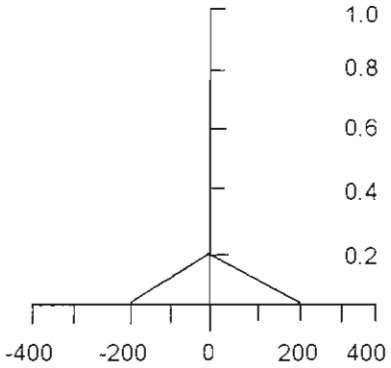
ART - Normal

2. Ossicular discontinuity



ART - Absent

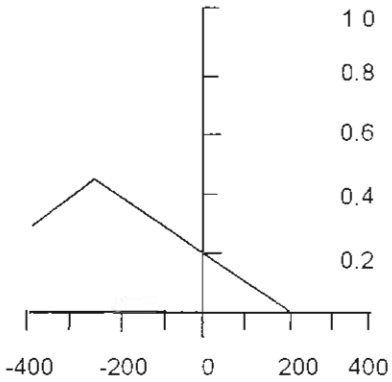
3. Tympanosclerosis/otosclerosis



Tympanosclerosis ART - elevated or absent

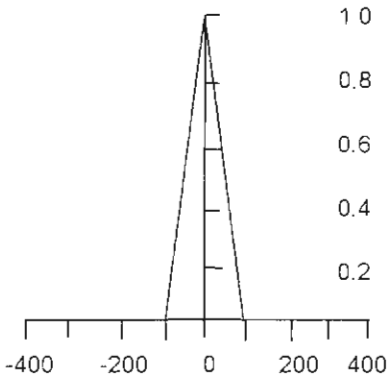
Otosclerosis ART - usually absent

4. Eustachian tube dysfunction



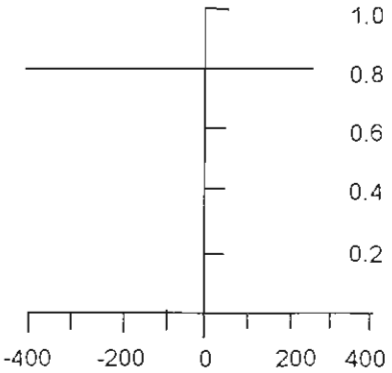
ART - Elevated

5. Healed perforation (thin scar)



ART - Normal or Elevated

6. Perforated drum



High ear canal volume

ART = Acoustic Reflex Threshold

Aetiology: Normal

AUDIOMETRIC FINDINGS

Presentation: . . .. Hearing within normal limits.

Degree of Impairment: .. .. (a-c thresholds = < 20 dB HL (0 25 -> 8 kHz).

CHL OR SNHL: ....

MIDDLE EAR IMPEDANCE FINDINGS

Tympanogram Type: .... .Type A (normal)

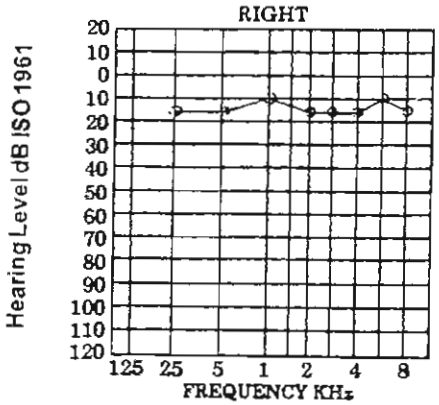
Acoustic Reflex Thres: .. . . Normal levels (85-95 dB)

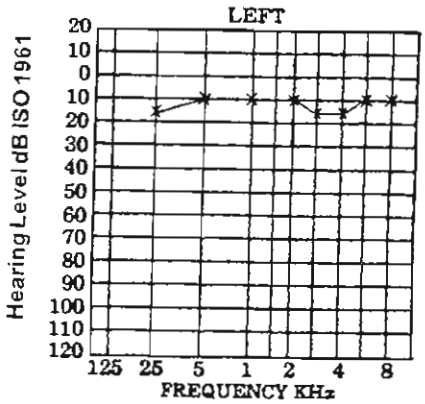
Middle Ear Pressure: .... Normal range (-100 -> 50 DaPa)

Middle Ear Compliance: .... Normal range (0.3 -> 1.6 ml)

Ear Canal Volume: ... . .Normal range

TYPICAL AUDIOGRAM

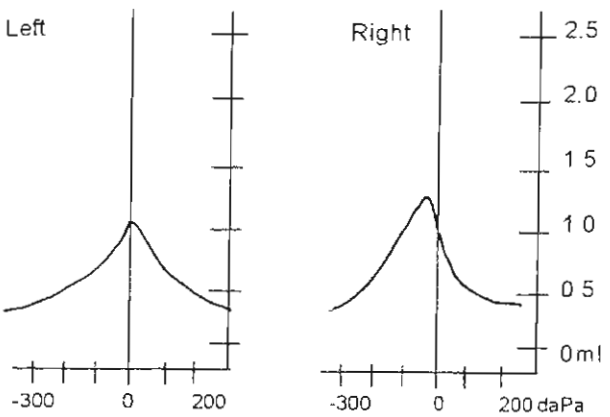




TYPICAL TYMPANOMETRY AND REFLEXES

Tympanogram Date _____

Name _____



Ipsilateral Acoustic Reflex Threshold

Stimulus	RIGHT	LEFT
500 Hz	85 dB	85 dB
1000 Hz	90 dB	90 dB
2000 Hz	85 dB	90 dB
4000 Hz	85 dB	85 dB

N/R = Reflex not recorded at maximum available level

Aetiology: Otitis Media (Secretory)

AUDIOMETRIC FINDINGS

Presentation: ..... Unilateral or Bilateral

Degree of Impairment: ..... Normal to moderate hearing loss

CHLOR SNHL: ..... Conductive Hearing Loss

MIDDLE EAR IMPEDANCE FINDINGS

Tympanogram Type: ..... Type B (reduced compliance, no peak)

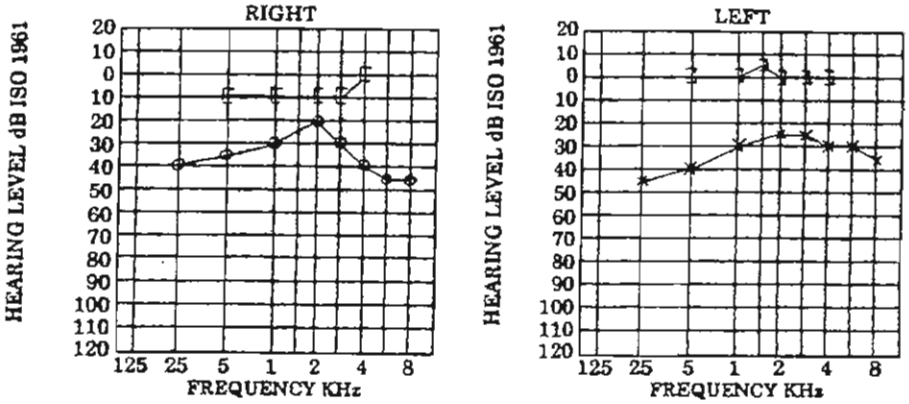
Acoustic Reflex Thres ..... Elevated or absent

Middle Ear Pressure: ..... Normal (-100 -> 50 Da Pa) or negative

Middle Ear Compliance: ..... Low compliance (> 0.3 ml)

Ear Canal Volume: ..... Normal range

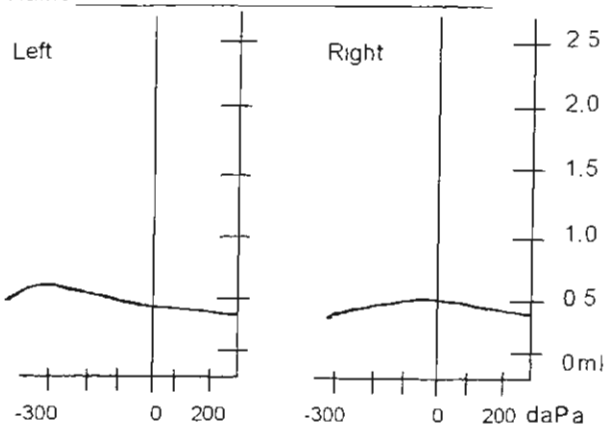
TYPICAL AUDIOGRAM



TYPICAL TYMPANOMETRY AND REFLEXES

Tympanogram Date _____

Name _____



Ipsilateral Acoustic Reflex Threshold

Stimulus	RIGHT	LEFT
500 Hz	N/R dB	N/R dB
1000 Hz	N/R dB	N/R dB
2000 Hz	N/R dB	N/R dB
4000 Hz	90 dB	N/R dB

N/R = Reflex not recorded at maximum available level

Aetiology: Otitis Media (Thin Healed Scar)

AUDIOMETRIC FINDINGS

Presentation: ..... Usually unilateral

Degree of Impairment: ..... Normal to mild hearing loss

CHLOR SNHL: ..... Conductive

MIDDLE EAR IMPEDANCE FINDINGS

Tympanogram Type: ..... Steep Type A

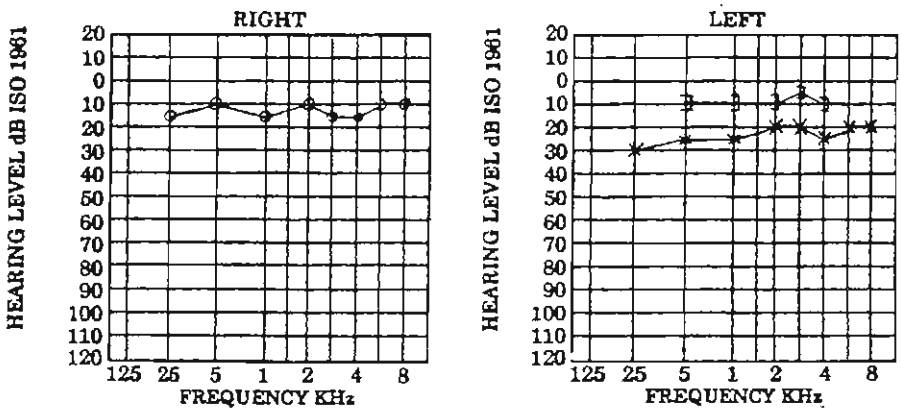
Acoustic Reflex Thres: ..... Normal or elevated

Middle Ear Pressure: ..... Normal range (-100 -> 50 Da Pa)

Middle Ear Compliance: ..... Abnormal (> 1.6 ml)

Ear Canal Volume: ..... Normal range

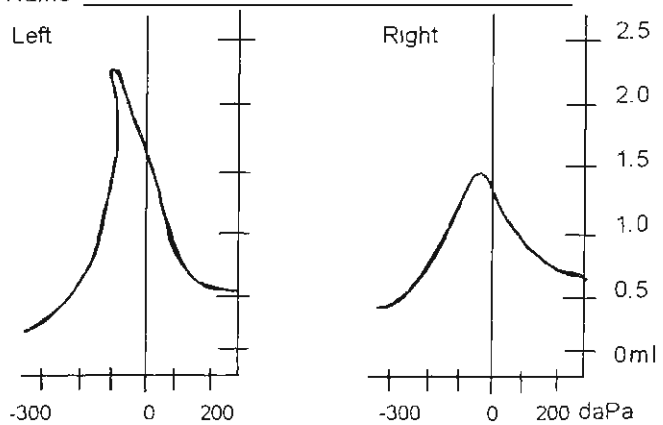
TYPICAL AUDIOGRAM



TYPICAL TYMPANOMETRY AND REFLEXES

Tympanogram Date _____

Name _____



Ipsilateral Acoustic Reflex Threshold

Stimulus	RIGHT	LEFT
500 Hz	85 dB	95 dB
1000 Hz	85 dB	95 dB
2000 Hz	90 dB	N/R dB
4000 Hz	85 dB	N/R dB

N/R = Reflex nct recorded at maximum available level

Aetiology: Otitis Media (Tympanosclerosis)

AUDIOMETRIC FINDINGS

Presentation: ..... Unilateral or Bilateral

Degree of Impairment: ..... Normal or mild hearing loss

CHLOR SNHL: ..... Conductive

MIDDLE EAR IMPEDANCE FINDINGS

Tympanogram Type: ..... Shallow Type A

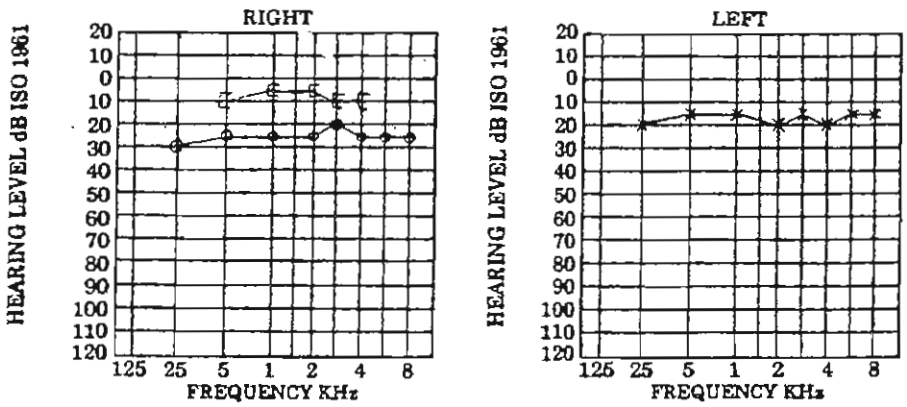
Acoustic Reflex Thres: ..... Elevated or absent

Middle Ear Pressure: ..... Normal (-100 -> 50 Da Pa)

Middle Ear Compliance: ..... Low (< 0 3 ml)

Ear Canal Volume: ..... Normal range

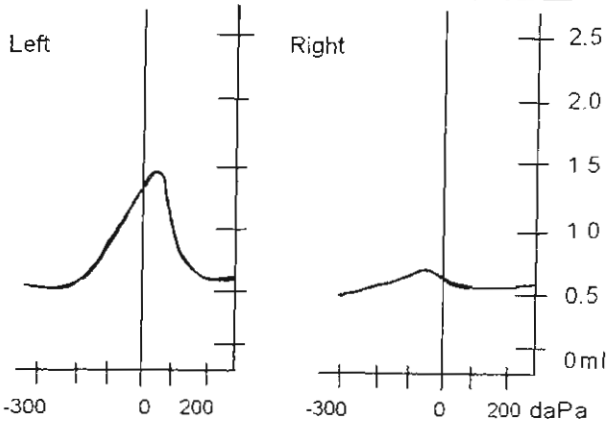
TYPICAL AUDIOGRAM



TYPICAL TYMPANOMETRY AND REFLEXES

Tympanogram Date _____

Name _____



Ipsilateral Acoustic Reflex Threshold

Stimulus	RIGHT	LEFT
500 Hz	N/R dB	90 dB
1000 Hz	N/R dB	95 dB
2000 Hz	N/R dB	95 dB
4000 Hz	N/R dB	90 dB

N/R = Reflex not recorded at maximum available level.

Aetiology: Otitis Media (Perforation)

AUDIOMETRIC FINDINGS

Presentation: ..... Unilateral or possibly Bilateral

Degree of Impairment: ..... Normal to moderate hearing loss

CHLOR SNHL. ..... Conductive

MIDDLE EAR IMPEDANCE FINDINGS

Tympanogram Type: .....

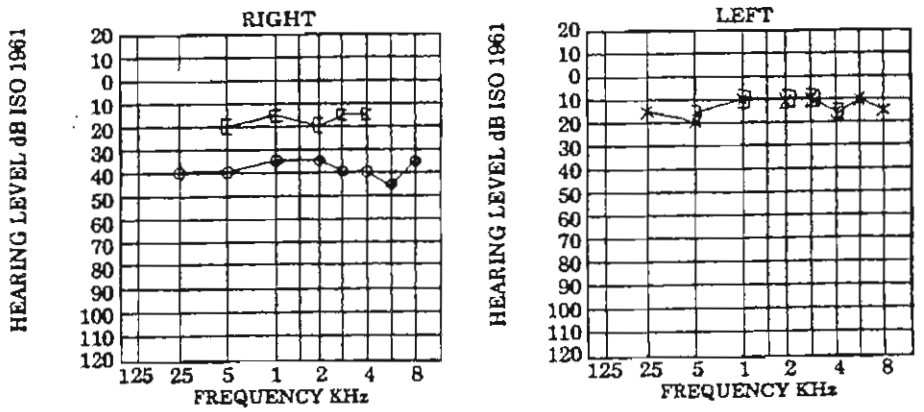
Acoustic Reflex Thres. ..... N/A

Middle Ear Pressure: ..... N/A

Middle Ear Compliance: ..... N/A

Ear Canal Volume: ..... High ear canal volume (eg > 2.0 ml)

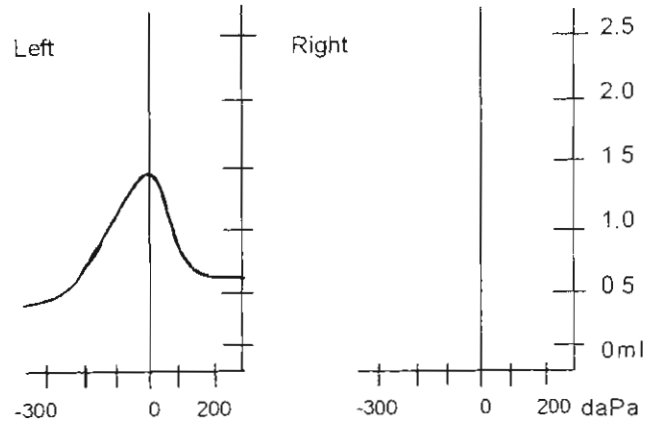
TYPICAL AUDIOGRAM



TYPICAL TYMPANOMETRY AND REFLEXES

Tympanogram Date _____

Name Perforation



Ipsilateral Acoustic Reflex Threshold

Stimulus	RIGHT	LEFT
500 Hz	N/A dB	85 dB
1000 Hz	N/A dB	90 dB
2000 Hz	N/A dB	90 dB
4000 Hz	N/A dB	90 dB

N/R = Reflex not recorded at maximum available level.

Aetiology: Otosclerosis

AUDIOMETRIC FINDINGS

Presentation: ..... Usually Bilateral

Degree of Impairment: ..... Mild to moderate, progreessive

CHLOR SNHL: ..... Conductive, Carhart notch @ 2 KHz

MIDDLE EAR IMPEDANCE FINDINGS

Tympanogram Type: ..... Shallow Type A

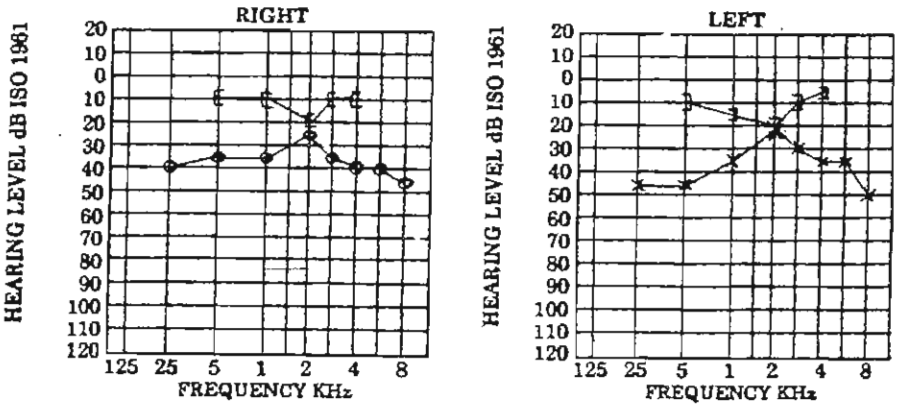
Acoustic Reflex Thres: ..... Usually absent bilaterally

Middle Ear Pressure: ..... Normal (-100 -> 50 Da Pa)

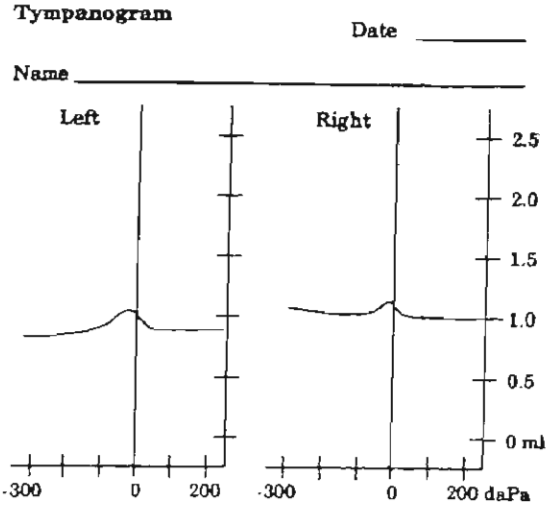
Middle Ear Compliance: ..... Reduced compliance (< 0 3 ml)

Ear Canal Volume: ..... Normal range

TYPICAL AUDIOGRAM



TYPICAL TYMPANOMETRY AND REFLEXES



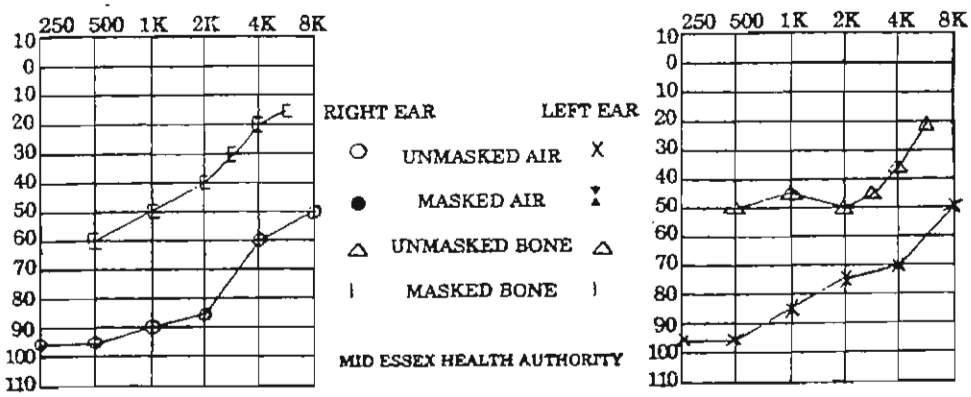
Ipsilateral Acoustic Reflex Threshold

Stimulus	RIGHT	LEFT
500 Hz	N/R dB	N/R dB
1000 Hz	N/R dB	N/R dB
2000 Hz	N/R dB	N/R dB
4000 Hz	N/R dB	N/R dB

N/R = Reflex not recorded at maximum available level.

Aetiology: Otosclerosis

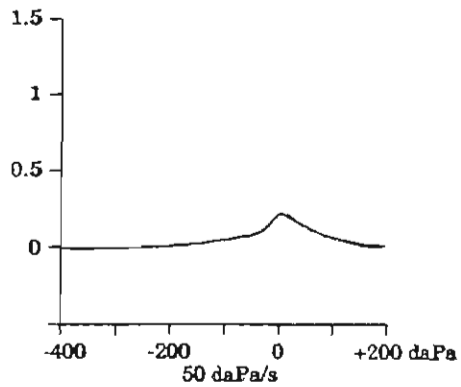
SURNAME:	CHRISTIAN NAMES:	HOSPITAL NO	DOB
INSTRUMENT	REMARKS		
FREQUENCY HZ	DATE	FREQUENCY HZ	



Date: ..... Ear Tip: .....

Tymp Diagnostic

ml

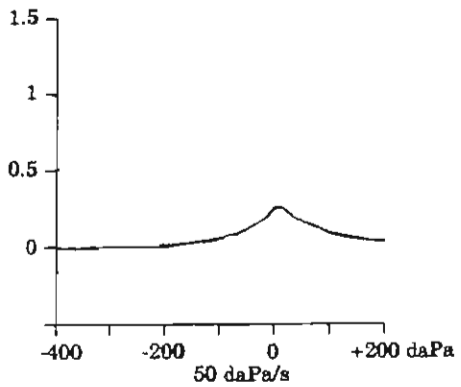


EAR CANAL VOLUME: 1.0

	daPa	ml
TYMP 1:	0	0.2
TYMP 2:		

Test 3 Tymp Diagnostic

Ytm 226 Hz L ml



EAR CANAL VOLUME: 1.0

	daPa	ml
TYMP 1:	5	0.3
TYMP 2:		
TYMP 3:		
GRADIENT:	0.4	

Test 3

Ytm 226 Hz P

Aetiology: Ossicular Discontinuity

AUDIOMETRIC FINDINGS

Presentation: ..... Usually unilateral

Degree of Impairment: ..... Moderate hearing loss (typically 30-50dB)

CHLOR SNHL: ..... Conductive Hearing Loss

MIDDLE EAR IMPEDANCE FINDINGS

Tympanogram Type: ..... Steep Type A

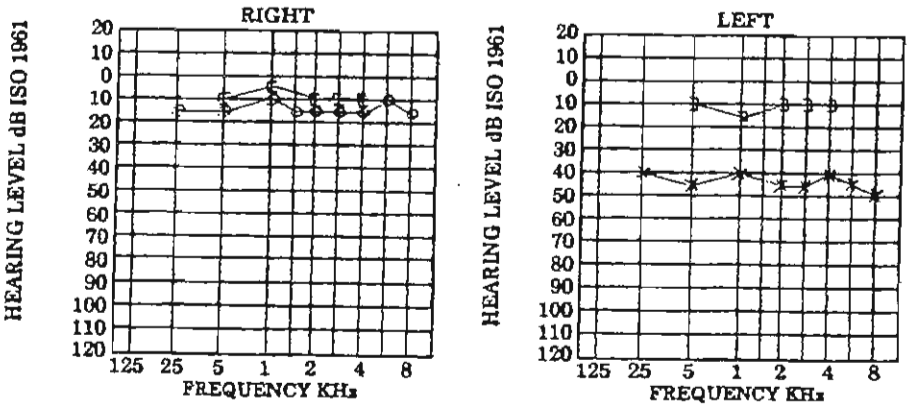
Acoustic Reflex Thres: ..... Usually absent with probe in affected ear

Middle Ear Pressure: ..... Normal range

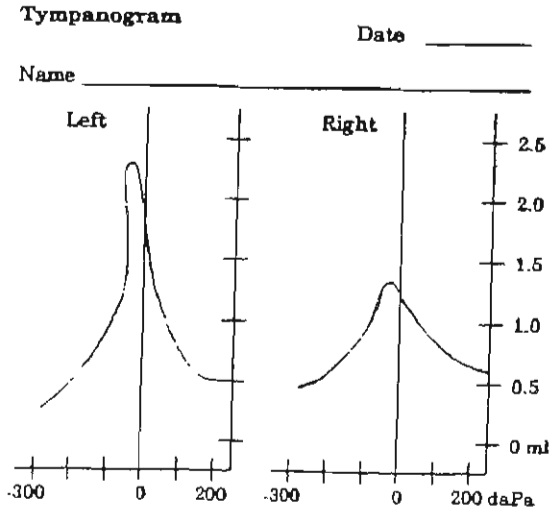
Middle Ear Compliance: ..... Abnormal (> 1.6 ml)

Ear Canal Volume: ..... Normal range

TYPICAL AUDIOGRAM



TYPICAL TYMPANOMETRY AND REFLEXES



Ipsilateral Acoustic Reflex Threshold

Stimulus	RIGHT	LEFT
500 Hz	N/R dB	N/R dB
1000 Hz	N/R dB	N/R dB
2000 Hz	N/R dB	N/R dB
4000 Hz	90 dB	N/R dB

N/R = Reflex not recorded at maximum available level.

Aetiology: Eustachian Tube Dysfunction

AUDIOMETRIC FINDINGS

Presentation: ..... Bilateral, possibly Unilateral

Degree of Impairment: ..... Normal or mild hearing loss

CHLOR SNHL: ..... Conductive Hearing Loss

MIDDLE EAR IMPEDANCE FINDINGS

Tympanogram Type: ..... Type C (reduced middle ear pressure)

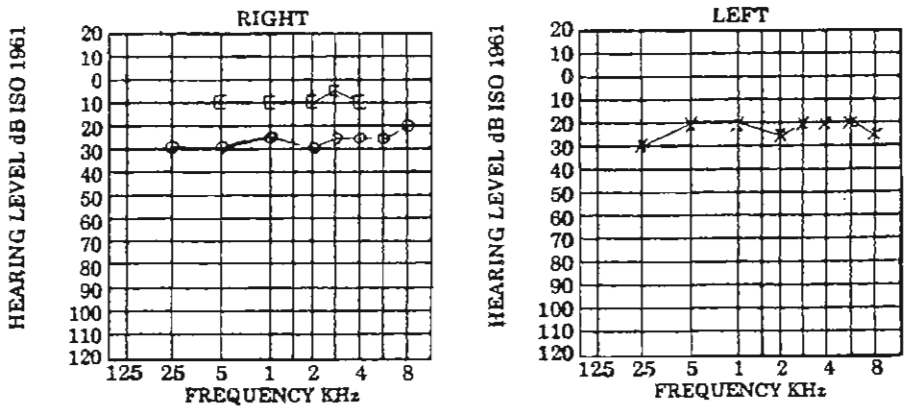
Acoustic Reflex Thres: ..... Elevated

Middle Ear Pressure: ..... Abnormal (<-100 Da Pa)

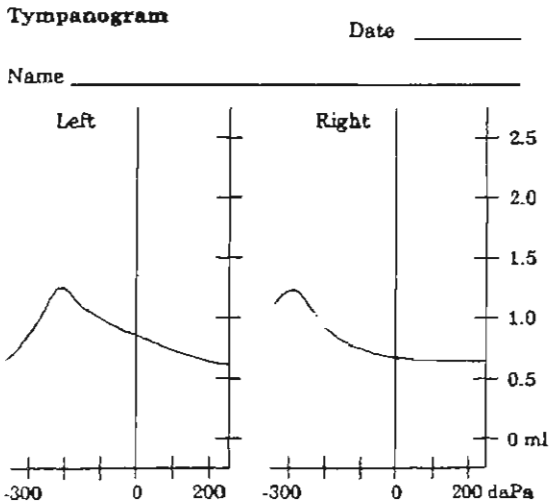
Middle Ear Compliance: ..... Normal range (0 3 -> 1.6 ml)

Ear Canal Volume. ..... Normal range

TYPICAL AUDIOGRAM



TYPICAL TYMPANOMETRY AND REFLEXES



Ipsilateral Acoustic Reflex Threshold

Stimulus	RIGHT	LEFT
500 Hz	N/R dB	N/R dB
1000 Hz	N/R dB	N/R dB
2000 Hz	N/R dB	N/R dB
4000 Hz	90 dB	N/R dB

N/R = Reflex not recorded at maximum available level.

Aetiology: Non-Organic Hearing Loss

AUDIOMETRIC FINDINGS

Presentation: ..... Usually Bilateral

Degree of Impairment: ..... Mild to severe, variable or unreliable thresholds

CHLOR SNHL: ..... Apparent sensorineural or conductive

MIDDLE EAR IMPEDANCE FINDINGS

Tympanogram Type: ..... Type A (normal)

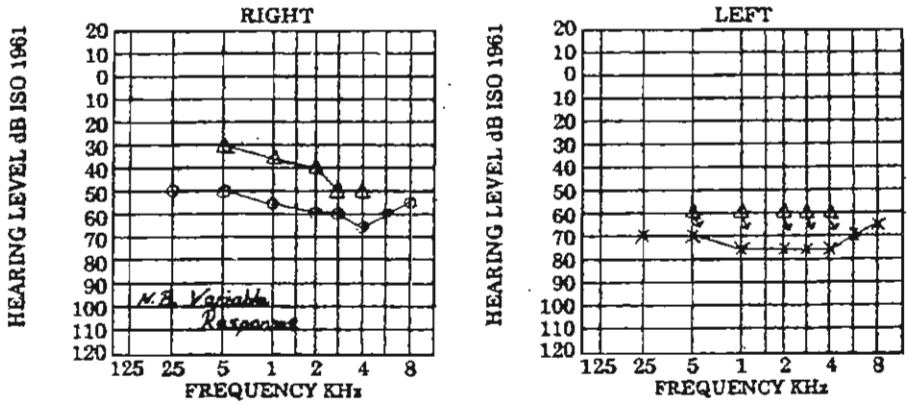
Acoustic Reflex Thres: ..... Normal levels (85-95 dB)

Middle Ear Pressure: ..... Normal range (-100 -> 50 Da Pa)

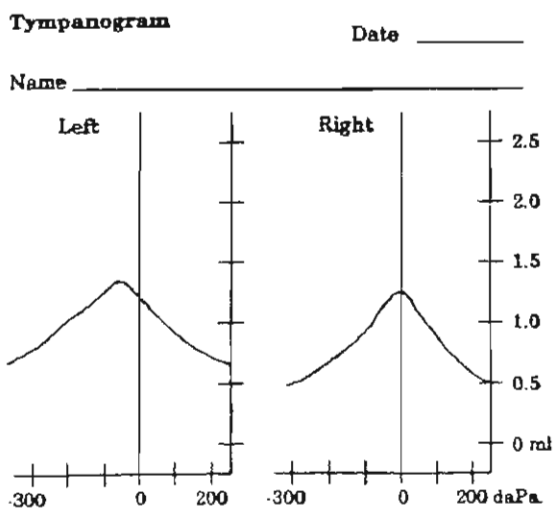
Middle Ear Compliance: ..... Normal range (0.3 ml -> 1.6 ml)

Ear Canal Volume: ..... Normal range

TYPICAL AUDIOGRAM



TYPICAL TYMPANOMETRY AND REFLEXES



Ipsilateral Acoustic Reflex Threshold

Stimulus	RIGHT	LEFT
500 Hz	N/R dB	N/R dB
1000 Hz	N/R dB	N/R dB
2000 Hz	N/R dB	N/R dB
4000 Hz.	90 dB	N/R dB

N/R = Reflex not recorded at maximum available level.

Aetiology: Acoustic Neuroma

AUDIOMETRIC FINDINGS

Presentation: ..... Unilateral

Degree of Impairment: ..... Mild to severe, initially in high frequencies

CHLOR SNHL: ..... Marked high frequency hearing loss

MIDDLE EAR IMPEDANCE FINDINGS

Tympanogram Type: ..... Type A

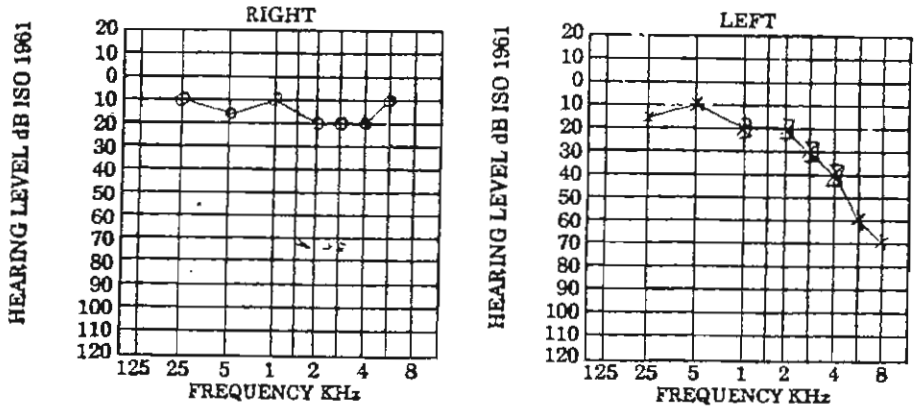
Acoustic Reflex Thres: ..... Elevated or absent with stimulus affected ear

Middle Ear Pressure: ..... Normal range (-100 -> 50 Da Pa)

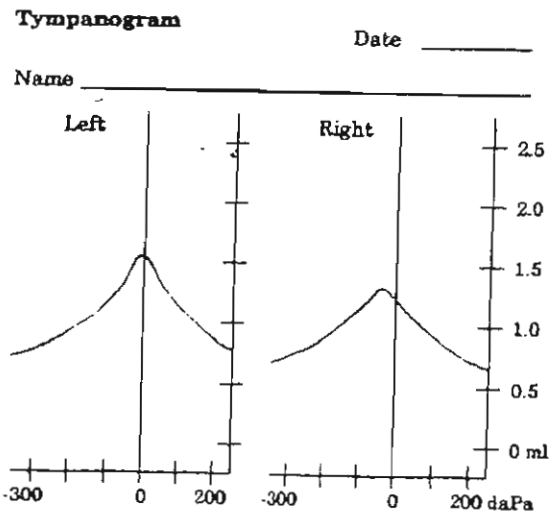
Middle Ear Compliance: ..... Normal range (0.3 -> 1.6 ml)

Ear Canal Volume: ..... Normal range

TYPICAL AUDIOGRAM



TYPICAL TYMPANOMETRY AND REFLEXES



Ipsilateral Acoustic Reflex Threshold

Stimulus	RIGHT	LEFT
500 Hz	85 dB	85 dB
1000 Hz	90 dB	90 dB
2000 Hz	90 dB	100 dB
4000 Hz	90 dB	N/R dB

N/R = Reflex not recorded at maximum available level

War Pensions Agency
Norcross
Blackpool FY5 3WP
England

Tel: 01253 858858
Fax: 01253

Monday - Thursday: 8.15am - 5.15pm
Friday: 8.15am - 4.30pm

WAR PENSIONS AGENCY

An executive agency of the Department of Social Security

If you get in touch with us please tell us this reference number

Date

Office use

Priority treatment

Thank you for your enquiry about hospital treatment. War pensioners are entitled to priority in NHS hospitals, both as out-patients and in-patients, for any examination or treatment which relates to the conditions for which they receive their War Pension.

You should show this form to your GP or consultant. It confirms that you are a war pensioner, and that you are receiving a War Pension for the following conditions

In case of a query by the GP or consultant, the latest Health Service guidelines relating to priority treatment for war pensioners are contained in _____.

Please note that the degree of priority given is a matter for the hospital doctor in charge of your case. There may be emergencies or other cases demanding higher clinical priority. The War Pensions Agency cannot influence the decision.

Please turn over >

If you need any more information about War Pensions, please let us know.

If you contact us, please tell us your reference number, which is shown at the top of the front page of this form.

If you wish to discuss anything in this form, please quote WPA352.

For Chief Executive
War Pensions Agency

To Medical Adviser

WPA816

BMI Quality Monitoring - Medical

Please read the instructions overleaf before completion

NI number

BMI test site

Date of test / /

	Yes	No	N/A	Nature of Error/Comments
Answers to all questions recorded				
Otoscopy findings recorded				
Audiogram in accordance with WPA requirements				
Tuning fork test performed				
Tympanogram/ART performed in accordance with WPA criteria				
Comments provided in respect of accuracy of audiometric responses				
Form completed legibly				
CERA report completed fully				

In addition please tick one box to indicate the overall quality of the attached test report

	5	Very high standard
	4	High standard
	3	Acceptable standard
	2	Below required standard
	1	Failure

Additional comments:

Thank you for completing this form.
Please return it to:

MA's name stamp

Instructions for completion

General

Please read these instructions before completing the form overleaf.

The NINO, and date will be inserted by the administrative staff.

If you tick "No", please explain the nature of the error in the space provided.

Please stamp your name in the box provided. This is in case we need to contact you for clarification.

History

Answers to all the questions must be recorded.

Examination

The state of the auditory canals (including the presence of wax) and tympanic membranes should be recorded. This should be a statement of fact. An opinion is not required.

Audiometric tests

The Pure Tone Audiogram (PTA) must demonstrate air conduction over 250Hz, 500Hz, 1,2,3,4,6 and 8 Khz and bone conduction over 500Hz, 1,2,3 and 4 Khz, with masking if appropriate. Masking is appropriate in the following circumstances:

1. Air conduction plots should be masked if there is a right/left difference of 40 dB or more.
2. Bone conduction plots should be masked if the not masked bone conduction threshold is better than the air conduction threshold by 10dB or more (ie an air/bone gap of 10dB).

Tuning Fork Test

Rinne and Weber tests should be performed in all cases.

Tympanogram/ART

Relevant history and otoscopic findings should have been taken into account before proceeding to tympanometry.

Tympanometry and middle ear function tests including ARTs should be performed where there is a significant conductive loss, ie, a conductive loss which is greater than 10dB at either 500Hz or 1Khz. It should also be carried out where wax is obstructing the view of the tympanic membrane.

CERA

CERA must be performed only when requested by a WPA MA. The thresholds measured must be recorded. The report should indicate any circumstances which may affect the quality of the readings.

Other

Comments must be completed in respect of the accuracy of the claimant's audiometric responses, (on proforma BMI 301 initially, then on revised WPA 301 when this comes into use).

Form WPA 301 and any attachments must be completed legibly.

War Pensions Agency
Norcross
Blackpool FY5 3WP
England

Tel: 01253 858858
Fax: 01253

WAR PENSIONS AGENCY

An executive agency of the Department of Social Security

Reason for rejection of medical advice

Customer details

NI number

Surname

Other names

■ **Advice rejected because** (tick one box only)

		Tick box	Nature of error/comments
A	Advice given is not fair and impartial or could compromise adjudication or decision making		
B	Advice given is not legible and concise		
C	Advice given is not in accordance with relevant legislation	**Not for WPA use**	
D	Advice given is not comprehensive, does not clearly explain the medical issues raised		

Please turn over >

8/98 WPA1067

■ **Advice rejected because - continued** (tick one box only)

		Tick box	Nature of error/comments
E	Advice given is not in plain English and is not free of medical jargon		**Not for WPA use**
F	Advice given is not complete and information is missing or some questions unanswered		

■ **Additional supporting information**

Signature

Date

Section

Room

Ext

Table showing average relation of height and weight at different age groups

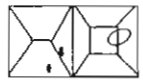
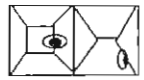
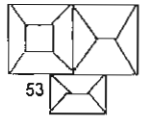
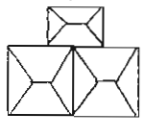
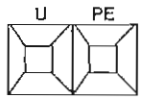
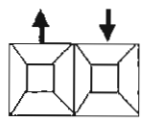
Heavy type shows weight in kilograms. Light type shows weight in stones and pounds.

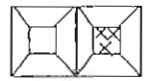
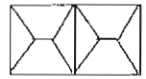
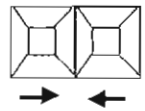
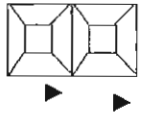
Height		Ages 15-16		Ages 17-19		Ages 20-24		Ages 25-29		Ages 30-39		Ages 40-49		Ages 50-59		Ages 60-69		Height	
cms	ft ins	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women	cms	ft ins
148	4 10				**44.9**		**46.3**		48.5		52 2		55.3		56 7		57.6		
			6-13		7-1		7-4		7-9		8-3		8-10		8-13		9-1	148	4 10
150	4 11		**45.3**		**46.3**		**47.6**		49 9		53.1		56 2		57 6		58.5		
			7-2		7-4		7-7		7-12		8-5		8-12		9-1		9-3	150	4 11
153	5 0	**44.4**	**46.7**	**51.2**	**47.6**	**55.3**	**50.0**	**58.1**	**51.2**	**59.4**	**54.4**	**60.8**	**57.6**	**61.7**	**59.0**	**60.3**	**59.4**		
		7-0	7-5	8-1	7-7	8-10	7-10	9-2	8-1	9-5	8-8	9-8	9-1	9-10	9-4	9-7	9-5	153	5 0
155	5 1	**46.3**	**48.5**	**52.6**	**49.4**	**56.7**	**50.8**	**59.4**	**52.6**	**60.8**	**55.8**	**62.1**	**59.0**	**63.0**	**60.3**	**61.7**	**60.8**		
		7-4	7-9	8-4	7-11	8-13	8-0	9-5	8-4	9-8	8-11	9-11	9-4	9-13	9-7	9-10	9-8	155	5 1
158	5 2	**48.5**	**50.3**	**54.0**	**51.2**	**58.1**	**52.2**	**60.8**	**54.0**	**62.1**	**57.1**	**63.5**	**60.3**	**64.4**	**61.7**	**63.0**	**62.1**		
		7-9	7-13	8-7	8-1	9-2	8-3	9-8	8-7	9-11	9-0	10-0	9-7	10-2	9-10	9-13	9-11	158	5 2
160	5 3	**50.8**	**51.7**	**55.8**	**52.6**	**59.9**	**53.5**	**62.6**	**55.3**	**63.9**	**58.5**	**65.3**	**61.7**	**65.8**	**63.5**	**64.4**	**63.9**		
		8-0	8-2	8-11	8-4	9-6	8-6	9-12	8-10	10-1	9-3	10-4	9-10	10-5	10-0	10-2	10-1	160	5 3
163	5 4	**53.0**	**53.0**	**57.6**	**54.4**	**61.7**	**54.9**	**63.9**	**56.7**	**65.8**	**59.9**	**67.1**	**63.5**	**67.6**	**65.3**	**66.2**	**65.8**		
		8-5	8-5	9-1	8-8	9-10	8-9	10-1	8-13	10-5	9-6	10-8	10-0	10-9	10-4	10-6	10-5	163	5 4
165	5 5	**55.3**	**54.9**	**59.4**	**56.2**	**63.0**	**56.7**	**65.3**	**58.5**	**67.6**	**61.2**	**68.9**	**64.9**	**69.4**	**67.1**	**68.0**	**67.6**		
		8-10	8-9	9-5	8-12	9-13	8-13	10-4	9-3	10-9	9-9	10-12	10-3	10-13	10-8	10-10	10-9	165	5 5
168	5 6	**57.6**	**56.7**	**61.2**	**57.6**	**64.4**	**58.5**	**67.1**	**60.3**	**69.4**	**63.0**	**70.8**	**66.7**	**71.2**	**68.9**	**69.8**	**69.4**		
		9-1	8-13	9-9	9-1	10-2	9-3	10-8	9-7	10-13	9-13	11-2	10-7	11-3	10-12	11-0	10-13	168	5 6
170	5 7	**59.8**	**58.1**	**63.0**	**59.0**	**65.8**	**59.9**	**68.5**	**61.7**	**71.2**	**64.4**	**73.0**	**68.5**	**73.5**	**70.8**	**72.1**	**71.2**		
		9-6	9-2	9-13	9-4	10-5	9-6	10-11	9-10	11-3	10-2	11-7	10-11	11-8	11-2	11-5	11-3	170	5 7

Table showing average relation of height and weight at different age groups (contd)

Height		Ages 15-16		Ages 17-19		Ages 20-24		Ages 25-29		Ages 30-39		Ages 40-49		Ages 50-59		Ages 60-69		Height	
cms	ft ins	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women	cms	ft ins
173	5 8	62.1	59.8	64.9	60.8	67.6	61.7	70.3	63.5	73.0	66.2	74.8	55.3	75.3	72.6	73.9	73.0		
		9-11	9-6	10-3	9-8	10-9	9-10	11-1	10-0	11-7	10-6	11-11	8-10	11-12	11-6	11-9	11-7	173	5 8
175	5 9	64.4	61.7	66.7	62.6	69.4	63.5	72.1	65.3	74.8	68.0	76.6	70.3	77.1	74.4	76.2	74.8		
		10-2	9-10	10-7	9-12	10-13	10-0	11-5	10-4	11-11	10-10	12-1	11-1	12-2	11-10	12-0	11-11	175	5 9
178	5 10	66.2		68.5	64.4	71.2	65.3	73.9	67.1	77.1	69.8	78.9	72.1	79.4	76.6	78.5			
		10-6		10-11	10-2	11-3	10-4	11-9	10-8	12-2	11-0	12-6	11-5	12-7	12-1	12-5		178	5 10
180	5 11	68.0		70.3	66.7	73.0	67.6	75.7	69.4	78.9	72.1	80.7	76.6	81.6	78.9	80.7			
		10-10		11-1	10-7	11-7	10-9	11-13	10-13	12-6	11-5	12-10	12-1	12-12	12-6	12-10		180	5 11
183	6 0	69.8		72.6	68.9	75.3	69.8	78.0	71.7	81.2	74.4	83.0	78.9	83.9	81.6	83.0			
		11-0		11-6	10-12	11-12	11-0	12-4	11-4	12-11	11-10	13-1	12-6	13-3	12-12	13-1		183	6 0
186	6 1	72.1		74.4		77.1		80.3		83.0		84.8		85.7		85.3			
		11-5		11-10		12-2		12-4		13-1		13-5		13-7		13-6		186	6 1
188	6 2	74.4		76.2		78.9		82.5		85.3		87.1		88.0		87.5			
		11-10		12-0		12-6		13-0		13-6		13-10		13-12		13-11		188	6 2
191	6 3	76.6		78.0		80.7		84.4		87.5		89.3		90.3		89.8			
		12-1		12-4		12-10		13-4		13-11		14-1		14-3		14-2		191	6 3
193	6 4			79.8		82.1		86.2		90.3		92.1		93.0		92.5			
				12-8		12-13		13-8		14-3		14-7		14-9		14-8		193	6 4

Dental Chart

SYMBOL	MEANING	EXAMPLE
O	CAVITY	
●	SOUND RESTORATION	
⊙	UNSOUND RESTORATION	
CODE FOR TOOTH (Eg 53 plus) 	RETAINED DECIDUOUS TOOTH IN ADDITION TO PERMANENT DENTITION	 53
FOR CODE FOR TOOTH (eg 65)	RETAINED DECIDUOUS TOOTH IN POSITION OF UNERUPTED OR MISSING PERMANENT TOOTH	 65
S plus 	SUPERNUMERARY TOOTH	
U	UNERUPTED TOOTH	U PE 
PE	PARTIALLY ERUPTED TOOTH	
↑↓	INSTANDING OR OUTSTANDING	

SYMBOL	MEANING	EXAMPLE
—	MISSING TOOTH	
X	TOOTH FOR EXTRACTION	
X	RETAINED ROOT SHOWING NUMBER OF ROOTS	
	¾ CROWN	
	FULL CROWN	
	PONTIC	
NV	NON-VITAL TOOTH	 NV RF
RF	ROOT-FILLED TOOTH	
	DRIFTED TOOTH SHOWING DIRECTION OF DRIFT	
	ROTATED TOOTH SHOWING DIRECTION OF ROTATION	

Note: Annual charting should be in RED and subsequent treatment in BLACK

Dates of changes in medical opinion

Condition	Date
Schizophrenia	1.2.76
Lower Limb Amputations and Atherosclerosis	15.2.79
Hodgkin's Disease and Non-Hodgkin's Lymphoma	1.12 83
Multiple Sclerosis	6. 6.84
Diabetes Mellitus (Type 1, Insulin Dependent)	1.12.85
Leukaemia (Except Chronic Lymphatic) Multiple Myeloma Polycythaemia Rubra Vera Accepted in UK Nuclear Test Participants	28. 1 88
Meniere's Disease	3.6.88
H Pylori	1. 3.93
Leukaemia (Except Chronic Lymphatic) Polycythaemia Rubra Vera Accepted in UK Nuclear Test Participants if Manifest Within 25 Years of Participation NB: Multiple Myeloma no Longer Accepted	11.12.93

Widows/Entitlement - Pre Appeal Scrutiny/Submission

NI number

Surname

Other names

Widows full name

Widows NI number

Date of death
(Widows Appeal) / /

Intention to appeal dated / / at Doc

Subject of Appeal (Disablement/Death from)	Date of claim	Entit. decision	Previous advice	Relevant article

Accepted Disablement	Entitlement	Assessment

Please turn over>

4/98 WPA766-Revised

When preparing the Reasons for Decision please bear in mind the following

Details of claimed contentions/incidents/risk factors identified and SOS Decisions	Accepted	Not accepted	362 at doc

Only read this part if we have ticked the box

☐ **Appeals MA -** Please identify any relevant extracts in

Description of document	From	To	Filed at Docs
A & T cards	/ /	/ /	
	/ /	/ /	
	/ /	/ /	
	/ /	/ /	
NI records	/ /	/ /	
	/ /	/ /	
	/ /	/ /	
	/ /	/ /	
HCNs from	/ /	/ /	
	/ /	/ /	
	/ /	/ /	
	/ /	/ /	

Record of evidence identified by an Appeal's caseworker for inclusion in a SOC in the event of an appeal

Please read box we have ticked

A previous

☐ translucent ☐ word processor

Statement of Case, covering the period from / / to / / , is filed at document_____.

Date	Document Description	Document number	Rule 22 Required	SOC Check
	EO caseworker's initials			

Please turn over >

To Appeals MA

An intention to appeal has been received. Will you please provide the Medical Reasons for Decision and indicate which documents have been used to reach the decision in this case. Please attach any relevant appendices.

Please read the parts we have ticked

☐ Further claims have been received and are referred for your advice in respect of

☐ Further condition claim

☐ Deterioration review

☐ Departmental review

☐ WPA361 completed

☐ WPA369 completed

☐ WPA373 completed

Signature and name stamp

Date / /

Section

Room

Ext

Assessment - Pre Appeal scrutiny/submission

NI number

Surname

Other names

Intention to appeal dated / / at Doc

Please tick the appropriate box

☐ Interim assessment ☐ Final assessment

Accepted disablement	Entitlement	Assessment	Period	
			From	To
Decision/Review	notified on	/ /		

AD	Symptoms included as P & P

Doc	Rejected condition(s)

Please turn over>

■Part A - Suitable for lay RFD only

Please tick the appropriate boxes

- ☐ Intention in-time
- ☐ Recent medical evidence
- ☐ Only one period involved
- ☐ NISHL true assessment 1, 2, & 3 kHz provided
- ☐ No OMD required **(see WPA363)**
- ☐ Reverse of WPA363 completed

■Part B - Refer to Appeals MA for medical RFD/Advice

Please tick the appropriate boxes

- ☐ Intention out of time
- ☐ Evidence over 12/12 old
- ☐ More than one period
- ☐ Limitation applies IRO of AD_____ certified Doc _____
- ☐ Finality applied Doc_____ (Non/Pre 7/1/93 NISHL)
- ☐ GD applies
- ☐ NISHL true assessment required
- ☐ OMD required **(see WPA363)**
- ☐ Reverse of WPA363 not completed
- ☐ Paired organs apply
- ☐ Reduced assessment Doc_____refers
- ☐ Medically complex cases

AD	Greater disablement accepted in respect of

	Other conditions not accepted

- ☐ Employment difficulties/ loss of earnings Doc_____
- ☐ Previous PAT assessment decisions Doc_____

■ Record of evidence identified by an Appeal's caseworker for inclusion in a SOC in the event of an appeal

Please read box we have ticked

A previous

☐ translucent ☐ word processor

Statement of Case, covering the period from / / to / / , is filed at document _____.

Date	Document Description	Document number	Rule 22 Required	SOC Check
	EO caseworker's initials			

Please turn over >

To Appeals MA

An intention to appeal has been received. Will you please provide the Medical Reasons for Decision and indicate which documents have been used to reach the decision in this case. Please attach any relevant appendices.

Please read the parts we have ticked

☐ Further claims have been received and are referred for your advice in respect of

☐ Further condition claim ☐ WPA361 completed

☐ Deterioration review ☐ WPA369 completed

☐ Departmental review ☐ WPA373 completed

Signature and name stamp

Date / /

Section **Room** **Ext**

To:

Appeals worker

Section

Room

War Pension Information

Surname

Other names

NINO

A certificate has been prepared ☐

Conditions rejected ☐ Label(s):

OMD(s) prepared ☐ Label(s)

If applicable - formerly rejected as:

Please turn over >

2/98 WPA 765

Rule 22 applied ☐ To OMD ☐

To SOC ☐

Appendix attached ☐ Title

Rule 22 Appendix (black lined and abridged copies) Attached ☐

Appendix not for issue to appellant ☐

Radiation appendix Required ☐

Signature

		Date: 16 February 2000
Section:	Room:	Ext:

National Insurance No:

War Pensioner's full name

RECORD OF EVIDENCE IDENTIFIED BY MEDICAL ADVISER FOR INCLUSION IN A SOC IN THE EVENT OF AN APPEAL

DOCUMENT DESCRIPTION	DOCUMENT NUMBER
Service Medical Records	
Information from the GP	
War Pensions Medical Examination	
AEX and/or Audiogram	
Evoked Response Audiometry Report	
Consultant/specialist Report	
Regional Consultant's Report	
Extracts from Hospital Case Notes	
National Insurance records	
X-ray Report	
Laboratory Reports	
The Post-Mortem Report	
The Death Certificate	
Other (please specify)	

Signature

Date 16 February 2000

Section

Room:

Ext:

War Pension - Entitlement now accepted

To:

Section

Room

From:

Name SMO

Section Ext

Room Date

Acceptance of entitlement previously rejected

NI number

Pensioner's surname

Other names

Following this change in medical advice back payment of pension may be appropriate.

Please tick the parts that apply

1. The earlier decision to reject entitlement was reasonable in view of
   - the evidence then before the Medical Advisor considering the case **and**
   - the medical knowledge at that time

   No ☐ Please give details on the back page

   Yes ☐ Go to 2

2. There was additional evidence available

   No ☐ Go to 4

   Yes ☐ Go to 3

3. A competent doctor ought reasonably to have obtained the evidence **and** that evidence would have led to a different decision.

   No ☐ Go to 4

   Yes ☐ Please give details on the back page

4. The present change of medical decision is because of
   - ☐ new evidence now available.
   - ☐ a change in the climate of medical opinion.
   - ☐ a change in the interpretation of the law. Please see details on the back page stating which HIGH COURT decision led to this.

Please turn over >

Any other information.

Signature SMO Date / /

REASONS FOR OVERTURNING AT APPEAL

ASSESSMENT APPEALS MONTH: YEAR: NAME:

- NON MA FACTOR			MA ERROR	IF MA ERROR	
ACCEPTANCE OF NEW CONDITION	NEW EVIDENCE		PREVIOUS DECISION INCORRECT	NAME OF MA	FILE NUMBER
	NOT PREVIOUSLY AVAILABLE	PREVIOUSLY AVAILABLE			

REASONS FOR OVERTURNING AT APPEAL

ENTITLEMENT APPEALS MONTH: YEAR: NAME:

NON MA FACTOR			MA ERROR		PREVIOUS "D" REVIEW	IF MA ERROR	
CHANGE OF SECRETARY OF STATE'S OPINION	CHANGE OF MEDICAL OPINION ON AETIOLOGY	NEW EVIDENCE		REJECTION CANNOT BE MAINTAINED		NAME OF MA	FILE NUMBER
		NOT PREVIOUSLY AVAILABLE	PREVIOUSLY AVAILABLE	PREVIOUS DECISION INCORRECT			

Pensions Appeal Tribunal

Special report by Departmental Representatives

Entitlement ☐ Assessment ☐

Appellant's details

NI number

Surname

Other names

PAT reference

Was this raised at the hearing ☐ No ☐ Yes

If yes by who?

Did this lead to an adjournment ☐ No ☐ Yes

■ Part 1 Error or Complaint details

Please turn over >

■ Part 2 Further action

Departmental Representative's signature

	Date / /

■ Part 3 Comments by Section or Expert Caseworker

Note: Please return this form to BAU, Room 6229 when completed. A copy should be kept on the file. Send a copy to the Departmental Representative if necessary.

Signature and name stamp

	Date / /

Section	**Room**	**Ext**

OMD-1 - Pre-Service condition: Article 4

Opinion of Medical Division
Department of Social Security

1. This Opinion sets out the reasons why the Department's Medical Officers are unable to provide a certificate in accordance with Article 4 of the Naval, Military and Air Forces etc (Disablement and Death) Service Pensions Order 1983 that the disablement $ is attributable to service ^C; or existed before or arose during service and has been and remains aggravated thereby.

2. We are medically of the opinion, from the evidence of ^C, that the condition on which the claim and appeal are based is $. A medical appendix relating to this condition is attached.

3. We are further medically of the opinion that the evidence of ^C shows, beyond any doubt, that this condition existed prior to £'s service. It cannot, therefore, be attributable to service.

^C4. The entry dated ^C in the in-service medical records shows that £'s condition $ came to light in the course of routine medical examination. The evidence of those service records shows that he had not made any complaint or suffered any disablement from $. As soon as the condition was noted, he was discharged from service as a precaution. It was not that thee was any disablement resulting from $ but rather that the very presence of the condition rendered him unfit for retention in the service. We are, therefore, medically of the opinion that, beyond reasonable doubt, there was no aggravation by service since £ was no worse at the date of his discharge than he would have been had he never served.

4. Whilst we would accept that $ was aggravated by service, we are medically of the opinion, from the evidence of ^C, that £'s condition was promptly and properly treated and from the evidence of ^C that it was no worse at the date of his ^C release discharge than it would have been had he never served. Consequently, we are of the opinion that, beyond reasonable doubt, such service aggravation no longer remained at the date of £'s ^C release discharge.

4. Whilst we would accept that $ was aggravated by service and that such aggravation remained at the date of £'s ^C release discharge, we are medically of the opinion that the evidence of ^C shows, beyond reasonable doubt, that £'s condition was then no worse than it would have been had he never served, the effects of service aggravation having been ^C nullified by treatment overtaken by natural progress of the condition. Consequently, we are medically of the opinion that service aggravation of $ no longer remained at ^C.

4. £'s service medical documents do not contain any record of attendance or treatment for $. We are medically of the opinion that, had he indeed suffered from the condition, he would have reported for treatment and a record would have been made. We are, therefore, firmly of the opinion that the absence of such a record ^C in the presence of records of attendances for other conditions shows positively, beyond reasonable doubt, that the condition was not aggravated by service.

4. It has already been accepted that £'s condition $ was aggravated by service and that such aggravation remains.

5. ^C.

6. In conclusion, we remain of the opinion that, beyond reasonable doubt, £'s condition $ is not attributable to service ^C and that ^C it was not aggravated by service any service aggravation no longer remained at the date of his ^C discharge release claim.

Date:

Signed:
Medical Officer authorised to sign for and on behalf of
Chief Medical Adviser (Social Security)

OMD-2 Pre-Service Condition: Article 5

Opinion of Medical Division
Department of Social Security

1. This Opinion sets out the reasons why the Department's Medical Officers are unable to provide a certificate in accordance with Article 5 of the Naval, Military and Air Forces etc (Disablement and Death) Service Pensions Order 1983 that the disablement $ is attributable to service ^C; or existed before or arose during service and has been and remains aggravated thereby at the date of claim.

2. We are medically of the opinion, from the evidence of ^C, that the condition on which the claim and appeal are based is $. A medical appendix relating to this condition is attached.

3. We are further medically of the opinion that the evidence of ^C shows, beyond any doubt, that this condition existed prior to £'s service. It cannot, therefore, be attributable to service.

^C4. The entry dated ^C in the in-service medical records shows that £'s condition $ came to light in the course of routine medical examination. The evidence of those service records shows that he had not made any complaint or suffered any disablement from $. As soon as the condition was noted, he was downgraded and, as is shown by the evidence of ^C, he did not manifest any disablement from $ at the date of his ^C discharge release claim. We are, therefore, medically of the opinion that there was no aggravation by service.

4. Whilst we would accept that $ was aggravated by service, we are medically of the opinion, from the evidence of ^C, that £'s condition was no worse at the date of his ^C release discharge claim than it would have been had he never served. Consequently, such service aggravation no longer remained at the date of ^C discharge release claim.

4. Evidence has not been adduced to show that £ suffered from $ during his period of service ^C or, indeed, for many years thereafter. We are consequently of the opinion that there was no aggravation of $ by service.

4. It has already been accepted that £'s condition $ was aggravated by service and that such aggravation remains.

5. ^C.

6. In conclusion, we remain of the opinion that reliable evidence has not been adduced to raise a reasonable doubt that £'s condition $ is attributable to service ^C or that ^C it was aggravated by service any aggravation by service remained at the date of ^C discharge release claim.

Date:

Signed:
Medical Officer authorised to sign for and on behalf of
Chief Medical Adviser (Social Security)

OMD-3 In service condition: Article 4

Opinion of Medical Division
Department of Social Security

1. This Opinion sets out the reasons why the Department's Medical Officers are unable to provide a certificate in accordance with Article 4 of the Naval, Military and Air Forces etc (Disablement and Death) Service Pensions Order 1983 that the disablement $ is attributable to service ^C; or existed before or arose during service and has been and remains aggravated thereby.

2. We are medically of the opinion, from the evidence of ^C, that the condition on which the claim and appeal are based is $.

^C

3. Reference to the attached medical appendix relating to $ will show that this condition is held, by the experts in this field, to be endogenously determined and causally unrelated to external factors. Therefore, despite the fact that the evidence of ^C shows that $ arose during service, it cannot be attributable to that service. Service merely provided the setting in which it became clinically manifest.

3. Reference to the attached medical appendix relating to this condition will show that, in spite of considerable medical investigation into $, no causative factors other than ^C have been discovered. ^C We are of the opinion that the evidence of ^C shows that ^C such factors were not present in £'s case that any such factors were not related to service. With regard to the question as to whether any other factors could be implicated, we are of the opinion, beyond reasonable doubt, that such factors would have been revealed by the considerable investigation into $.

3. We are advised by the Secretary of State that the incident which £ claims led to $ is not accepted as ^C having occurred being related to service. In the light of that advice, we are of the opinion that $ cannot be attributable to service. Even if it were to be accepted that that incident was related to service, we are medically of the opinion that $ cannot be causally connected with such an incident.

^C

4. The evidence of the service medical records shows that, as soon as £'s condition $ came to light, it was promptly and properly treated and, by the time of his ^C release discharge, his condition was no worse that it would have been had he never served. We are, therefore, medically of the opinion that, beyond reasonable doubt, $ was not aggravated by service.

4. Whilst we would accept that $ was aggravated by service, we are medically of the opinion, from the evidence of ^C, that £'s condition $ was no worse at the date of his ^C release discharge than it would have been had he never served. We are, therefore, of the opinion that service aggravation no longer remained at the date of his ^C release discharge.

4. Whilst we would accept that $ was aggravated by service and that such aggravation remained at the date of £'s ^C, release discharge we are medically of the opinion that the evidence of ^C shows, beyond reasonable doubt, that £'s condition $ was then no worse than it would have been had he never served, the effects of service aggravation ^C having been nullified by treatment having been overtaken by natural progress of the condition. Consequently, we are medically of the opinion that service aggravation of $ no longer remained at ^C.

4. It has already been accepted that £'s condition $ was aggravated by service and that such aggravation remains.

5. ^C.

6. In conclusion, we remain of the opinion that, beyond reasonable doubt, £'s condition $ is not attributable to service ^C and was not aggravated by service and that any service aggravation no longer remained at the date of his ^C release discharge claim.

Date:

Signed:
Medical Officer authorised to sign for and on behalf of
Chief Medical Adviser (Social Security)

OMD-4 In-service condition: Article 5

Opinion of Medical Division
Department of Social Security

1. This Opinion sets out the reasons why the Department's Medical Officers are unable to provide a certificate in accordance with Article 5 of the Naval, Military and Air Forces etc (Disablement and Death) Service Pensions Order 1983 that the disablement $ is attributable to service ^C; or existed before or arose during service and has been and remains aggravated thereby at the date of claim.

2. We are medically of the opinion, from the evidence of ^C, that the condition on which the claim and appeal are based is $.

^C

3. Reference to the attached medical appendix relating to $ will show that this condition is held, by the experts in this field, to be endogenously determined and causally unrelated to external factors. Therefore, despite the fact that the evidence of ^C shows that $ arose in service, it cannot be attributable to that service. Service merely provided the setting in which it became clinically manifest.

3. Reference to the attached medical appendix relating to this condition will show that, in spite of considerable medical investigation into $, no causative factors other than ^C have been discovered. ^C We are of the opinion that evidence has not been adduced to show ^C the presence of such factors in £'s case that any such factors were related to service. $ cannot, therefore, be attributable to service.

3. We are advised by the Secretary of State that the incident which £ claims led to $ is not accepted as being ^C related to service having occurred. In the light of that advice, we are of the opinion that $ cannot be attributable to service. Even if it were to be accepted that that incident was related to service, we are of the opinion that £ has not adduced reliable evidence which raises a reasonable doubt causally connecting such an incident with $.

^C

4. The evidence of the service medical records shows that, as soon as £'s condition $ came to light, it was promptly and properly treated and, by the time of his ^C release discharge, his condition was no worse than it would have been had he never served. We are, therefore, medically of the opinion that, beyond reasonable doubt, $ was not aggravated by service.

4. Whilst we would accept that $ was aggravated by service. we are medically of the opinion, from the evidence of ^C, that £'s condition was no worse at the date of his ^C release discharge claim than it would have been had he never served. We are, therefore, of the opinion that service aggravation no longer remained at the date of ^C release discharge claim.

4. It has already been accepted that £'s condition $ was aggravated by service and that such aggravation remains.

5. ^C.

6. In conclusion, we remain of the opinion that reliable evidence has not been adduced to raise a reasonable doubt that £'s condition $ is attributable to service ^C or that it was aggravated by service that any service aggravation remained at the date of his ^C release discharge claim.

Date:

Signed:
Medical Officer authorised to sign for and on behalf of
Chief Medical Adviser (Social Security)

OMD-5 Post-service condition: Article 4

Opinion of Medical Division
Department of Social Security

1. This Opinion sets out the reasons why the Department's Medical Officers are unable to provide a certificate in accordance with Article 4 of the Naval, Military and Air Forces etc (Disablement and Death) Service Pensions Order 1983 that the disablement $ is attributable to service; or existed before or arose during service and has been and remains aggravated thereby at the date of claim.

2 We are medically of the opinion, from the evidence of ^C, that the condition on which the claim and appeal are based is $. A medical appendix relating to this condition is attached.

^C

3. Reference to the attached medical appendix relating to $ will show that this condition is held, by the experts in this field, to be endogenously determined and causally unrelated to external factors. In the light of this evidence, we are firmly of the opinion that, beyond reasonable doubt, $ cannot be attributable to service.

3. Reference to the attached medical appendix relating to $ will show that, in spite of considerable medical investigation into the condition, no causative factors other than ^C have been discovered. The evidence of £'s service records shows that none of these factors was present as a result of service. We are consequently medically of the opinion that, beyond reasonable doubt, $ cannot be attributable to service. With regard to the question as to whether any other factors could be implicated, we are of the opinion, beyond reasonable doubt, that any such factors would have been revealed by the considerable investigation into $.

3. The evidence of ^C shows that the first manifestation of $ was on ^C, this being ^C after service factors had ceased to operate. We are medically of the opinion, beyond reasonable doubt, that this time interval is far too long for there to be a causal connection and, consequently, $ cannot be attributable to service.

^C

4. As we have pointed out at paragraph 3 above, the evidence shows that £'s condition $ did not arise until after his period of service had ceased. Since it neither existed before nor arose during service it could not have been aggravated thereby.

4. As we have pointed out at paragraph 3 above, the evidence shows that $ first became manifest on ^C, this being ^C after service factors had ceased to operate We are medically of the opinion that this time interval is far too long for service factors to have played any part in the progress of $ and we are consequently of the opinion that the condition was not aggravated by service.

5. ^C.

6. In conclusion, we remain of the opinion that, beyond reasonable doubt, £'s condition $ is not attributable to service and was not aggravated by service.

OMD-6 Post-service condition: Article 5

Opinion of Medical Division
Department of Social Security

1. This Opinion sets out the reasons why the Department's Medical Officers are unable to provide a certificate in accordance with Article 5 of the Naval, Military and Air Forces etc (Disablement and Death) Service Pensions Order 1983 that the disablement $ is attributable to service; or existed before or arose during service and has been and remains aggravated thereby at the date of claim.

2. We are medically of the opinion, from the evidence of ^C, that the condition on which the claim and appeal are based is $. A medical appendix relating to this condition is attached.

^C

3. Reference to the attached medical appendix relating to $ will show that this condition is held, by the experts in this field, to be endogenously determined and causally unrelated to external factors. In the light of this evidence, we are medically of the opinion that $ cannot be attributable to service.

3. Reference to the attached medical appendix relating to $ will show that. in spite of considerable medical investigation, no causative factors other than ^C have been discovered. The evidence of £'s service records does not show that any of these factors was present as a result of service and we are, therefore, medically of the opinion that $ cannot be attributable to service.

3. The evidence of ^C shows that the first manifestation of $ was on ^C, this being ^C after service factors had ceased to operate. We are medically of the opinion that this time interval is far too long for there to be a causal connection and, consequently, $ cannot be attributable to service.

^C

4. As we have pointed out at paragraph 3 above, the evidence shows that £'s condition $ did not arise until after his period of service had ceased. It therefore neither existed before nor arose during service and thus could not have been aggravated by service.

4. The evidence does not show that £ suffered from any manifestation of $ during his period of service. The evidence of ^C does show that $ first became manifest on ^C, this being ^C after service factors ceased to operate. We are medically of the opinion that this time interval is far too long for service factors to have played any part in the progress of $ and we are, therefore, of the opinion that the condition was not aggravated by service.

5. ^C

6. In conclusion, we remain of the opinion that £ has not, by reliable evidence, raised a reasonable doubt that his condition $ is attributable to service or that it existed before or arose during service and was aggravated thereby.

Date:

Signed:
Medical Officer authorised to sign for and on behalf of
Chief Medical Adviser (Social Security)

OMD-7 Death appeal: Article 4

Opinion of Medical Division
Department of Social Security

1. This Opinion sets out the reasons why the Department's Medical Officers are unable to provide a certificate in accordance with Article 4 of the Naval, Military and Air Forces etc (Disablement and Death) Service Pensions Order 1983 that £'s death at the age of ^C years, was due to or hastened by a wound, injury or disease which was attributable to service; or the aggravation by service of a wound, injury or disease which existed before or arose during service.

^C2. We are medically of the opinion, beyond ^C any reasonable doubt, from the evidence of ^C, that £'s death, which occurred ^C in service weeks months years after service, was due to the ^C condition conditions $. ^C In addition, we are medically of the opinion from the evidence of ^C, that £'s death was hastened by the ^C condition conditions $.

3. For the reasons given in the attached Opinions relating to $, we are medically of the opinion that, beyond reasonable doubt, $^C was were not attributable to service ^C, nor ^C was it were they aggravated thereby.

4. It has already been accepted that £'s condition ^C was aggravated by service and that aggravation remained at the date of ^C release discharge death. Under the terms of Article 9(2)(b)(i) of the Service Pensions Order, in assessing the degree of disablement existing at the date of termination of service, account is to be taken of the total disablement existing at that date arising from the accepted conditions and not just the increase in disablement produced by the service aggravation. The assessment of ^C on which £'s pension was based was not a true reflection of the service aggravation, since the evidence of ^C shows that any actual service aggravation was minimal. We are medically of the opinion that, beyond reasonable doubt, such minimal service aggravation could not have contributed in any way to the fatal processes and that worsening of ^C after service factors ceased to operate was entirely the result of natural progress of the condition and/or the effect of post service factors as is shown by the evidence of ^C.

5. ^C.

6. In conclusion, we remain medically of the opinion that, beyond reasonable doubt, £'s death was not due to or hastened by a wound, injury or disease which was attributable to service or the aggravation by service of a wound, injury or disease which existed before or arose during service.

Date:

Signed:
Medical Officer authorised to sign for and on behalf of
Chief Medical Adviser (Social Security)

OMD-8 Death appeal: Article 5

Opinion of Medical Division
Department of Social Security

1. This Opinion sets out the reasons why the Department's Medical Officers are unable to provide a certificate in accordance with Article 5 of the Naval, Military and Air Forces etc (Disablement and Death) Service Pensions Order 1983 that £'s death at the age of ^C years, was due to or substantially hastened by a wound, injury or disease which was attributable to service; or the aggravation by service of a wound, injury or disease which existed before or arose during service.

^C

2. We are medically of the opinion, from the evidence of ^C, that £'s death, which occurred ^C years after service had ended, was due to $. ^C In addition, we are medically of the opinion that £'s death was substantially hastened by $.

3. For the reasons set out in the attached opinions relating to $, we are medically of the opinion that reliable evidence has not been adduced to raise a reasonable doubt that $ ^C was were attributable to service or was were aggravated thereby.

4. It has already been accepted that £'s ^C condition(s) ^C was aggravated by service and that such aggravation remained at the date of ^C release discharge death. Under the terms of Article 9(2)(b)(i) of the Service Pensions Order, in assessing the degree of disablement existing at the date of termination of service, account is to be taken of the total disablement existing at that date arising from the accepted conditions and not just the increase in disablement produced by service aggravation. The assessment of ^C on which £'s pension was based was not a true representation of the service aggravation since the evidence of ^C shows that any service aggravation was minimal. We are medically of the opinion that such minimal service aggravation could not have contributed in any way to the fatal processes and that worsening of ^C after service factors had ceased to operate was entirely the result of natural progress of the condition and/or the effect of post-service factors as is shown by the evidence of ^C.

5. ^C

6. In conclusion, we remain of the opinion that reliable evidence has not been adduced to raise a reasonable doubt that £'s death was due to or substantially hastened by a wound, injury or disease which was attributable to service or the aggravation by service of a wound, injury or disease which existed before or arose during service.

Date:

Signed:
Medical Officer authorised to sign for and on behalf of
Chief Medical Adviser (Social Security)

Ref:

OMD-9 Not found: either article

Opinion of Medical Division
Department of Social Security

1 This opinion sets out the reasons why the Department's Medical Officers are unable to provide a certificate in accordance with Article 4/5 of the Naval, Military and Air Forces etc (Disablement and Death) Service Pensions Order 1983 that the disablement $ is attributable to service or existed before or arose during service and has been and remains aggravated thereby.

2 On ~ F£ made a claim in respect of disablement arising from $.

3 The evidence of ^C shows, on balance of probabilities, that £ does not suffer and never has suffered from $. Therefore, we are firmly of the opinion that £ has not satisfied the primary onus upon him of showing the presence of the claimed disablement.

4 (For Article 4 cases) We are medically of the opinion, therefore, that beyond reasonable doubt, $ is neither attributable to nor aggravated by service.

5 (For Article 5 case) We are medically of the opinion, therefore, that a reasonable doubt is not raised that $ is attributable to or was aggravated by service.

6 In arriving at this conclusion, we have had regard to the general principle expressed in the Judgement in the High Court case of ROYSTON (Reports of Selected War Pensions Appeals Vol 3 p 1593).

Date: 28 March 2001 Signed:

Medical Officer authorised to sign for and on behalf
of Chief Medical Adviser (Social Security)

OMD-10 Assessment

Opinion of Medical Division
Department of Social Security

X We are firmly of the opinion, from the evidence of ^C, that there is now no remaining disablement arising from ^C.

X We are medically of the opinion, from the evidence of ^C, that the present assessment adequately reflects the degree of disablement arising from ^C for the period under appeal.

X We are medically of the opinion that the accepted condition ^Cs will not deteriorate further and that finality is appropriate.

^C

X The evidence of ^C shows that the condition ^Cs arose pre-service. Entitlement of Aggravation is, therefore, correct. In accordance with Article 9(2)(b)(i) of the Service Pensions Order 1983, the whole of the disablement present at service ^C release discharge was included in the assessment. This included all pre-service disablement, any increase in disablement during service caused by non-service factors, as well as any actual service aggravation. The evidence of ^C shows that there was no deterioration of the accepted condition ^Cs for ^C years after service had ended.

X In our opinion, therefore, the assessment of ^C% adequately reflects all disablement arising from service aggravation of ^C. Any disablement found above this level ^C is due would be due, in our medical opinion, to post-service factors and/or natural progress of the condition and accordingly, having regard to Article 9(2)(b)(ii) of the Service Pensions Order 1983, has to be excluded from the assessment. In view of this, we are of the opinion that finality is appropriate.

^C

X Disablement arising from ^C is excluded from the assessment. ^C This These condition^Cs ^C is are not being accepted as related to service.

X On ^C, an Entitlement Appeal Tribunal determined that the condition^Cs ^C ^C is are unrelated to service. Disablement arising from ^C this these conditions cannot, therefore, be included in the assessment.

^C

X The evidence of ^C shows that there is adverse interaction between the accepted condition ^Cs and the non-accepted condition ^Cs ^C. The Greater Disablement principle has, therefore, been applied and the assessment includes ^C% in respect of increased disablement arising from the non-accepted condition ^Cs as a result of this interaction.

X The evidence does not show any adverse interaction between the accepted and non-accepted conditions. We are, therefore, medically of the opinion that an increase in assessment under the Greater Disablement provisions is not warranted.

X. The evidence of ^C shows a degree of interaction between the accepted and non-accepted conditions, but this is not of sufficient severity to warrant an increase in assessment under the Greater Disablement provisions.

^C

X. We note that £ makes reference to ^C, which ^C is a factor or factors relating to individual circumstances. However, under the terms of Article 9(2)(a) of the Service Pensions Order 1983, ^C this factor has been these factors have been disregarded in the assessment of disablement.

X. In conclusion, we are firmly of the opinion that the ^C combined assessment of ^C fully reflects all disablement arising from the accepted condition.

Date:

Signed
Medical Officer authorised to sign for and on behalf of
Chief Medical Adviser (Social Security)

A

C

Current invalidings

D

Deafness cases

E

Entitlement considerations

Evidence and evidence collection

J

Joint applications

M

Q

S

T

Treatment Allowances

W

War Pensions Agency Medical Services (WPAMS) Administration