**IN THE UPPER TRIBUNAL** **Appeal No. *UA-2023-000866-AFCS***
**ADMINISTRATIVE APPEALS CHAMBER** **[2024] UKUT 191 (AAC)**

On appeal from the First-tier Tribunal (War Pensions and Armed Forces Compensation Chamber)

**Between:**

**J.H.**

Appellant

- v -

**Secretary of State for Defence**

Respondent

**Before: Upper Tribunal Judge Wikeley**

Hearing date: 20 June 2024
Decision date: 1 July 2024

**Representation:**

| | |
|---|---|
| Appellant: | Ms Jasmine Skander of Counsel, instructed by Irwin Mitchell LLP |
| Respondent: | Mr Will Hays of Counsel, instructed by the Government Legal Department |

## DECISION

**The decision of the Upper Tribunal is to dismiss the appeal.** The decision of the First-tier Tribunal made on 25 April 2023 under case number AFCS/00735/2020 does not involve any material error of law (section 11 of the Tribunals, Courts and Enforcement Act 2007).

## REASONS FOR DECISION

### The subject matter of this appeal to the Upper Tribunal

1. This appeal is about a claim for compensation for Post-Traumatic Stress Disorder (PTSD) made under the Armed Forces Compensation Scheme (AFCS).

### A bare outline of the course of the appeal

2. The Veterans UK decision-maker, acting on behalf of the Secretary of State for Defence, decided that the claimant was entitled to an AFCS award on the basis of his PTSD at Table 3, Item 4, Level 12. The claimant appealed to the First-tier Tribunal, which allowed his appeal in part, ruling that the appropriate descriptor was a step higher at Table 3, Item 3, Level 10. The claimant now appeals to the Upper Tribunal against the decision of the First-tier Tribunal, having argued that the proper descriptor to be applied was in fact at the still higher rate of Table 3, Item 1, Level 6.

### The Upper Tribunal oral hearing of the appeal

3. I held an oral hearing of this appeal at the Manchester Civil Justice Centre on 20 June 2024. The Appellant was represented by Ms J Skander of Counsel, instructed by Irwin Mitchell, Solicitors. The Respondent, the Secretary of State for Defence, was represented by Mr W Hays of Counsel, instructed by the Government Legal Department on behalf of Veterans UK. I am grateful to both counsel for their oral and written submissions.

### A summary of the Upper Tribunal's decision

4. I dismiss the claimant's further appeal to the Upper Tribunal. This is because the decision of the First-tier Tribunal does not involve any material legal error.

5. To protect the claimant's privacy, I refer to the claimant in this decision as simply 'the Appellant' or as 'Mr H' rather than by name. To avoid the risk of 'jigsaw identification', I also provide only the barest information about the factual background to the appeal. However, the limited details that are supplied are sufficient to understand the context of the case.

### The factual background to this appeal

6. The Appellant served as an infantry private in the Army from 2003 until 2009. He witnessed distressing incidents while on tours of duty in both Northern Ireland and Iraq. In 2017 a consultant psychiatrist (Dr Cahill) diagnosed the Appellant as suffering from PTSD. In the same year Veterans UK accepted that AFCS service was the predominant cause of the Appellant's PTSD and accordingly made an interim award of compensation under the Armed Forces and Reserve Forces (Compensation Scheme) Order 2011 (SI 2011/517, 'the 2011 Order'). In 2019 Veterans UK finalised that interim award by placing the Appellant's PTSD at Table 3, Item 4, Level 12 of Schedule 3 to the 2011 Order. That final award was confirmed following reconsideration in January 2020.

## The legal background to this appeal

7. Table 3 of Schedule 3 to the 2011 Order provides as follows:

Table 3 - Mental disorders(*)

| Item | Column (a) | Column (b) |
|---|---|---|
| | Level | ***Description of injury and its effects ("descriptor")*** |
| | | |
| A1 | 4 | Permanent mental disorder causing very severe functional limitation or restriction[(aa)] |
| 1 | 6 | Permanent mental disorder, causing severe functional limitation or restriction[(a)] |
| 2 | 8 | Permanent mental disorder, causing moderate functional limitation or restriction[(b)] |
| 3 | 10 | Mental disorder, causing functional limitation or restriction, which has continued, or is expected to continue for 5 years |
| 4 | 12 | Mental disorder, which has caused, or is expected to cause functional limitation or restriction at 2 years, from which the claimant has made, or is expected to make, a substantial recovery within 5 years |
| 5 | 13 | Mental disorder, which has caused, or is expected to cause, functional limitation or restriction at 26 weeks, from which the claimant has made, or is expected to make, a substantial recovery within 2 years |
| 6 | 14 | Mental disorder, which has caused or is expected to cause, functional limitation or restriction at 6 weeks, from which the claimant has made, or is expected to make, a substantial recovery within 26 weeks |

(*) In assessing functional limitation or restriction in accordance with article 5(6) account is to be taken of the claimant's psychological, social and occupational function.

(*) Mental disorders must be diagnosed by a clinical psychologist or psychiatrist at consultant grade.

[(aa)] Functional limitation or restriction is very severe where the claimant's residual functional impairment after undertaking adequate courses of best practice treatment, including specialist tertiary interventions, is judged by the senior treating consultant psychiatrist to remain incompatible with any paid employment until state pension age.

[(a)] Functional limitation or restriction is severe where the claimant is unable to undertake work appropriate to experience, qualifications and skills at the time of onset of the illness and over time able to work only in less demanding.jobs.

[(b)] Functional limitation or restriction is moderate where the claimant is unable to undertake work appropriate to experience, qualifications and skills at the time of onset of the illness but able to work regularly in a less demanding job.

8. Accordingly, this case has involved consideration of three different descriptors. The Secretary of State's decision was that the appropriate descriptor was "Mental disorder, which has caused, or is expected to cause functional limitation or restriction at 2 years, from which the claimant has made, or is expected to make, a substantial recovery within 5 years" (Item 4, Level 12). The First-tier Tribunal, however, decided that the proper descriptor was "Mental disorder, causing functional limitation or restriction, which has continued, or is expected to continue for 5 years" (Item 3, Level 10). The Appellant, on the other hand, contended that "Permanent mental disorder, causing severe functional limitation or restriction" was the applicable descriptor (Item 1, Level 6).

9. By way of comparison, these descriptors translate into amounts of £10,300 (Level 12), £27,810 (Level 10) and £144,200 (Level 6) respectively (see Table 10 'Tariff amounts' of Schedule 3 to the 2011 Order). The double step change from Item 3 (Level 10) to Item 1 (Level 6) is therefore marked.

10. There is one other provision of note in the 2011 Order. Article 5(7)(a) provides as follows:

> (7) Functional limitation or restriction is —
>
> (a) "permanent" where following appropriate clinical management of adequate duration—
>
> (i) an injury has reached steady or stable state at maximum medical improvement; and
>
> (ii) no further improvement is expected.

**The consultant psychiatrist's 2017 report**

11. The consultant psychiatrist's 2017 report (by Dr Cahill), which made the original diagnosis of the Appellant's PTSD, included the following passage (now suitably anonymised and with bold emphasis as in the original) under the heading 'Treatment':

> [Mr H] has not received any formal psychological treatment to date. He has had a number of assessments, and at one point was offered group therapy or Eye-Movement Desensitisation and Reprocessing (EMDR), but these never reached fruition.
>
> He has tried pharmacological treatment in the form of two SSRIs (Selective Serotonin Reuptake Inhibitors Antidepressants), with some reduction of symptoms.
>
> The **treatment requirement** for PTSD is trauma-focussed therapy in the form of either **Trauma Focussed Cognitive Behavioural Therapy** or **Eye-Movement Desensitisation and Reprocessing** (EMDR).
>
> However, in my opinion, [Mr H] needs a lot of 'psychological preparation' before embarking on a structured form of therapy. He needs to build up a therapeutic, trusting relationship with a professional to work on some low-grade coping strategies, and anxiety management in the form of relaxation, mindfulness and graded exposure, prior to discrete work on the trauma.
>
> If [Mr H] can embark on some form of therapy, for example the EMDR which is in the pipeline, I envisage this will take a lot longer than the standard 18-24 sessions normally prescribed.

12. As will become evident, much of the debate in the present appellate proceedings has revolved around the meaning of the expression "formal psychological treatment" (as it appears in the first paragraph of this passage in Dr Cahill's report). This passage is especially relevant to the first three of the four primary grounds of appeal.

13. In the next passage of his report, Dr Cahill addressed the prognosis for Mr H as it appeared in 2017:

> Evidence suggests that 2 in 3 people with PTSD eventually get better without treatment. 1 in 3 may have more lasting effects, which can last for years and can be very severe. Outcome will depend on length and severity of trauma but the majority of those with severe cases respond well to highly specific trauma focused therapies. The trauma aspect of the illness is relatively uncomplicated to treat but associated factors such as alcohol, illicit drug use, relationship breakdown, financial difficulties, poor self-esteem and social withdrawal are harder to tackle.
>
> Positive factors include, but not limited to, a robust premorbid personality, above average cognitive ability, good social skills, optimism, social and environmental stability and strong social support, less severe trauma, early intervention, minimal duration of trauma, trauma not experienced up close, and absence of alcohol and illicit drug use. Males have better overall prognosis.
>
> Taking these factors into account, in my opinion, [Mr H]'s prognosis is poor. There is a predisposition to anxiety and evidence of poor coping mechanisms. He joined the Army at a young age, when his personality was still forming, and there is evidence that he struggled to cope, as well as forming solid relationships and it is likely there were elements of his personality which were not robust.
>
> There is evidence of poor self-esteem, pessimism and social withdrawal. However, he has a strong family support network.
>
> He has suffered for many years without being able to engage in the support or treatment he has required. There appears to be a barrier to accessing treatment which he first must overcome.

14. This passage on prognosis is particularly relevant to the fourth and final ground of appeal.

**The Secretary of State's decision**

15. The Appellant made a claim under the AFCS in respect of his PTSD in August 2017. On 5 October 2017 the Veterans UK decision-maker placed the Appellant's PTSD as an interim award at Table 3, Item 4, Level 12. On 4 April 2019 that award was finalised on the same basis, the decision-maker accepting medical advice to the effect that Mr H did "not appear to be engaging with specialist services and is not receiving any specialist mental health input". That decision was maintained following reconsideration on 6 January 2020. On 13 February 2020 the Appellant lodged an appeal.

**The First-tier Tribunal's decision**

16. The First-tier Tribunal (from now on, simply 'the Tribunal') held a remote CVP hearing of the appeal on 14 March 2023. It issued its decision notice a few days later on 20 March 2023, giving the following summary reasons:

    (1) The Tribunal was satisfied that, at the date of the decision, [the Appellant's] mental disorder caused a functional limitation or restriction which was expected to continue for 5 years.

    (2) The Tribunal was not satisfied that [the Appellant's] mental disorder is permanent for the purposes of the descriptors in items 1 and 2 of Table 3.

    (3) In reaching our decision, the Tribunal carefully considered the legal submissions on the meaning of the word "permanent" in this context.

17. This decision notice was followed by the Tribunal's full written reasons (signed off on 23 April 2023, issued on 25 April 2023).

18. Having set out its findings about the process leading up to the Appellant's diagnosis by Dr Cahill, the Tribunal made the following findings of fact (here suitably anonymised):

    33. The first diagnosis of PTSD was made by a consultant psychiatrist – Dr Cahill – on 5 June 2017. This was in a report requested by Veterans UK.

    34. Mr H currently spends most of his time at home, sitting in one room. He is unable to be left alone. His partner is his carer. His children are home schooled. He avoids social situations. His family are unable to go on days out. He constantly fears that something will happen to his children.

    35. Mr H has not received any formal psychological treatment. He has had a number of assessments and at one point was offered group therapy or Eye-movement Desensitisation and Reprocessing. However, these have not been completed (page 64 reverse in the bundle.)

    36. Mr H has completed 12 sessions of Cognitive Behavioural Therapy ["CBT"]. These were mostly online, so he did them from home where his partner was able to support him. The sessions did not result in an improvement of his symptoms. Mr H did learn some coping mechanisms from the CBT.

    37. The opinion of Dr Cahill is that Mr H "needs a lot of 'psychological preparation' before embarking on a structured form of therapy. He needs to build up a therapeutic, trusting relationship with a professional to work on some low-grade coping strategies, and anxiety management in the form of relaxation, mindfulness and graded exposure, prior to the discrete work on the trauma....If [he] can embark on some form of therapy, for example the EMDR which is in the pipeline, I envisage this will take a lot longer than the standard 18-24 sessions normally prescribed."

    38. Mr H has been unable to engage in the support or treatment he requires and there is a barrier to accessing treatment that he must overcome (page 65 in the bundle). However, Mr H's evidence is that he thought he had responded well to Dr Cahill. He explored the possibility of private treatment with Dr Cahill, but the cost was prohibitive.

> 39. There is medical evidence that the prognosis for Mr H is poor. Dr Cahill says that "there is a predisposition to anxiety and evidence of poor coping mechanisms. [Mr H] joined that Army at a young age, when his personality was still forming, and there is evidence that he struggled to cope, as well as forming solid relationships, and it is likely that there were elements of his personality which were not robust." (See page 65 in the bundle.)
>
> 40. Mr H has a strong family support network, which is positive.
>
> 41. Mr H has had many medication changes, which is managed by his GP.
>
> 42. Mr H has not been in paid work since he left service. At some point, he worked for his father on his father's market stall, but this was unpaid. His evidence to us was that, when he was discharged, that he was thinking of being a vehicle mechanic. He started a college course relating to vehicle mechanics, but was not successful. This was in part due to loud noises that he found difficult to cope with. He also attempted sports fitness coaching course but it was too much for him to deal with. Mr H has considered working in mental health, and found a course that interested him, but could not complete all of the necessary assessments.
>
> 43. During service, Mr H underwent a silver service course, a signalling course, a medics course and he re-took his maths and English exams (as he said that his grades from school were not good). He had a driving licence, but no longer uses it. Currently he has a provisional driving licence. Mr H reported being good at working in a team, being reasonably organised and that he could deal with noisy places.
>
> 44. Mr H is of the opinion that he is unable to cope with trauma therapy. He feels that the online therapy sessions he has been able to do have provided him with coping tools. He strongly believes his PTSD will remain indefinitely.

19. In the final section of its decision, headed 'Conclusions', the Tribunal then reasoned as follows:

> 45. We are satisfied that, at the date of the decision, Mr H's mental disorder caused a functional limitation or restriction which was expected to continue for 5 years.
>
> 46. We are not satisfied that Mr H's mental disorder, at the date of the decision, was permanent for the purposes of the descriptors in items 1 and 2 of Table 3.
>
> 47. In reaching our decision, we carefully considered the legal submissions on the meaning of the word "permanent" in this context.
>
> 48. In respect of whether Article 5(7)(a) should be used to define permanence for the purposes of the descriptors in items 1 and 2 of Table 3 (and indeed item A1, but that was not a part of this case), we were not satisfied that it should, at least on an absolute basis. That is because the descriptors for items A1, 1 and 2 are written in a different way to those in items 3, 4 5 and 6. In items 3, 4, 5 and 6 the reference is to a mental disorder with a functional limitation that is tied to a specified duration. Therefore, it

can be seen (as set out in the case of *PQ* (see paragraph 18 above) that the duration is relevant to the functional limitation or restriction.

49. In items A1, 1 and 2, the word “permanent” is directly before the word “disorder”. There is then a specific definition of functional limitation or restriction (“very severe”, “severe” and “moderate”) to be applied and defined in the footnotes. As such, an ordinary reading would suggest that the mental disorder, rather than the functional limitation or restriction, must be permanent.

50. In addition, there is use of the phrase “permanent significant functional limitation or restriction” in other tables (for example Table 8, item 1). This suggests that where government intended the functional limitation or restriction to be permanent, it said so and provided the legal definition to be applied (in Article 5(7)(a)).

51. However, we do think that Article 5(7)(a) provides a useful guide to the approach to permanence in the 2011 Order in respect of Table 3.

52. The Oxford English Dictionary defines ‘permanent’ as follows: “Continuing or designed to continue or last indefinitely without change; abiding, enduring, lasting; persistent. Opposed to *temporary*.”

53. In our view, it is not as clear cut as entirely relying on either Article 5(7)(a) or a straightforward dictionary definition of the word permanent in the context of items A1, 1 and 2 in Table 3. Cases where such an award is possible are, by definition, likely to be medically complicated. Applying only a dictionary definition is too simplistic – mental disorders commonly change as people respond to treatment and medication. It stands to reason that if there has not been appropriate clinical management of the mental disorder, maximum medical improvement has been reached, and that common treatment options are available but have not been undertaken, then those are relevant factors in deciding if a mental disorder is permanent or not.

54. Mr H has not yet carried out a course of EMDR treatment. Dr Cahill’s evidence did not rule out future therapy. He said that significant preparatory work will be needed, and that a longer than normal course of treatment of EMDR is likely to be required. Mr H is clearly capable of developing a trusting relationship with doctors. He has done so with his GP and, in our view, with Dr Cahill. We appreciate that Mr H does not believe he will be able to undertake trauma related therapy. However, in our view, as we have highlighted, the evidence is that if he has a relationship with a doctor that he trusts then there may be an improvement in his condition and the impact it has on his life.

55. We therefore do not find that Mr H’s mental disorder is permanent because we are not satisfied that it will last indefinitely without change (to use the dictionary definition) or that he has is at a point where it can be said that he has reached maximum medical improvement. However, we do find that – at the date of the decision – it was expected continue for at least five

years and has caused functional limitation or restriction during that time. Mr H has been unable to work in paid employment, is unable to leave the house, takes medication regularly and is unable to fully participate in family life. He is reliant on his partner to support him, including enabling him to attend medical appointments.

20. On 21 June 2023 Judge Monk, the Chamber President, refused the Appellant's application for permission to appeal to the Upper Tribunal. She gave the following reasons:

> 4. In detailed grounds of appeal, the appellant only really seeks to challenge one aspect of the Tribunal's conclusion that the appellant's mental health disorder was permanent. That is around whether he could be said to have reached a state of maximum medical improvement if he had not exhausted certain possible therapy options.
>
> 5. The application for permission to appeal suggests that the Tribunal fell into error by an over reliance on a comment in the report from a Dr Cahill who stated that [the Appellant] had not received 'any formal psychological treatment'. As Dr Cahill had recommended EMDR or Trauma focussed CBT [64r of the bundle] and [the Appellant] accepted he had not undertaken any EMDR the Tribunal concluded he could not be said to have reached maximum medical improvement.
>
> 6. The appellant's [representative] rightly points out that, since Dr Cahill's report was written in 2017, the Tribunal had evidence from [the Appellant] that he had undergone some CBT which had ended in February 2020. It is suggested that the Tribunal have disregarded the CBT and have concluded, without adequate reasoning, that the CBT was not 'formal psychological treatment'. It is clear from the Tribunal's findings of facts [paragraphs 35 and 36] that they concluded that CBT could not be the formal psychological treatment envisaged as needed by Dr Cahill with good reason. Dr Cahill said in his report at paragraph 6 that [the Appellant] '*needs a lot of 'psychological preparation' before embarking on a structured form of therapy*'. [The Appellant's] evidence to the Tribunal was that he had had 12 sessions of CBT, mostly online, and they had not resulted in an improvement. His own witness statement from February 2022 described the sessions as not being much therapy but giving him 'very low-level coping tools' and he talked about having asked for a re-referral for further sessions.
>
> 7. On the basis of that evidence the Tribunal's conclusion that the appellant had not received any formal psychological treatment cannot be said to be an error of law or procedurally wrong. The Tribunal clearly considered carefully whether [the Appellant's] condition, as at 2020, satisfied a wide definition of permanence based on all the evidence before them. They explained clearly and cogently why they could not conclude that [the Appellant's] PTSD was permanent. That was because he had not exhausted recommended course of treatment by Dr Cahill of either more structured CBT or EMDR. They concluded therefore that he had not completed all recommended treatment and it could not be said that he had reached a steady state of maximum medical improvement. In the circumstances the panel's decision that he had not achieved maximum

> medical improvement nor would the condition last indefinitely without change could not be said to be irrational or perverse.
>
> 8. The test for permanence for mental health conditions is a complex one, as the panel acknowledged. They took a broad approach to the definition of permanence and it was open to them on the evidence before them to conclude as they did that the condition had not reached a state of permanence and determine that therefore Level 10 was the most appropriate descriptor. Their conclusions are reasoned and based on the evidence before them; I do not therefore consider that there is any arguable error of law.

21. The application for permission to appeal was then renewed before the Upper Tribunal.

**The Upper Tribunal's grant of permission to appeal**

22. On 23 August 2023 I gave the Appellant permission to appeal, making the following observations:

> I am persuaded on balance that the application for permission to appeal is arguable. I am not at this stage persuaded that the appeal is more likely than not to succeed, but that is not the appropriate test at the permission stage. I note that there is no challenge by the Appellant to the FTT's approach to the meaning of the term "permanent". The challenge, as I understand it, is more to the way in which the FTT applied that test to the evidence. There is, therefore, the risk that this appeal is really an attempt to re-argue the case on its factual merits but dressed up as an appeal on a point of law. If so, then the appeal will not succeed, not least for the reasons identified by Judge Monk CP when she refused permission to appeal on behalf of the FTT. In granting permission to appeal I also bear in mind that the determination of such PTSD cases poses several definitional problems for FTT panels in applying the tariff.

**The test for permanence**

23. Both counsel confirmed in the course of the Upper Tribunal proceedings that neither party sought to challenge the Tribunal's approach to the meaning of "permanent" for the purpose of Table 3. This agreed approach is relevant to understanding the context of the appeal. The Tribunal declined to adopt a prescriptive definition of the term "permanent" (as in "permanent mental disorder", in effect the gateway to an award at levels 4, 6 or 8, namely Items A1, 1 and 2) but expressed the following views.

24. First, the dictionary definition of "permanent" implied something that lasted indefinitely without change, whereas mental disorders "commonly change as people respond to treatment and medication". The dictionary definition, applied in isolation, was therefore too "simplistic" (paragraph 54).

25. Second, the definition of "permanent" in Article 5(7)(a) of the 2011 Order was not directly applicable, because that definition governed the meaning of "permanent functional limitation or restriction" in Table 3 and not the permanence or otherwise of the mental disorder itself (paragraph 50).

26. Third, however, the Tribunal considered that the Article 5(7)(a) definition provided a "useful guide", noting that "It stands to reason that if there has not been

appropriate clinical management of the mental disorder, maximum medical improvement has [not] been reached, and that common treatment options are available but have not been undertaken, then those are relevant factors in deciding if a mental disorder is permanent or not" (paragraph 54).

27. It followed that the Tribunal considered that when deciding whether a mental disorder was "permanent", two factors would be relevant. The first was whether there has been "appropriate clinical management". The second was whether "common treatment options are available but have not been undertaken".

**The Appellant's grounds of appeal**

28. Ms Skander, on behalf of the Appellant, submitted that the Tribunal's decision discloses four manifest errors of law.

29. The first is that the Tribunal allegedly made a material mistake as to fact. In particular, Ms Skander alighted on the distinction between Dr Cahill's report - which had recorded that the Appellant had "not received any formal psychological treatment *to date*" (emphasis added) – and the Tribunal's decision which, having found that the Appellant had "not received any formal psychological treatment" (without the qualifier "to date"), went on to find as a fact that he had undergone a course of CBT. Ms Skander submitted that the Tribunal had misunderstood Dr Cahill's evidence – in doing so, it had erroneously adopted evidence that was correct when it had been stated in 2017 as still being correct six years later in 2023.

30. The second is a submission, in the alternative, that if there was no mistake then there must have been a procedural irregularity. Ms Skander contended that if the Tribunal was using "formal psychological treatment" in a technical sense, for example, as excluding CBT, then as a matter of fairness the point should have been put to the Appellant for comment (who may have wished to adduce further evidence by way of reply). In this context counsel prayed in aid the principle in *Butterfield and Creasy v Secretary of State for Defence* [2002] EWHC 2247 (Admin).

31. The third is that the reasons for the Tribunal's decision are said to be inadequate, applying the well-known test adumbrated in *South Bucks District Council v Porter (No.2)* [2004] UKHL 33. Ms Skander's submission was that the question of the permanence of the Appellant's mental disorder was central to the appeal before the Tribunal, and as such the Appellant needed to understand how the panel had resolved the question of treatment. As it was, she argued, the Appellant and his advisers were at a loss to understand what was meant by the expression "formal psychological treatment" as deployed by the Tribunal.

32. The fourth avers that the Tribunal gave weight to immaterial matters. In particular, it is submitted that the Tribunal "rearranged the sentences and words of Dr Cahill's report, thereby changing the meaning of what was conveyed in his evidence and in doing so gave weight to matters that were immaterial" (skeleton argument at paragraph 38). As such, Ms Skander submitted the present case was effectively on all fours with the Upper Tribunal's decision in *LM v Secretary of State for Defence* (CAF/2760/2019), where it was found that the FTT had misunderstood the expert medical evidence.

**The Respondent's response**

33. Mr Hays, for the Secretary of State, argued that the appeal invited consideration of an immaterial question, namely whether certain therapy that the Appellant had undergone counted as "formal psychological treatment". His core submission was that the Tribunal's decision did not depend on the answer to that question at all. Rather, as he put it in his skeleton argument (at paragraph 16):

> The FTT's central reasoning had nothing to do with whether or not CBT is a "*formal*" type of psychological treatment. In paragraph 55 of its judgment, the FTT identified the treatment which remained for the Appellant to complete, as recommended by Dr Cahill, and that if the right doctor could be found there may be an improvement in the Appellant's condition. It was that consideration which led the FTT to conclude (Judgment, 56) that the condition was not permanent. None of this reasoning is affected by the question of whether or not CBT is properly to be defined as "*formal psychological treatment*".

34. The Respondent therefore argues that the Appellant's focus on the expression "formal psychological treatment" is entirely misplaced. It is immaterial because the Tribunal's conclusion was based on the psychological therapy that remained to be done, and did not depend on the adjective used to describe the therapy or other treatment that the Appellant had already completed.

**Analysis**

*Introduction*

35. The Appellant's skeleton argument asserted that "the grounds of appeal go to the FtT finding of fact that at the time of the hearing '[Mr H] has not received any formal psychological treatment' at §35" (paragraph 7). In her oral submissions Ms Skander sought to argue that the materiality of this finding of fact was in effect self-evident, contending that there were two ways of viewing its relevance. The first was by way of what she described as a broad analysis, namely that a finding of fact that there had been no formal psychological treatment was plainly material to the question of permanency. The second was what she termed as a more forensic approach. In particular, she submitted that one cannot safely answer the question as to what remans to be done and whether it was clinically indicated without safe findings of fact as to what treatment had already been undertaken.

36. However, I am satisfied that the Tribunal's finding that the Appellant had not received any formal psychological treatment was, as Mr Hays submitted, immaterial to the outcome of the appeal. The Tribunal applied the correct and agreed legal test for permanence, which took into account both the dictionary definition and the Article 5(7)(a) definition. In applying that more holistic test, the Tribunal was plainly aware both that Dr Cahill's report dated from 2017 and that its own task was to consider the Appellant's current state (namely, as at the date of the decision under appeal). At paragraphs 35 and 36 of its decision, the Tribunal had summarised the treatment that the Appellant had already received. There is, moreover, no suggestion that in doing so the Tribunal had overlooked any relevant treatment in its summary. In its conclusions, at paragraph 55, the Tribunal focussed on EMDR treatment as therapy which had been recommended as being of potential benefit to the Appellant but which had not as yet been accessed. Applying the appropriate legal test, the Tribunal accordingly found that

the Appellant's mental disorder was not permanent. In reaching that conclusion the Tribunal's reasons had properly considered the treatment that had already been undertaken. The label or adjective used to describe that previous treatment was in no way determinative of the appeal. Indeed, the Appellant might have had the treatment summarised at paragraphs 35 and 36, or might (hypothetically) have had no relevant treatment at all, but either way the findings at paragraphs 55 and 56 explained adequately, and independently, why the Tribunal concluded that his mental disorder was not "permanent" such that he might qualify for a higher level Table 3 descriptor in respect of his PTSD.

37. Furthermore, and in any event, the Appellant's four more specific grounds of appeal are not persuasive for the following reasons.

*Ground 1*

38. The first ground of appeal asserts that paragraph 35 of the Tribunal's reasons discloses a material mistake of fact. The Appellant's submission is that there is a flat contradiction between the Tribunal's findings respectively that the Appellant (a) "has not received any formal psychological treatment" (paragraph 35) and yet (b) "has completed 12 sessions of Cognitive Behavioural Therapy ['CBT']" (paragraph 36).

39. This contradiction is at best superficially apparent and is certainly not for real. I am entirely satisfied that the expression "formal psychological treatment" is not being used in any highly technical sense. This much is clear both from the ordinary meaning of the words and from the context of Dr Cahill's report.

40. So far as the ordinary meaning of the words is concerned, there has been no suggestion that the substantive phrase "psychological treatment" requires unpacking or further elucidation. Rather, it is the qualifying adjective "formal" which Ms Skander takes issue with. The dictionary definition of "formal" includes "officially sanctioned or recognised" and "done in accordance with convention". So, on the face of it at least, "formal psychological treatment" simply means no more and no less than e.g. "relevant approved psychological treatment".

41. As regards the context of Dr Cahill's report, and on a fair reading of the passage discussing the Appellant's treatment (see paragraph 11 above), it is tolerably clear that Dr Cahill was referring to PTSD-specific treatment. In the first two paragraphs of that passage the consultant summarised the Appellant's limited treatment to date (including assessments and pharmacological intervention). This stands in stark contrast to what Dr Cahill describes (in the third paragraph), namely that "The **treatment requirement** for PTSD is trauma-focussed therapy in the form of either **Trauma Focussed Cognitive Behavioural Therapy** or **Eye-Movement Desensitisation and Reprocessing** (EMDR)" (emphasis as in the original). Dr Cahill then referred to the preparatory psychological work that would be needed before engaging in such specialist treatment.

42. It is plain from its reasons that the Tribunal was adopting the same approach as Dr Cahill. As such it was drawing a distinction between non-formal types of psychological treatment (e.g. psychological preparation, help with coping strategies and other limited interventions) and formal treatment (being the trauma-focussed CBT or EMDR highlighted by Dr Cahill. Given that broad categorisation, and given the evidence the FTT received as to the low-level nature of the CBT sessions attended by the Appellant, it is both reasonable and

entirely understandable that the Tribunal did not regard the CBT sessions that the Appellant completed as meriting the description of being "formal psychological treatment". In a nutshell, it was not trauma-focussed therapy. At best it could be described as a form of psychological preparation for such advanced therapy.

43. I should add that there was some debate at the Upper Tribunal oral hearing as to whether it was appropriate to have regard to the NICE guidelines on treatment for PTSD. I simply observe that in the event I have not needed to consider those guidelines. I am satisfied that the Tribunal's findings were open to the panel on the basis of Dr Cahill's report and the other evidence it received.

*Ground 2*

44. This second ground of appeal posits that the Tribunal's failure to invite submissions from the Appellant on whether the CBT sessions he had undertaken amounted to "formal psychological treatment" constituted procedural unfairness. However, this assumes that the phrase in question carries some technical meaning that needed to be explored. For the reasons discussed above, that is a false premise. In addition, the appropriate adjective to be attributed to the CBT sessions was immaterial, given that the Tribunal's primary focus had to be on what type(s) of future treatment remained relevant to assessing the question of permanence.

*Ground 3*

45. The reasons challenge fares no better. On one reading it must surely stand or fall with the first two grounds of appeal. Insofar as it is a freestanding ground of appeal, the relevant standard for adequacy of reasons is not in dispute and was helpfully described by Upper Tribunal Judge Poole QC (as she then was) in *DS v SSWP (ESA)* [2019] UKUT 347 (AAC). There, she said that the question is whether the first instance tribunal "deal with the substantial questions in an intelligible way, leaving the informed reader in no real and substantial doubt as to the reasons for the decision and what material considerations were taken into account" (at paragraph [9]). On any fair reading the Tribunal's reasons in this case comfortably meet that threshold. In short, and in summary, the Tribunal found that the previous treatment undergone by the Appellant was insufficient to show permanence. Instead, the Tribunal concluded there were further treatment options reasonably open to the Appellant before it could be said that he had achieved a state of "maximum medical improvement" as envisaged by the test for permanence.

*Ground 4*

46. The final ground of appeal concerns the way in which parts of Dr Cahill's report were taken in a different order by the Tribunal and thereby (so it is said) changing its meaning. I reject this submission. The key finding in Dr Cahill's report was that the Appellant's prognosis was "poor". The Tribunal was well aware of that assessment and indeed quoted directly from it. As such, the present case is far removed from the circumstances obtaining in *LM v Secretary of State for Defence*. That was a case in which the first instance tribunal misunderstood the expert medical evidence whereas in the present case the Tribunal both understood and reiterated the central point being made by the expert witness. It is plain from the Tribunal's judgment that it was well aware of the difficulties faced

by the Appellant. However, the fact that the prognosis was poor (both when Dr Cahill was reporting in 2017 and indeed when the Tribunal was sitting in 2023) did not necessarily mean that the Appellant's condition was "permanent" as that term was properly understood.

## Conclusion

47. I therefore conclude that the decision of the First-tier Tribunal does not involve any material error of law. I therefore dismiss the appeal (Tribunals, Courts and Enforcement Act 2007, section 11).

**Nicholas Wikeley**
**Judge of the Upper Tribunal**

Authorised for issue on 1 July 2024