PO-21077

Ombudsman's Determination

Applicant	Mr D
Scheme	Armed Forces Pension Scheme 1975 (**AFPS 75**)
Respondent	Veterans UK

Outcome

1. I do not uphold Mr D's complaint and no further action is required by Veterans UK.

2. My reasons for reaching this decision are explained in more detail below.

Complaint summary

3. Mr D disagrees with the decision not to revise his AFPS 75 attributable benefit.

Background information, including submissions from the parties

Army Pension Warrant 1977

4. The Army Pension Warrant 1977 (as amended) applies to individuals whose service ended before 6 April 2005.

5. Articles 149A to 151B relate to Attributable Invaliding Pensions. Under Article 149A, references to "degree of disability" mean:

> "the assessment of the degree of disablement made by the Veterans Agency … in respect of any injuries or conditions which directly resulted in the individual being invalided from service."

6. "Veterans Agency" is defined as: "that part of the Ministry of Defence which discharges the functions of the Secretary of State for Defence concerning war pensions …".

7. The amount of pension awarded is the greater of the minimum rate of Service Attributable Pension (**SAP**) according to rank and percentage of disability or a non-attributable Service Invaliding Pension (**SIP**).

8. Article 150 provides:

> "This Article applies where the soldier's disability arises on or before 31st March 2004. Unless the Defence Council decide otherwise, a soldier who is invalided from the Army as a result of a disability which is accepted by the Veterans Agency as attributable to or aggravated by his service and whose degree of disability is assessed at 20 per cent or more may be granted a Service Attributable Pension. This shall be either the award for which he is entitled under Article 149 [non-attributable Invaliding Pension] or the minimum rate of Service Attributable Pension … according to his rank and percentage of disability, whichever is the greater. Service Attributable Pension may be awarded irrespective of length of service but is subject to adjustment or cessation ... In cases where the Defence Council so decide, the grant and the amount of Service Attributable Pension shall be at their discretion. This subparagraph applies regardless of whether the soldier has opted out of the Armed Forces Pension Scheme."

9. Article 150C provides that, where an individual is granted a SAP, the award can be adjusted up or down within the first 12 months following invaliding. The pension will not be less than the rate of SIP to which he might otherwise have been eligible. After the first 12 months following invaliding, the pension can be adjusted if the individual's degree of disability rises or if it falls below 20%. The new rate of pension is paid from the day following the adjustment to the degree of disability. Where the degree of disability falls below 20%, the SAP will cease. However, the individual may still receive a SIP, if eligible.

Background

10. Mr D was medically discharged from the Army on 9 January 2005. The Principal Invaliding Condition (**PIC**) was low back pain. The Veterans Agency accepted Mr D's PIC as attributable to his Army service. This was initially on the basis of a degree of disability of 6-14%. This was later revised to 40%. The AFPS 75 provides for payment of either a SAP or a SIP; whichever is the greater. In Mr D's case, the SIP is greater. If Mr D's degree of disability were to reach 60%, the SAP would be the greater.

11. Mr D was also awarded a War Pension under the War Pensions Scheme (**WPS**). His WPS entitlement has been reassessed on a number of occasions. In 2010, the WPS assessed Mr D as 60% disabled. The percentage attributed to Mr D's back injury was 40%. In 2013, Mr D's assessment was revised to 80%, backdated to 2011. However, the percentage attributed to his back injury and low back pain remained at 40%.

12. Mr D's AFPS attributable benefit has also been reviewed on a number of occasions since 2005. This investigation concerns the latest review which was undertaken in 2017.

13. In 2011, Mr D's WPS award was reviewed by an appeal tribunal. As a result of the tribunal's decision in his case, Mr D's degree of disability was revised to 80%. The WPS is also administered by Veterans UK but by a separate branch. The WPS administrators notified the Pensions Award Branch that Mr D's entitlement to a war pension had been reviewed. It did so by way of a form WPA0405. This showed that Mr D's "Combined Assessment" was now 80%. The "Separate Assessment" for Mr D's back injury (1999), back injury (2000) and low back pain syndrome was 40%.

14. Mr D requested a review of his attributable pension following the revised assessment of his degree of disablement by the WPS. Veterans UK wrote to Mr D, on 7 August 2017, explaining that, although the WPS had now assessed his overall degree of disablement to be 80%, the degree of disablement from his low back pain remained at 40%. Veterans UK said the other conditions which had contributed to the 80% assessment had not been listed as disabilities leading to his medical board. Veterans UK said they were not related to Mr D's PIC and could not be considered in relation to his claim for a SAP. It went on to say that Mr D had been awarded a SIP of £3,687.19 in 2005 and this was greater than a SAP for 40% disablement.

15. Mr D submitted an appeal. He said an MRI scan had shown a deterioration in his spinal injury and his WPS degree of disablement had been increased as a result. Mr D said that a number of other conditions were a result of nerve damage relating to his spinal injury. He also provided contact details for his treating physicians.

16. On 22 September 2017, Veterans UK wrote to Mr D's doctors asking for copies of his hospital notes. On receipt of the notes, Mr D's case was referred to one of Veterans UK's medical advisers (**MA**). The MA was asked to advise whether Mr D's other conditions should be considered part and parcel of his PIC.

17. The MA responded:

> "… It has already been agreed that low back pain syndrome, back injury 1999 and 2000 are part and parcel of the PIC.
>
> Anal pain has already been considered unlikely to be connected in any way to the PIC. The start of the pain followed his spinal injury and [Mr D] is of the opinion that anal spasm and other symptoms related to this have been caused by nerve damage at the time of his back injury. There are results of a lower GI anorectal manometry study in 2015 … Unfortunately, there is no interpretation of these results and I have no training in how to interpret them. I am therefore unable to comment on whether there is any evidence of nerve damage affecting anal tone.
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> MRI scan of lumbar spine on 9/12/10 showed degenerative disc disease at L4/5 and L5/S1 with a left para-central disc extrusion of the L5/S1 disc causing displacement of the S1 nerve root. However, there was no nerve root compression. A repeat MRI scan on 23/3/13 showed no significant changes.

There is no MRI scan evidence of nerve injury and on the balance of probabilities the anal symptoms would not be part and parcel of the PIC.

Chronic idiopathic urticarial and angioedema is by its very terminology of unknown cause … [Mr D] had two allergic reactions in 2011. It is not clear if he has had any allergic problems since that date. On the balance of probabilities the chronic idiopathic urticarial and angioedema would not be associated with his back injury.

Injury to the neck and left shoulder predated the back injury in 1999. The Medical Board of 23/9/04 makes no mention of neck or shoulder injury … [Mr D] … refers to winging of the scapular which occurred following accidents in 1995 and 1999. The most common cause of scapular winging is serratus anterior paralysis. This is typically caused by damage to the long thoracic nerve … There are numerous ways in which the long thoracic nerve can sustain trauma-induced injury. These include … Even if this injury were to be confirmed it is not part of the PIC but a separate injury which occurred at a different time from the event which precipitated the PIC.

The F Med 19 records that [Mr D] had low mood and was tearful in most consultations, with poor sleep and appetite. He had refused antidepressants. The document does not state whether the low mood was as a consequence of his low back pain. The GP notes confirm that low mood has been a persistent problem up to the current time. An assessment from a Community Psychiatric Nurse in March 2010 revealed a history of childhood abuse and poor self-esteem.

A letter from the Pain Management Clinic on 25/6/13 recorded that "[Mr D] seemed to be very low in mood and did break down into tears several times … He ascribed his low mood to the fact that he was not sleeping very well but did admit that the loss of a few good friends recently, has also contributed."

On 8/8/17 [Mr D] was seen at the Veterans' Mental Health Transition, Intervention and Liaison Service. The letter states that he was diagnosed with PTSD in 2005 and implies that the riding accident causing the back injury contributed to this disorder. He also had a CT scan arranged because of headaches and this has shown reduced density areas in the left thalamus and basal ganglia probably due to previous trauma …

Back injury, chronic pain and loss of status following discharge might all contribute to the development of low mood. "Depressive Disorder" may be consequential to the low back pain. However, a consequential condition can only be considered if WPS accepted the condition from the day after discharge on 9/1/05. The date accepted by WPS was 26/8/10. Therefore depressive disorder cannot be considered as a consequential condition.

> In reaching these decisions I have referred to appropriate Synopses of Causation, an internet search on Chronic Urticaria and the guidance notes on Attributable Awards under the AFCS."

18. The MA was also asked to consider whether Mr D's right inguinal hernia could be considered part and parcel of his PIC. The MA noted a referral for a right inguinal hernia in 2012. He said it had not been stated when the hernia had developed and Mr D had not wanted anything done. He also noted a reference to the hernia in Mr D's GP notes in 2012. The MA said these appeared to be the only references to a hernia in Mr D's medical notes. He then went on to list a number of common risk factors for the development of a hernia. The MA concluded:

> "I would advise that on the balance of probabilities the development of an inguinal hernia would not be associated with the PIC of low back pain syndrome. I would advise that the hernia would not, on the balance of probabilities, have been associated with the back injury several years earlier."

19. Veterans UK determined that Mr D's degree of disablement should remain at 40%.

20. Mr D appealed this decision on the following grounds:-

- He had been assessed as 80% disabled following a judgment in a court of law. The judge had said he could not be awarded a higher percentage because he was not in a wheelchair.
- Veterans UK had quoted an MRI scan from 2013 when his 80% award had been based on an MRI scan from 2010. The 2013 scan showed that his condition had not improved.
- The 2011 tribunal judge had found that his spinal injury had got significantly worse and awarded him the maximum on this basis alone. Yet Veterans UK had not referred to this finding.
- Every medical professional dealing with his back condition had referred to the impact it had on his mental health.
- He had been receiving facet joint injections but had been advised that a better option would be to have the nerve endings burnt. Yet Veterans UK had said that there were no signs of nerve damage and his anal spasming was not a result of this. His anal pain had started since his spinal injury and he had complained of this prior to his medical discharge.
- He asked to be told the qualifications held by the decision-maker and if they were a medical professional.
- He had injured his neck/shoulder in Bosnia in 1997.
- His pain management doctor would not sign him fit for work because of his spinal injury but Veterans UK had stated that there was no deterioration. He

had gone from paid employment to receiving unemployment benefits. This was on the grounds of his spinal injury.

- He had not been properly informed about the attributable benefit scheme or his appeal rights.
- Veterans UK used abbreviations to confuse him in the hope that he would drop his claim.
- He had first been diagnosed with low mood and depression in 2001, following an attack in which his jaw had been broken. He had been attacked because he was in uniform. He had been told not to speak to anyone about the attack and no help was provided for him.

21. Mr D's case was referred to another MA. The MA referred to the manometry results and said this was a relatively new technique and normative values were not well established. He said the dysfunction demonstrated probably represented a muscular incoordination, which would normally be treated by biofeedback training. He noted that Mr D had declined this approach and had not attended a follow-up[1]. The MA noted that Mr D had referred to a WPS Tribunal decision and asked to see the WPS files and the Tribunal decisions. Summaries of the reports referred to are provided in an appendix.

22. On receipt of the medical records, Mr D's case was reviewed. The MA expressed the view that Mr D had not understood how the AFPS attributable benefits worked and their relationship with the WPS. The MA said:

> "In relation to the depressive illness, as always with mental health problems, the disorder is multifactorial and in fact the notes indicate that [Mr D] first presented and was diagnosed with reactive depression in 1994 i.e. pre-enlistment. Both his Bosnia service and physical problems have also contributed but on the balance of probabilities low back pain is not the only or necessarily the main cause and the disorder was accepted under the WPS, with its low standard of proof and need to accept disorders where ANY potential cause is a service cause. It was accepted as aggravated by service and assessed and remains so, at 1-5%. As referenced … regardless of all that the disorder cannot be accepted for occ pensions as war pensions entitlement was not established until 2010 i.e. five years post service termination.
>
> Much of [Mr D's] appeal focusses on the extent of disablement attached to various accepted conditions and his allegation that the AFPS decision-makers are ignoring this. In any case if his disablement is worsening that should first be reflected in the war pensions assessment. Scrutiny of the notes confirms that he has not recently claimed deterioration for any of his accepted war pensions conditions. He has frequently defaulted from hospital appointments

[1] Letter from Mr Skinner, 28 January 2015

and withdrawn two war pensions appeals. For AFAB the key issue is entitlement governed by the scheme rules. Assessment follows directly from War pensions assessments."

23. Mr D's appeal was declined.

Mr D's position

24. Mr D submits:-

- In 2017, he became aware that Veterans UK had his war pension recorded at 60% when it had been revised to 80% with effect from 2011.
- He was told that Veterans UK would require evidence of his primary injuries becoming worse. In 2011, a tribunal had determined that his primary injury had worsened and this was evidenced by an MRI scan in 2010. It was on this basis that his war pension was increased to 80%.
- Veterans UK has refused to accept that his primary injuries have become worse despite this being proved in a court of law. It refuses to increase his pension.
- In 2012, he was advised to give up work because of his injuries. This was after a medical carried out by the WPS. He lost a salary of £25,000 per annum and received unemployment benefit of £6,600 per annum. He does not qualify for state benefits because of his wife's salary.
- The medical professionals treating him refuse to sign him off as fit for work; even when he has asked them to on the grounds that it would be therapeutic for him.
- He has been diagnosed with Post Traumatic Stress Disorder (**PTSD**) as a result of his injuries and time in the Army. He is currently being assessed by a new pain management team. They are of the view that his anal spasming and related issues may be due to a problem with his hips caused by his initial injury.

Adjudicator's Opinion

25. Mr D's complaint was considered by one of our Adjudicators who concluded that no further action was required by Veterans UK. The Adjudicator's findings are summarised below:-

- To qualify for a Service Attributable Pension (SAP), Mr D had to have been invalided from the Army as a result of a disability which was accepted by the Veterans Agency as attributable to or aggravated by his service. He also had to have a degree of disability which had been assessed at 20% or more (Article 150).

- However, Article 150 also provided that any SAP should be compared to the Service Invaliding Pension (SIP) which Mr D would otherwise be entitled to. He would receive the higher of the two. As it stood, Mr D was being paid a SIP because the SAP was lower.

- Mr D had asked for his benefits to be reviewed because he had been assessed as 80% disabled for the purposes of the WPS. The WPS had accepted a number of conditions for the purposes of Mr D's war pension. These were: back injury (1999), back injury (2000), low back pain syndrome, anal pain, injury to neck and left shoulder (1995 and 1999), right inguinal hernia, chronic idiopathic urticaria and angioedema, and depressive disorder.

- Mr D had been assessed as 80% disabled on the basis of the combined effect of these conditions. However, the level of accepted disability assigned to his back injuries and low back pain was 40%.

- For the purposes of Article 150, degree of disablement was defined as:

  "the assessment of the degree of disablement made by the Veterans Agency … in respect of any injuries or conditions which directly resulted in the individual being invalided from service."

- "Veterans Agency" was defined as:

  "that part of the Ministry of Defence which discharges the functions of the Secretary of State for Defence concerning war pensions …"

- Thus, the degree of disablement by which Veterans UK had to assess Mr D's AFPS attributable benefit was that which the WPS had assigned to his Principal Invaliding Condition (PIC). This was the condition which directly resulted in Mr D being invalided from service. The Medical Board Record (F Med 23) stated that this was low back pain. Since the WPS had assigned a degree of disablement of 40% to Mr D's low back pain, this was the level which Veterans UK had to apply to his attributable benefit.

- Mr D had referred to an MRI scan from 2010 which he argued showed that his PIC had worsened. He argued that it was for this reason that the tribunal determined that his war pension should be increased. Mr D's combined degree of disablement under the WPS was increased to 80% but the percentage assigned to his low back pain remained 40%. Mr D was concerned that Veterans UK's MA had referred to a later MRI scan in 2013 and said there had been no significant changes. There was a later scan which showed that there had been little change in Mr D's results since the 2010 scan. The Adjudicator said her understanding was that this was what the MA was referring to when he said there had been no significant change. In other words, he meant no significant change since the 2010 scan.

- As a result of Mr D's request for a review, Veterans UK asked its MAs to consider whether any of his other reported conditions should be considered "part and parcel" of his low back pain. If they were part and parcel of Mr D's PIC, it would be possible to include the degree of disablement assigned by the WPS to these other conditions. For any injuries or conditions to count for the purposes of Article 150, they had to have directly resulted in Mr D being invalided from service.

- Mr D had argued for his anal pain and related symptoms to be considered part and parcel of his low back pain. He had argued that they were the result of nerve damage sustained at the time of his back injury in 2000. Mr D's anal pain was first included in the conditions accepted by the WPS with effect from September 2009. However, this was not sufficient for Veterans UK to include it in its assessment of Mr D's SAP. He would have to show that it was part and parcel of the low back pain for which he was invalided; that is, the injury or condition which directly led to his being invalided.

- The advice Veterans UK received from its MAs was that it was unlikely that Mr D's anal symptoms were connected with his back injury. The Adjudicator noted, however, that the first MA had advised Veterans UK that he was not qualified to comment on the results of a manometry study. This did not appear to have been picked up by Veterans UK; inasmuch as it did not seek any further clarification at that time. The Adjudicator thought it would have been prudent for it to have done so. The second MA did comment on the manometry results and advised that the dysfunction demonstrated probably represented a muscular incoordination.

- It was clear, from the extensive medical notes provided in connection with his case, that Mr D had been under investigation for his anal symptoms for some time. However, none of the available evidence appeared to indicate that the symptoms were related to his back injury in 2000. On that basis, the advice Veterans UK received from its MAs was not inconsistent with the medical evidence available in 2017.

- The Adjudicator noted that Mr D was now under the care of a new pain management team and it had been suggested that his symptoms were related to a problem with his hips. The Adjudicator said she understood it was thought that this could be the result of his 2000 back injury. This was, however, a recent development in Mr D's case and was not something which Veterans UK could have taken into account in making its 2017 decision. If there were further developments in the investigation of Mr D's anal symptoms, it was something which he could ask Veterans UK to review in the future with the benefit of additional evidence.

- Mr D's depressive disorder was accepted by the WPS with effect from 2010. As with his anal symptoms, Mr D would have to establish that his depressive

disorder was part and parcel of his low back pain for the reasons given above. The advice Veterans UK received was that the disorder was multifactorial. Its MA also noted that Mr D had been diagnosed with reactive depression prior to enlisting. A number of possible causes for Mr D's low mood had been referred to in the available medical records. The MA's advice was not inconsistent with this.

- In summary, the key issue for Mr D was that the injury or condition for which he qualified for a SAP was the one which directly resulted in him being invalided from service. This was the Principal Invaliding Condition recorded by the Medical Board. In Mr D's case, this was low back pain. Veterans UK had to then apply the degree of disablement assigned to this condition by the WPS in determining Mr D's SAP. It was then necessary for Veterans UK to compare the SAP with the SIP Mr D would otherwise receive and pay him the greater of the two. While the WPS assigned a degree of disablement of 40% to Mr D's low back pain, his SIP was the higher amount and he would continue to receive this.

26. Mr D did not accept the Adjudicator's Opinion and the complaint was passed to me to consider. Mr D provided his further comments which do not change the outcome. I agree with the Adjudicator's Opinion and I will therefore only respond to the key points made by Mr D for completeness.

Mr D's further submissions

27. Mr D submits:-

- He has now been diagnosed with Post Traumatic Stress Disorder (PTSD), which his GP attributes to his Army service. He was never offered counselling whilst in the Army or after discharge. He has been receiving counselling for 18 months and has been told he will need a further one to two years, which his GP is organising.

- He may have missed one to three appointments over a 10 year period. He believes this will have been as the result of illness.

- Every medical professional has related his low mood to his spinal injury. However, because he has spoken of having troubles in his childhood, it is easier to blame his low mood on this rather than the injuries and violence he experienced in the Army. He knows many people from his own regiment who are experiencing mental health difficulties related to their service.

- After discharge, he was under the care of a pain management specialist, Professor Rice, who advised him to move closer to family for support. Professor Rice explained that his injuries would deteriorate. This was raised at the 2011 tribunal but has not been considered.

- The tribunal decision, in 2011, was solely the result of a deterioration in his spinal injury. The RBL were present at the tribunal and will confirm this. At the time, Veterans UK withheld evidence in the form of the MRI scan which showed his condition had deteriorated.
- The tribunal was in a court of law with a presiding judge. The judge and the panel of medical experts awarded him 80%. His pension should have been increased in line with this award but it was not.
- The tribunal's decision was based on the MRI scan in 2010; not the 2013 scan.
- His mental health condition was never low mood; it has been diagnosed as PTSD.

Ombudsman's decision

28. Mr D receives his SIP under the provisions of the Army Pensions Warrant 1977. Any entitlement he might have to a SAP would also arise under these provisions. In particular, articles 149A to 151B must be applied. The WPS is an entirely separate scheme.

29. However, the degree of disability which must be used to assess Mr D's eligibility for a SAP is that which has been assigned to him by the WPS "in respect of any injuries or conditions which **directly** resulted in [him] being invalided from service" (emphasis added). In other words, the degree of disability which has been assigned to his Principal Invaliding Condition or PIC. In Mr D's case, this is his back condition.

30. Mr D has pointed out that an appeal tribunal determined that his degree of disability should be 80% for the purposes of the WPS. He expects his SAP to be calculated on the basis of the same degree of disability.

31. However, the 80% degree of disability is a "Combined Assessment". Veterans UK was notified of the amendment to Mr D's degree of disability following the tribunal's decision. It was sent a form WPA0405 which showed the Combined Assessment of 80%, but it also showed that the Separate Assessment for Mr D's back condition was 40%.

32. Mr D argues that the tribunal reached its decision on the basis of there having been a deterioration in his back condition. The tribunal's remit was to consider Mr D's appeal in connection with his WPS award. Veterans UK (in its role as administrator of the AFPS 75) was not a party to the appeal. I acknowledge that it is confusing that Veterans UK has both roles. However, the tribunal's decision was binding on Veterans UK only in its role as the administrator of the WPS.

33. In its role as administrator of the AFPS 75, Veterans UK must apply the degree of disability which the WPS has assigned to Mr D's back condition. In view of this, I do not find that it was maladministration on the part of Veterans UK to accept what it was

told on form WPA0405. It was not required to apply the appeal tribunal's decision directly to its assessment of Mr D's eligibility for a SAP.

34. If Mr D is of the opinion that the WPS has misinterpreted the appeal tribunal's findings, he should take this up with the WPS. In the absence of a revised form WPA0405, Veterans UK should continue to apply the 40% degree of disability in respect of his back condition.

35. The alternative route by which a degree of disability of more than 40% might apply would be if Mr D were able to establish that some or all of the other conditions which the WPS has accepted are "part and parcel" of his PIC. This was considered by Veterans UK.

36. Veterans UK took advice from its medical advisers when considering whether Mr D's other conditions should be considered part and parcel of his back condition. I find this to be the appropriate approach.

37. It is clear that Veterans UK and its medical advisers took steps to obtain adequate medical evidence to inform its decision. Mr D's hospital notes were requested and there is a considerable file of evidence relating to his case. The reports from Veterans UK's medical advisers indicate that they considered all of Mr D's conditions. The reports also show that the medical advisers understood what they were being asked to advise on. The advice provided by Veterans UK's medical advisers was not inconsistent with the views expressed by Mr D's treating physicians.

38. I note Mr D's particular concern that there were references to an MRI scan undertaken in 2013. He is at pains to point out that the WPS appeal tribunal reached its decision on the basis of a scan undertaken in 2010. Veterans UK's medical adviser referred to both the 2010 scan and the 2013 scan. He commented that the 2013 "showed no significant changes". I do not find this to be evidence that Veterans UK took its decision on the basis of the 2013 scan alone and ignored the 2010 scan. The medical adviser was merely commenting that there had been no significant change since the 2010 scan. This was confirmed by Dr Duttagupta in June 2013 (see appendix).

39. I do not find, therefore, that there were any cogent reasons why Veterans UK should not have accepted the advice it received from its medical advisers. It was not maladministration for it to base its decision on that advice.

40. Therefore, I do not uphold Mr D's complaint.

Anthony Arter

Pensions Ombudsman
19 March 2019

Appendix

Medical evidence

41. A copy of the medical records consulted in Mr D's case has been provided. These are extensive and it would not be practical to summarise them all here. The following are summaries of or extracts from reports specifically referred to by the parties.

MRI scan dated 9 December 2010

> "Normal segmentation and alignment. Diminished disc space volume at L4/5 and L5/S1. There is a concentric disc bulge at L4/5 with no overt focal protrusion or extrusion. At L5/S1 there is a concentric bulge but in addition, there is a left para-central disc extrusion with left S1 displacement. The left S1 root does not appear to be compressed against the facet, but the position of the extrusion would certainly cause left S1 irritation.
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> Comment:
>
> Degenerative disc disease L4/5 and L5/S1 with a left para-central disc extrusion L5/S1 disc, with left S1 displacement."

MRI Scan dated 23 March 2013

> "Comparison with the previous study dating 09.12.10 was done which showed the following:-
>
> The L4/5 disc bulge is still detected with no protrusion.
> The L5/S1 left para-central disc protrusion is still the same.
> Nil significant interval changes.
> There is no significant nerve root compression.
> Normal appearance of L3/4 intervertebral discs.
> Modic type II change is noted at L4/5 level.
> Unremarkable para-spinal soft tissues of muscle planes.
>
> Conclusion:
>
> L4/5 diffuse disc bulge.
> L5/S1 left para-central disc protrusion.
> Degenerative changes of the lumbar spine."

Ms Cooper, community psychiatric nurse, 11 March 2010

42. Ms Cooper wrote to Mr D's GP explaining that he had been discharged from her service. She explained that Mr D had been assessed on 18 February 2010 and seen on two occasions. She said he had subsequently cancelled appointments with her team and had failed to respond to their requests that he contact them.

43. Ms Cooper said Mr D found it difficult to focus on the future and appeared to have been "catapulted into crisis" by a suggestion from the British Legion that he apply to

have his Army pension reviewed. She said Mr D felt he could not face confronting memories of past injuries and the way he perceived he had been treated by the Army. She went on to say that, on a subsequent visit, Mr D had made links between his early life and family, and recent stressors. Ms Cooper said Mr D's time in the Army had provided him with a strong identity which had allowed him to submerge earlier feelings of worthlessness. She said these had been reactivated by Mr D's current situation.

Dr Duttagupta, consultant in pain management, 25 June 2013

44. In a letter to Mr D's GP, Dr Duttagupta said:

> "… the recent scan done on 23 March 2013, has not shown any change in the L4/5 disc bulge and the L5/S1 left paracentral disc bulge, which has [*sic*] been seen in the previous scan. There was no neurological impairment.
>
> … [Mr D] seemed to be very low in mood and did breakdown into tears several times in my clinic. He ascribed his low mood to the fact that he was not sleeping very well, but did admit that the loss of a few good friends recently, has also contributed …"

Mr Skinner, consultant surgeon, 28 January 2015

45. In a letter to Mr D's GP, Mr Skinner said:

> "… I note you have had biofeedback in the past and this has not particularly helped your symptoms. Your pressures show that these are low for both squeeze and resting pressures and as such, if you have not been helped with the usual treatments such as reducing your fibre and …, you will be assessed in the Pelvic Floor Clinic to see if any non-invasive treatments would be helpful …"

46. Mr D did not attend his appointment at the clinic in April 2015.