Ombudsman's Determination

Applicant	Mr N
Scheme	Armed Forces Pension Scheme 2015 (**the AFPS 15**)
Respondent	Veterans UK

Outcome

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

Complaint summary

2. Mr N's complaint concerns Veterans UK's decision not to award him benefits in the Naval and Marines Attributable Benefits Scheme ("the benefits Scheme").

Background information, including submissions from the parties

3. The provisions of the Naval and Marines Attributable Benefits Scheme are set out in Schedule 2 of the Naval and Marine Pensions (Armed Forces Pension Scheme 1975 and Attributable Benefits Scheme) (Amendment) Order 2010 (as amended) (**the Naval Pensions Order**).

> Rule B.1: Entitlement to annual compensation payment and attributable lump sum, of the Naval Pensions Order states:
>
> "Subject to paragraph (2), a person is entitled to an annual compensation payment and a lump sum as compensation for an injury in accordance with these provisions if—
>
> (a) the person was discharged from the Royal Navy or Royal Marines on medical grounds;
>
> (b) the injury was caused by service in the Royal Navy or Royal Marines in the period beginning with 31st March 1973 and ending with 5th April 2005;
>
> (c) an award has been made to the person under the [Naval, Military and Air Forces Etc. (Disablement and Death)] Service Pensions Order 2006 "the Service Pensions Order"], in respect of disablement which is due to

a relevant disabling condition, that takes effect from the day following the date of the person's discharge;

(d) the person's degree of disablement due to a relevant disabling condition is not less than 20%; and

(e) the service in which the injury was sustained is not excluded service".

4. Rule B.2: Relevant disabling condition, of the Naval Pensions Order, states:

"(1) An injury is a relevant disabling condition if—

(a) it is the principal invaliding condition;

(b) in the case of a discharge from the Royal Navy or Royal Marines in the period 1st January 2000 and ending on 5th April 2005 it would alone have resulted in the person being unfit for service if another injury had not done so; or

(c) in the case of a discharge from the Royal Navy or Royal Marines in the period 1st January 2000 and ending on 5th April 2005 the injury was a result of another injury within sub-paragraph (a) or (b) and which was present at the date of discharge".

(2) In this part "principal invaliding condition [**PIC**]" means the injury identified as the main reason for the person's permanent unfitness for service in the Royal Navy or Royal Marines which is stated on the person's medical discharge Certificate".

5. Mr N joined the Armed Forces in May 2002 and is a member of the AFPS 15. He is a former Royal Navy personnel and worked as a traffic warden for the Waterfront Manning Office.

6. In September 2015, Mr N was transferred to Scotland while awaiting a laparoscopy.

7. In October 2017, Mr N was medically discharged from the Royal Navy under the AFPS 15. His PIC was recorded as "Abdominal Pain".

8. On 23 January 2018, the Department of Gastroenterology and Hepatology wrote to Mr N's GP Surgery (**the GP**). The letter explained that Mr N was still complaining of intermittent abdominal pain "mainly in the right iliac fossa"; he should be referred to the local surgeons for further advice.

9. On 3 May 2018, a local Consultant General Surgeon (**the Consultant General Surgeon**) wrote to the GP (**the May 2018 Letter**) and advised:

"I reviewed this gentleman on the 2 May [2018] following his recent laparoscopy. This showed no evidence of adhesions within the abdominal cavity and I do not think that this is responsible for his abdominal pain. He does have quite [localised] tenderness in the right iliac fossa and I have arranged for an ultrasound scan to be

done of this area to identify any abnormalities. I will see Mr [N]…again on 6th June with the result of the scan".

10. The results of an examination carried out on 18 May 2018, referred to Mr N having long standing issues with abdominal pain, which were thought to be due to adhesions but the results of the laparoscopy were normal. The report referred to possible localised tenderness in the right groin. The report concluded that there was no evidence of a significant right "inguinal hernia."

11. On 23 May 2018, the Consultant General Surgeon wrote to the GP regarding the laparoscopy he performed on Mr N on 25 April 2018. He advised that on "inspecting the bowel cavity there was no sign of any adhesions of the small bowel. The bowel was "peristalsing freely and there were no abnormal constriction points". He said that he would refer Mr N to the Clinic to discuss further.

12. In a subsequent letter to the GP, dated 7 June 2018, the Consultant General Surgeon referred to the results of Mr N's recent ultrasound. He said that it showed no evidence of a hernia or other abnormality in the right iliac fossa. He had reassured Mr N that there was "nothing serious going on". He advised that all the symptoms Mr N had described, could point to "something in the muscles" rather than in the abdomen itself. Mr N may require a referral to a specialist to determine whether the problem was in the muscular skeletal system.

13. On 30 August 2018, Mr N was notified that he would automatically be considered for a Discretionary Award Review (**DAR**) because he had been awarded a pension under the War Pensions Scheme "WPS" "for 20%" in respect of his membership of the AFPS 15. Veterans UK advised that his invaliding condition had been accepted as attributable to service under the WPS or Armed Forces Compensation Scheme.

14. On 5 October 2018, Mr N's case was referred to a medical adviser (**the MA**) to determine his eligibility for an award (**AFAB benefits**) in respect of the benefits Scheme. The MA was asked to review Mr N's medical record and provide an opinion on whether his PIC was attributable or aggravated by service in the Armed Forces.

15. The medical evidence is summarised below:-

- An "MRI" scan dated 4 October 2017 (**the October MRI**).
- The letter from the Department of Gastroenterology and Hepatology to the GP dated 23 January 2018.
- A report from the GP dated 25 October 2018 (**the October Report**), in which the GP explained that Mr N was experiencing abdominal pain and was awaiting surgery.
- An "official" medical report (**the Official Report**), which was not dated.

16. The Official Report stated:

> "Summary of Boarding Condition(s):
>
> "Longstanding right iliac fossa pain resulted in laparoscopy in 2010 which revealed a Meckel's diverticulum and adhesions of the caecum. He has recurring gastrointestinal symptoms since that time with vomiting and constipation and abdominal pain and is currently under the care of gastroenterology/surgery".

17. The Official Report explained that Mr N was "restless" and suffered from abdominal pain and found it difficult to walk uphill. It was noted that he also suffered from pain and lack of mobility.

18. The Official Report also explained that:

> "A Notional PIC is where another condition listed by the medical board, but not the main reason for discharge, has an assessment under the War Pensions or AFCS. It can only be deemed a Notional PIC if it is deemed service related using the balance of probabilities standard of proof. A Notional PIC would have led to a medical discharge in its own right had the PIC not been present. It also must be attributable to, or aggravated by service."

19. The Official Report included the following statement from Mr N:

> "I was drafted from Portsmouth to Scotland while undergoing clinical investigation. The specialist [(**the Consultant**)] I saw at [the Department of Gastroenterology and Hepatology at the] hospital stated she had an idea of my problem and had a plan for treatment. However, as I was leaving for Scotland directly after this consultation, I had to be referred for treatment in Scotland. This left me back at the beginning of the waiting list and as a result I have been at the mercy of NHS waiting times and regional policies. The doctors in Scotland have not followed up on the findings and advice of the [Consultant] I saw in Portsmouth and the surgeon here has stated that his policy is not to operate on my particular condition. I have asked to be re-referred to the [Consultant] I initially saw in Portsmouth whom I am confident will be able to treat my condition. I am currently on the waiting list to see her."

20. The Official Report recorded abdominal pain as the WPS "Accepted Condition."

21. The minutes of Mr N's medical board (**the Minutes**), dated 9 October 2018, recorded that he had suffered from right iliac fossa pain since childhood. At the time, he was noted to have a Meckel's diverticulum and adhesions. However, a CT scan (**the Scan**), taken in June 2016, showed no evidence of an inflamed Meckel's diverticulum.

22. The Minutes acknowledged that the cause of Mr N's pain had not been identified at the time of his medical board.

23. The Minutes concluded that:

> "Since the pain preceded [Mr N's] enrolment in the Navy and did not appear to be related to specific activities within the Navy, I would advise that the PIC was not attributable to or aggravated by Service."

24. In a memo dated 28 November 2018, the DAR Deciding Officer (**the DAR DO**) was asked to review the following documents when making their decision:-

- "F Med 23"
- "WPA assessment"
- The doctor's medical Opinion

25. Veterans UK advised the DAR DO that, on the balance of probabilities, Mr N's PIC was not attributable to or aggravated by service. Consequently, it could not be accepted for AFAB benefits. Veterans UK said that it had made the recommendation based on the evidence available at the time and had noted the comments that had been made by the doctor. In particular, that the cause of pain had not been identified at the time of Mr N's medical board and did not appear to be related to specific activities within the Royal Navy.

26. On 5 December 2018, the DAR DO advised the following:-

- He was content with the recommendation.
- Mr N had suffered from right Iliac fossa pain since childhood.
- "Febrile pain in the right iliac fossa is one of the most common reasons for consulting at an emergency service".
- Mr N underwent a laparoscopic appendicectomy on 24 February 2010. It was noted that he had Meckel's diverticulum and adhesions. Meckel's diverticulum is an outpouching or bulge in the lower part of the small intestine.
- The bulge is congenital (present at birth) and is the leftover of the umbilical cord. Meckel's diverticulum is the most common congenital defect of the gastrointestinal tract.
- The cause of Mr N's abdominal pain had not been identified but appeared to predate his service in the Royal Navy. As his condition arose after 1 April 2004, "his invaliding" was not covered by the "Hulme" judgment.
- Consequently, the DAR DO was able to take a separate decision on whether the condition was attributable to service. In order to recommend that AFAB benefits be paid to Mr N for the condition, the DAR DO would need to be satisfied, on the balance of probabilities, that the PIC could have been attributable or aggravated by service.

27. On 5 December 2018, the DAR DO notified Veterans UK that Mr N's case had been rejected. The DAR DO said that given his history, on the balance of probability his abdominal pain was not attributable to or aggravated by service.

28. On 6 December 2018, following a review of Mr N's condition, the Consultant General Surgeon wrote to the GP (**the December 2018 Letter**). He informed the GP that a recent MRI scan showed no evidence of small bowel abnormality. He said that in light of this, and the laparoscopy:

> "I think we can clearly state there is no intra-abdominal cause for Mr [N's] pain. I think the next step would be to refer to a pain team and I have asked [Mr N] to see you in the next couple of weeks with a view to making this referral".

29. On 12 December 2018, Veterans UK notified Mr N that the DAR DO had decided that, under the AFAB rules, his PIC could not be accepted as attributable to or aggravated by service.

30. On 19 December 2018, Mr N appealed the decision under the Discretionary Award Appeals Review (**the DAAR**). He acknowledged that his PIC was not caused by service. However, he was of the view that his abdominal pain was aggravated by the Royal Navy drafting him to Scotland while he was undergoing medical investigation. He said that this had significantly delayed his diagnosis and treatment and had a cumulative detrimental effect on his PIC and his overall health.

31. Mr N enclosed a letter detailing the timeline of events. He also enclosed a separate letter appealing against his medical discharge (**the Letter of Appeal**), in which he included information on additional treatments and procedures he had received. He advised that he had included a copy of the results of a scan in September 2017, and a letter from the Consultant dated 5 January 2018. He said that it was clear from the documents that the delay in his treatment had a significant detrimental effect on his condition, his health and general wellbeing.

32. In his Letter of Appeal, Mr N said that currently the only treatment, for adhesions that cause complications, was surgical removal or separation of the adhesions; it was a matter of personal choice whether to proceed with surgery. He explained that he had been referred to the pain clinic for treatment that was not suited to pain caused by adhesions. In his view, no attempts were made to verify abdominal lesions, or any overt cause for his symptoms. Consequently, the statement made by the [doctor], that surgery would not help his abdominal pain, was merely an opinion rather than a diagnosis. Had the [doctor] carried out a further investigation, and confirmed the presence and severity of adhesions, at the very minimum he would have considered performing the procedure to alleviate his symptoms.

33. Mr N explained that he was referred back to the Consultant nine months before the medical board was due to review his case. However, because of NHS waiting lists, an appointment was not available until July 2017, which was a month after the medical board was due to convene. The medical board was aware of this; it was also aware that the appointment would most likely result in further investigations.

34. Mr N said that as a result of the consultation he had with the Consultant in July 2017, he will receive treatment for his condition that will enable him to recover sufficiently to return to full duties. The decision to draft him to Scotland, while he was undergoing medical investigation, had "directly hindered" his treatment and recovery resulting in his medical discharge.

35. Mr N's case was initially reviewed by the Senior Medical Adviser (**the SMA**) on 9 January 2019. Based on the evidence available at the time, the SMA agreed with the conclusions that had been reached by the MA and the DAR DO.

36. Veterans UK has explained that the SMA noted that Mr N had a pre-service history of pain. So, the SMA obtained a copy of Mr N's full service medical records but did not find on the balance of probabilities any evidence of "Service aggravation." The SMA noted that the October MRI, "showed multiple adhesions without current evidence of obstruction". Veterans UK has also explained that it noted from the October Report, that Mr N was experiencing abdominal pain and was awaiting investigations into his symptoms. As the GP stated that the diagnosis was uncertain, the SMA requested up to date medical information, including letters from the hospital and any relevant imaging reports.

37. On 6 February 2019, Veterans UK wrote to the Consultant General Surgeon to request further information regarding Mr N's abdominal pain. In particular:-

- The current position regarding Mr N's diagnosis.
- The current treatment and prognosis.
- Copies of letters from the hospital, "imaging reports and investigations".

38. Veterans UK sent a similar request for information to Mr N's GP.

39. On 14 February 2019, the Consultant General Surgeon advised the following:-

- He first saw Mr N on 7 March 2018, Mr N informed him that he had been suffering from tearing abdominal pain since 2015. Mr N was referred to a Gastroenterologist close to where he was based at the time.
- "Apparently when the Gastroenterologist reviewed his notes, he discovered that [Mr N] had his appendix removed in 2010, a note was made that he had a Meckel's diverticulum and multiple adhesions in the abdomen. He had a CT scan which apparently suggested that the adhesions could be causing the problem. He was then referred to a surgeon locally who considered that an operation was inappropriate.
- By the time he saw Mr N he said that he had episodes of nausea, vomiting and diarrhoea, approximately every two months, which were originally the only times that the abdominal pain developed, "but more recently the pain had become worse and was present almost constantly in the right iliac fossa".

- On examination, Mr N looked reasonably well although he was uncomfortable sitting. His abdomen was soft and there was some tenderness in the right iliac fossa. He did a laparoscopy on 25 April 2018, when he inspected the abdominal capacity he could see no sign of any adhesions, the bowel wall was of normal thickness and there were no constriction points.

- He then requested an ultrasound scan of Mr N's right groin to check for hernias and musculoskeletal abnormalities and again this was normal. So, he discharged Mr N back to his GP on 6 June 2018.

- Mr N was referred back to him with continuing symptoms on 3 October 2018. To completely eliminate a problem with the small bowel, He had an MRI scan on 31 October 2018. "This was reported as showing no evidence of small bowel IBS or other structural abnormality.

- He reviewed Mr N again on 5 December 2018. He told Mr N that he did not think that there was any intra-abdominal cause for his pain and discharged him back to his GP for further management.

40. On 13 March 2019, Veterans UK sent a follow up letter to the GP. Veterans UK explained that the MA required further information regarding Mr N's abdominal pain. In particular, the current position concerning his diagnosis, treatment and prognosis.

41. On 15 March 2019, the GP provided Veterans UK with a copy of his medical report (**the March Report**). In summary, he said:-

- Mr N had previously been seen by one of the partners at the surgery, who had since retired.

- He had seen Mr N on two separate occasions since January 2019. Mr N had provided him with a history of recurrent abdominal pain since 2015. He understood that this was investigated while he was serving in the Royal Navy.

- "Investigations seemed to suggest adhesions on the background of previous appendectomy in 2010". He understood that Mr N may need surgery. However, "this never transpired."

- Mr N was referred to a local surgeon by his partner at the practice. He had undergone fairly extensive investigations including a laparoscopy, which had been "unremarkable."

- Mr N had seen the musculoskeletal team who considered that the pain was not musculoskeletal.

- The GP had referred Mr N to the local pain clinic. However, the clinic considered that Mr N was not ready to engage as he "seemed convinced that there was an undiagnosed underlying cause." He had recently referred him to see a consultant gastroenterologist.

- The GP enclosed a copy of his most recent referral and exchanges with the Consultant Surgeon: the May 2018 Letter and the December 2018 Letter.

42. On 20 March 2019, Veterans UK resubmitted the case to the SMA and enclosed a copy of the March Report. It highlighted that the GP had advised that Mr N may require surgery and had referred him to a local surgeon. The SMA was asked to review the case before it was referred to the Assistant Head of Veterans UK, the DAAR DO, for a review.

43. On 10 April 2019, the case was referred for consideration under the Discretionary Award Appeals Review (**the DAAR**). Veterans UK explained that:-

- Mr N had advised that during an appointment in September 2015, his Consultant suspected that his pain was caused by abdominal adhesions and had referred him for an urgent laparoscopy. However, he was posted to Scotland the same day. Mr N considered that if the laparoscopy had been carried out, as planned, it is likely that he would have had surgery.

- As the GP had advised that the diagnosis was uncertain, the SMA had requested up to date information.

44. On 18 April 2019, an “M11 Form” was completed in connection with DAAR. It recorded that:-

- Mr N had acknowledged that his chronic lower back pain was not attributable to service. However, he considered that a delay in completing medical investigations had aggravated his condition.

- Mr N had a pre-service history of pain. The October MRI suggested widespread adhesions but this can often be over diagnosed. A further referral confirmed that surgery was “not supported”. The SMA concluded that this was normal practice and supported the opportunity for further investigation and for a correct diagnosis.

- Further surgery, and an examination in April 2018, confirmed no sign of adhesions in the abdominal cavity. The bowel wall was of normal thickness with no constriction points. An MRI in October 2018, showed no inflammatory bowel disease or other structural abnormalities.

- It was clear from the timeline and diagnosis that the alleged delay, in completing medical interventions, was not supported by the facts. The diagnosis had since shown no indication of the adhesions suggested during the earlier medical test.

45. On 23 April 2019, Mr N was notified that his appeal had been turned down. In summary, the letter said the gastroenterologist who treated him at the time suggested widespread adhesions but this can be frequently over-diagnosed. The letter also said that the DAAR DO had concluded that, on the balance of probabilities, his abdominal pain was not attributable to or aggravated by service. Consequently, no AFAB benefits were due to him.

46. **Summary of Mr N's position**

- His duties included patrolling the base for illegally parked cars and monitoring the parking spaces within the multi-story car park. He struggled with these tasks, as the base had several slopes and inclines. The car park was at the top of a steep hill. The walk to his accommodation block involved negotiating a steep incline which left him in severe pain on a daily basis.

- The decision not to award him AFAB benefits was heavily influenced by the fact that he had "pre-service pain" in his right lower abdomen, which had occurred intermittently since childhood. However, the pain that led to his medical discharge, although present in the same general area, was significantly different to any pain he had previously experienced in terms of "nature and associated symptoms". One of the main differences was the limitations to his mobility; any movement caused extreme spikes in pain.

- This is something that he frequently confirmed during medical consultations. In particular, he mentioned that he experienced severely increased pain when walking up "inclines", raising his right arm, bending, twisting his torso, or sitting in a chair. The only position that did not significantly increase his pain levels was lying straight on his back or standing straight without moving.

- These symptoms are typical of anterior cutaneous nerve entrapment syndrome (**ACNES**) and are due to aggravation to the affected nerve by contraction of the abdominal muscles. He has recently been diagnosed with ACNES. This confirms that his condition was aggravated by service and that it is attributable to service. Furthermore, it began after a period of "lifting and shifting" within the unit he worked in.

47. **Summary of Veteran UK's position**

- At the time of Mr N's medical board, the cause of his pain had not been identified. It was noted that the pain predated his enlistment in the Royal Navy and that it did not appear to be related to specific activities within the Royal Navy.

- It was also noted that febrile pain in the right iliac fossa is one of the most common reasons for contacting an emergency service. The main diagnosis is appendicitis; and the main complication is imperforation.

Adjudicator's Opinion

48. Mr N'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:-

- The Adjudicator explained that when someone complains that they have not been awarded the ill health or incapacity benefits they think they should get, the

Ombudsman would look at the way the decision has been reached. He can also look at whether there was any maladministration.

- The compensation award made to a former Royal Navy personnel may comprise of an award under the WPS and a separate award under the benefits Scheme. The fact that an award was made under the WPS does not mean that Mr N is eligible for an award of AFAB benefits.

- The Adjudicator said that it is a matter of whether Mr N satisfies the eligibility criteria under the Naval Pensions Order. If he does, he is entitled to AFAB benefits and Veterans UK has no discretion in the matter. To be eligible for an award under AFAB, a member must have a PIC which is attributable to or significantly aggravated by service. It is for the decision-maker to decide on the balance of probabilities whether the relevant criteria have been met.

- The "PIC" means the injury identified as the main reason for the officer's permanent unfitness for service in the Royal Navy. In Mr N's case, this was confirmed to be abdominal pain.

- The Adjudicator was not persuaded on reviewing the evidence that the alleged delay in the diagnosis of Mr N's condition was directly attributable to his service in the Royal Navy. The Adjudicator pointed out that the National Health Service (**NHS**) is a separate body: any delays in NHS waiting lists cannot be apportioned to a third party.

- The Adjudicator said that the evidence indicated that Mr N had been under investigation for abdominal pain since 2015. In the March Report, the GP explained that there had been fairly extensive investigations, including a laparoscopy, which had been "unremarkable."

- In the Adjudicator's opinion, it was not possible to say, with any degree of certainty, that if a laparoscopy had been performed at the time Mr N was posted to Scotland the results would have been any different. Consequently, the Adjudicator was not convinced that Veteran UK's decision could be successfully challenged on this basis. In taking this view, the Adjudicator considered the fact that the results of the laparoscopy in May 2018 was normal.

- Mr N considered that Veterans UK gave undue weight to his history of "pre-service pain". He had highlighted that the pain which led to his medical discharge, was a different type of pain and limited his mobility and caused extreme spikes in pain. Having considered the medical evidence, the Adjudicator was satisfied that the decision to refuse Mr N AFAB benefits was correct based on the information available at the relevant point in time. The Adjudicator was also satisfied that Veterans UK had followed a correct process by obtaining further medical information before resubmitting the case to the SMA.

- Mr N's more recent diagnosis of ACNES did not mean that it can now be shown that he would have satisfied the relevant eligibility test at the time that the decision

was taken. Specifically, that the condition was caused by service in the Royal Navy or Royal Marines.

- The Adjudicator said that where the original decision to refuse benefits was correct, based on the evidence available at the time, it was unlikely that there would be grounds for the Ombudsman to uphold the complaint. The medical information available to the decision-maker at the relevant time did not indicate a possible or confirmed diagnosis of ACNES. Consequently, the Adjudicator was unable to agree that the diagnosis was relevant to the decision which the decision-maker needed to make. It is open to Mr N to provide supporting medical evidence that proves that he satisfied the relevant eligibility test at the time of that decision.

49. Mr N did not accept the Adjudicator's Opinion and the complaint was passed to me to consider. Mr N provided his further comments which do not change the outcome. I agree with the Adjudicator's Opinion and note the additional points raised by Mr N, which are summarised below:-

- The Adjudicator's conclusions "are perfectly valid within the confines of the initial decision" not to award AFAB benefits. However, his complaint concerns the decision reached during the appeal process, which was based on "incomplete evidence as no official diagnosis had been made and investigations were still being conducted into the actual cause of his medical condition.

- The only reason no diagnosis was available at the time was because investigations and treatment were delayed. It is this delay that forms the basis of his complaint to TPO.

- The decision not to award AFAB benefits was made only a few months before the diagnosis of ACNES. He strongly believes that but for the delays he has mentioned, this diagnosis would have been available at the time of his discharge and the decision would have been based on this, rather than "conjecture".

- Having undergone further investigations, and obtained a definite diagnosis of ACNES, which he provided a copy of during the appeals process, it is now clear that his condition is not related to any pre-existing condition, but rather the result of an injury he sustained during his duties. He also provided a copy of a letter from his Consultant Gastroenterologist dated May 2019 (**the May Letter**: see Appendix 2). This supports his assertion that his discharge "was caused by this new, work related injury".

- The decision maker still considered that the cause of his discharge was the pre-existing condition, ignoring the significance of the diagnosis of ACNES.

- It is clear from the correspondence Veterans UK received from the Consultant General Surgeon during its investigation that he did not consider that there was any intra-abdominal cause for his pain. However, the decision maker's verdict was

abdominal pain and he was refused AFAB benefits on the grounds that he had a long standing history of intra-abdominal symptoms.

- The Consultant Gastroenterologist stated in an email on 29 January 2021 (**the January Email**: see Appendix 1) that she considers that he had long standing functional intra-abdominal symptoms, completely separate from the ACNES.

- ACNES is a trapped nerve, the result of injury, rather than a long term intra-abdominal illness. In the absence of any evidence of intra-abdominal causes, the decision to refuse AFAB benefits based on previous gastro-intestinal symptoms was arbitrary.

- In light of the new evidence he provided to the board, he strongly requests that the decision be reconsidered and that he might be granted the AFAB benefits to which he is entitled. It would be unjust to disqualify him from receiving AFAB benefits, given the long delay, attributable to his service, of a definite diagnosis and the significant impact this injury had, and continues to have, on his life.

50. Veterans UK's comments on Mr N's additional submissions are summarised below:-

- The information Mr N has presented postdates Veteran UK's decision. The medical condition it considered and determined not to be attributable to or aggravated by service, for the purposes of AFAB benefits, was "Abdominal Pain". This is the sole principal condition that led to Mr N's medical discharge from the Navy.

- The 'new' medical diagnosis Mr N now raises cannot be retrospectively considered as part of this appeal. Should he wish to have his principal invaliding condition changed on his medical board report, he would have to make an official request for this to be considered.

- Veterans UK acknowledges that Mr N has provided TPO with a copy of a letter from the Consultant Gastroenterologist dated June 2019 and a further letter dated September 2019 (**the June Letter** and **the September Letter**, summarised at Appendix 3 and 4). This medical evidence also postdates its decision.

- "The medical condition [Veterans UK] considered and determined not to be attributable to or aggravated by service, for the purposes of Armed Forces Attributable Benefits, was Abdominal Pain. This is the sole principal condition that led to Mr [N's] medical discharge from the Navy. The 'new' medical diagnosis [N's] now raises cannot be retrospectively considered as part of this appeal. Should he wish to have his principal invaliding condition changed on his medical board report, he would have to make an official request for this to be considered".

Ombudsman's decision

51. Mr N's main complaint concerns Veteran's UK's appeals process and its alleged failure to consider medical evidence that was available to Veterans UK after he

underwent further medical investigations. The outcome of those investigations is that he obtained a definite diagnosis of ACNES, which was unrelated to a pre-existing condition.

52. The question for me to answer is limited to considering whether Veteran UK's MA/SMA understood the eligibility criteria for an award under the benefits Scheme. Additionally, whether they considered the medical evidence before respectively giving their opinion. Similarly, the DOs before reaching their decisions.

53. To reach a view on this point, broadly I need to consider whether the relevant eligibility test has been correctly interpreted. Also, whether the medical information considered was appropriate and sufficient to form a view on whether Mr N met the eligibility test for an award.

54. On reviewing the evidence, I am unable to conclude that Veterans UK's MA/SMA (or the DOs) either did not understand the test to be applied; or applied the test incorrectly.

55. Under Rule B.2 of the Naval Pensions Order, the "PIC" means the injury identified as the main reason for the person's permanent unfitness for service in the Royal Navy or Royal Marines, as stated on the person's medical discharge Certificate.

56. Mr N's PIC was recorded as "Abdominal Pain". The test that needed to be applied, for the purposes of determining Mr N's eligibility for an award, was whether, on the balance of probabilities, his abdominal pain was sustained by service. The available medical evidence indicated that Mr N had long standing issues with abdominal pain. It did not indicate that it was an injury attributable to or aggravated by service; at the relevant points in time the cause of his pain had not been identified.

57. In light of the medical evidence available at the time the decisions were made, I do not consider that there are grounds for finding that the decisions were not properly made. While I sympathise with Mr N's position, his additional submissions relating to his subsequent diagnosis of ACNES do not change the outcome in the circumstances.

58. It is open to Mr N to make an official request to Veterans UK to reconsider the PIC that was noted on his medical board report.

59. I do not uphold Mr N's complaint.

Anthony Arter CBE

Deputy Pensions Ombudsman
16 August 2023

Appendix 1

The January Email from the Consultant Gastroenterologist

"Fri 29/01/2021 13:40

Hi [Mr N]…

I have had a chance to re-read the original correspondence from May 2019. I have copied in my secretary so she can send you a copy of my clinic letter from 01/05/2019 which I think will be helpful to you, it's pretty detailed.

Essentially I believe you have 2 clinically distinct issues – very longstanding intermittent functional bowel symptoms which were present even before 2010 when you had your appendicectomy, and also a chronic neuropathic type pain which began in 2015 –(the ACNES/Complex regional pain syndrome). The bowel issue had unsurprisingly continued but doesn't seem to me in any way related.

I can't comment on the causation of the nerve pain but I do take issue with the assertion that it's the same issue as the bowel symptoms – I fundamentally disagree with that.

I hope that's helpful,

KRs

[Consultant Gastroenterologist]"

Appendix 2

Summary of the contents of the May Letter

- Diagnosis: Probable CRPS, right flank and abdomen intermittent nausea and vomiting. Intermittent constipation - probable functional bowel disorder.
- Mr N has a long complex history and has been “investigated all over the place by numerous people”.
- Mr N had symptoms before his appendicectomy in 2010, with bouts of sickness and diarrhoea. Mr N was admitted to hospital in 2010 and had a laparoscopic appendicectomy. It subsequently transpires that the appendix was historically normal but during this procedure a Meckel’s diverticulum was noted but not removed.
- He continued to have occasional bouts of abdominal discomfort, diarrhoea and vomiting “but there wasn’t really an issue”. Then in 2015 he developed severe right sided pain with vomiting and an episode of severe constipation.
- At the time there was consideration given as to whether or not he had adhesions related to his previous appendicectomy and apparently laparoscopic investigation was planned when he was transferred.
- He saw a Medical Gastroenterologist there who disagreed with this diagnosis and treated him medically. Meanwhile Navy doctors referred him to a Surgeon who did a Meckel’s scan which confirmed the previous Meckel’s diverticulum but did not want to operate with another diagnostic laparoscopy. He was subsequently referred back to the Gastroenterologist in Portsmouth; by this point he had been medically discharged from the Navy. A scan at that point was reported as showing multiple adhesions in the lower abdomen, “although I am a bit dubious about this because I would not normally expect a CT to be reported as showing adhesions.”

Appendix 3

Summary of the contents of the June Letter, addressed to Mr N

- The Consultant Gastroenterologist was pleased that Mr N's colonoscopy and the MRI scan of his spine were entirely normal.
- She noted that Mr N would be seeing her again in September 2019. It may be worthwhile if Mr N spoke to his GP in the meantime about trying Amitriptyline or Gabapentin to treat his right sided abdominal pain, which she thought was "nerve pain".

Appendix 4

Summary of the contents of the September Letter, addressed to the Pain Management Team

- The Pain Management Team should direct Mr N to the most appropriate outpatient clinic.
- Mr N has been “extensively investigated for many years by many people for right sided abdominal pain with nothing ever found”.
- The Consultant Gastroenterologist says clinically she is sure Mr N has an anterior cutaneous nerve entrapment syndrome. She “MRI’d his spine and re-imaged him prior to making this referral and it is all entirely normal”.
- Mr N has had symptoms now for several years which have been severe enough to end his very successful career in the Royal Navy. He “would very much like to explore local nerve ablation therapy if such a thing could be done”.