CAS-82126-P3Y7

Ombudsman's Determination

Applicant	Mr G
Scheme	Armed Forces Pension Scheme 2005 (**AFPS 2005**)
Respondent	Veterans UK

Outcome

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

Complaint summary

2. Mr G has complained that he has not been awarded the appropriate tier of ill health retirement benefits. He contends that he should be awarded Tier 3 as he has been unable to work since 2018.

Background information, including submissions from the parties

3. Extracts from and summaries of the medical evidence are provided in Appendix 2.

4. Mr G was a member of Armed Forces Pension Scheme 2005[1].

5. Mr G was medically discharged from the Army in July 2015. He was then age 34. The Medical Board Record (F Med 23) notes his principal conditions as hypertension (high blood pressure) and non-freezing cold injury to his hands and feet (**NFCI**). He was awarded Tier 1 benefits; that is, a preserved pension for payment at his pension benefit age (65) and an immediate lump sum.

6. At the time of Mr G's discharge, the relevant provisions were contained in:

   - 'The Armed Forces Pension Scheme Order 2005' (SI2005/438) (as amended) (**AFPS Order 2005**); and
   - 'The Armed Forces Early Departure Payments Scheme Order 2005' (SI2005/437) (as amended) (**EDPS Order 2005**).

[1] Veterans UK has confirmed that Mr G retained membership in the AFPS 2005. He did not transfer to the Armed Forces Pension Scheme 2015. (**AFPS 2015**).

7. Three tiers of benefit are available for members of the AFPS 2005 who leave the Armed Forces as a result of ill health. The level of benefit is related to the severity of the impact the individual's condition has on their capacity for civilian employment. Tiers 2 and 3 are awarded under the AFPS Order 2005. Tier 2 is awarded to those whose ability to undertake other gainful employment is significantly impaired (rule D.6). Tier 3 is awarded to those who are permanently incapable of any full-time employment (rule D.5). At the time, Tier 1 was awarded under Article 16 of the EDPS Order 2005 to those who were unable to do their service job, but whose ability to undertake other gainful employment was not considered to be significantly impaired. Extracts from the AFPS Order 2005 and the EDPS Order 2005 are provided in Appendix 1.

8. In August 2018, Mr G was admitted to hospital.

9. On 7 January 2019, Veterans UK received Mr G's appeal of his Tier 1 award. Mr G said:-

   - He was awarded Tier 1 rather than Tier 3 benefits, despite constantly complaining of headaches, dizziness and weakness due to his medication.
   - Initially, he received State support with rent and council tax. But after this ended, and in need of income, he took work as a truck driver in 2016, the only job he could find.
   - To be able to drive he stopped taking his hypertension medication due to its side effects. As a result, he suffered high blood pressure and was admitted to hospital in 2018, where for a period he was put on life support.
   - His kidneys had failed, and he was waiting appointments and checks to go on dialysis.
   - He was confined at home still recovering and was unable to work due to a lack of strength and energy. He was currently on Universal Credit.
   - His pension on discharge should be reconsidered. Aside from being in university education and needing to cover bills, he also had children to support

10. With his appeal, Mr G submitted a copy of the hospital's 'Transfer of Care (Discharge Summary)'.

11. Veterans UK referred Mr G's case to one of its medical advisers (**MA**) (**the first MA**). In May 2019, the first MA gave their opinion that a Tier 2 award was merited.

12. The same month, Veterans UK's Deciding Officer (**DO**) accepted the first MA's opinion and awarded Tier 2 benefits from 7 January 2019 (the date of receipt of Mr G's appeal). This was subsequently internally queried and corrected to 22 July 2015 (the day after Mr G's date of medical discharge from the Army).

13. In February 2020, Mr G requested that the tier award be increased to Tier 3. Mr G said:-

    - His medical condition had not improved. In fact, the chronic pain from his NFCI had recently worsened.
    - In September 2019, Dr Haider (Pain Management Consultant) had advised that there might not be many options for his condition.
    - Aside from the NFCI, other health conditions were contributory factors to his plight. He was unable to work to earn an income.

14. With his request, Mr G submitted a copy of Dr Haider's September 2019 report.

15. The medical evidence was reviewed by another MA (**the second MA**), who found no evidence of deterioration in Mr G's conditions since the last tier review. The Deciding Officer (**DO**) accepted the second MA's opinion and Mr G's tier award was not changed.

16. In March 2021, Mr G appealed the decision, invoking the Scheme's single stage Internal Dispute Resolution Procedure (**IDRP**). Mr G said:-

    16.1 The information on which the decision had been made was not exhaustive and did not represent the true nature of his condition.

    16.2 His claim for hypertension was denied on grounds of time. This was currently going through a tribunal hearing.

    16.3 At the time he was awarded Tier 1, he complained to the representative of the Medical Board, but consideration was not given to his plea.

    16.4 The repeated argument was that he had stopped medication. But, if the right support had been provided from the outset he would not have had to go through the pressure to put a roof over his head and food on the table by taking the job he was doing.

    16.5 On discharge, he managed to support himself until early 2016. The Council and DWP then provided support for three months. Once this ended, he had to find work. As an HGV driver he had to stop taking medication due its side effects.

    16.6 These challenges were the catalyst to his emergency admission to hospital in 2018.

    16.7 The MA's comments on the medical evidence were selective and did not holistically bring forth his medical conditions.

    16.8 After taking morning medication, he had to stay in bed due to light-

headedness and chronic headaches. He had complained about this since his hospital discharge in September 2018 and necessitated the removal of Moxonidine from his list of medication.

16.9 His hypertension had a direct correlation to his kidney function. So, it was essential that he keep taking his medication despite the various side effects.

16.10 His blood pressure varied daily effecting his body. Currently, he had swollen ankles, painful intermittent boils on his legs, constant excruciating pain beneath his right shoulder blade and continuous flickering eyes.

16.11 His NFCI continued to painfully affect his hands and feet. His Pain Management Consultant had made it clear to him that there might not be many options for his condition apart from taking pain reliefs. When still in the Forces, he had been informed that NFCI could only be managed not cured.

16.12 In September 2019, he was physically assessed for the DWP by the Health Assessment Advisory Service as having limited capability for work and work-related activity. Also, the Department of Health and Social Care had categorized him as a clinically extremely vulnerable person, and he must follow shielding guidance[2].

16.13 He had always been independent, and his work ethic was second to none. A statement like, "Your conditions are unlikely to restrict your function to such severity that you would be permanently incapable of any full-time employment" saddened him the most. It smacked of a clear misunderstanding of his situation and that the true picture of his conditions was seen differently from other quarters.

17 Updated medical evidence was obtained and Veterans UK referred Mr G's appeal to another MA (**the third MA**). The third MA advised that as things currently stood there was no reason why Mr G's hypertension, renal impairment or NFCI would prevent him from doing full-time sedentary employment. Since the last review his kidney function had improved, he was discharged from the pain clinic around September 2019, and there was no evidence that his NFCI was causing any significant issues. The third MA advised that a Tier 1 award was appropriate now and there was no evidence to support an increase to Tier 3.

[2] Identified as clinically vulnerable to COVID-19.

18 In August 2021, after reviewing the medical evidence, the DO decided that Tier 2 remained appropriate. The DO said:

> "The Scheme Medical Advisor has advised that a Tier 1 award would now be appropriate, based on the medical evidence. I agree that the evidence does not currently support a Tier 3 award; however, I do not conclude that the award should be revised downward to a Tier 1 award, as I believe that there is sufficient evidence to demonstrate reduced capacity which significantly impairs [Mr G] from obtaining full time employment until pension age.
>
> Having considered all of the available evidence, I am satisfied that the original decision was correct and that Tier 2 benefits are appropriate. I do not accept that [Mr G] is severely disabled based on his medical records and is unable to do any full-time work at the moment. I accept that it may be difficult for [Mr G] to find the type of work he will be able to do. This may be work in a temperature-controlled environment, with minimal physical exertion such as office based or call centre-based work (these are only examples).
>
> However, the evidence does not support that [Mr G] has suffered a permanent breakdown in health such that he cannot work in any capacity, and that this will remain so for the next 20 years until pension age[3].
>
> [Mr G's] appeal is rejected and he remains entitled to a Tier 2 award."

Mr G's position

19 Mr G submits:-

- He has not been able to work since his admission to hospital in August 2018.
- A Tier 3 pension award would be fair, just and proper.

Veterans UK's position

20 Veterans UK submits:-

- Mr G states he has been unable to work since August 2018. He has not provided any new information that confirms a deterioration in his condition. The third MA's opinion was that Mr G's conditions had improved since the previous review was undertaken.
- Its position remains as per its IDRP decision.

[3] The DO mistakenly referred to the pension benefit age under the AFPS 2015. Nonetheless, the respective criteria for Tier 2 and Tier 3 benefits are the same for members of either or both the AFPS 2005 and the AFPS 2015. So, the error was not material to the outcome.

Adjudicator's Opinion

21 Mr G'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 set out below in paragraphs 22 to 47.

22 The Adjudicator explained that they had put to one side various medical documents that Mr G had submitted which post-dated the IDRP decision of August 2021, as a decision could only be assessed based on the evidence which was, or could have been, available to the decision-maker at the time it was made. The evidence relating to Mr G's circumstances after August 2021 was not available to Veterans UK when it decided to reject his appeal for Tier 3 benefits. So, it was not relevant to assessing whether Veterans UK's decision was taken in a proper manner.

23 Members' entitlements to benefits when taking early retirement due to ill health were determined by the relevant scheme rules or regulations. The scheme rules or regulations determined the circumstances in which members were eligible for ill health benefits, the conditions which they must satisfy, and the way in which decisions about ill health benefits must be taken.

24 In this case, the relevant rules were D.5, D.6, and D.8 in the AFPS Order 2005.

25 Under rule D.8, because Mr G was awarded Tier 1 on medical discharge from the Army, the review was limited to considering whether he satisfied the conditions set out in rule D.6; that was, the conditions for Tier 2 benefits. Namely, to have "suffered a breakdown in health as a result of which his capacity for gainful employment is significantly impaired".

26 The AFPS Order 2005 did not include a definition of "gainful employment". The Pensions Ombudsman had previously determined that gainful employment, for the purposes of rule D.6, must include some capacity for full-time employment. This was because rule D.5 applied if a member had suffered a permanent breakdown in health involving incapacity for any full-time employment. Rule D.6 provided for a lower level of benefits than rule D.5 and, logically, must be intended to provide benefits in respect of a lower level of impairment.

27 The decision as to whether Mr G satisfied the conditions for Tier 2 (or Tier 3) benefits was for Veterans UK (on behalf of the Secretary of State) to make. Before making its decision, rule D.8 required Veterans UK to have consulted with its MA as to Mr G's capacity for any full-time employment. Veterans UK was not, however, bound by any advice it received from its MA. It was still expected to reach a decision of its own. That being said, the weight which Veterans UK placed on any evidence relating to Mr G's case was for it to decide. It was open to Veterans UK to accept the advice of its MA; unless there was good reason for it not to do so, such as errors or omissions of fact or a misunderstanding of the relevant rules by the MA.

28 MAs did not come within the Pensions Ombudsman's jurisdiction as far as their medical opinions were concerned. They were answerable to their own professional

bodies and the General Medical Council. The Pensions Ombudsman would simply consider whether the MAs provided sufficient and appropriate advice on which it was reasonable for Veterans UK to rely on when making its decision. It was accepted that Veterans UK could only review medical advice from a lay perspective and could not be expected to challenge a medical opinion as such.

29 The first MA considered the Medical Board Record, Mr G's Service medical records, Mr G's letter requesting the review of his Tier 1 award and Hospital and GP medical evidence.

30 The first MA noted that Mr G had stopped taking antihypertensive medications during 2015 and was admitted as an emergency with malignant hypertension and hypertensive encephalopathy on 23 August 2018. Mr G had developed end-stage renal failure, secondary to poorly controlled hypertension and pyelonephritis. Mr G's persistent high blood pressure had also caused left ventricular hypertrophy of the heart and some ischaemic changes. On 12 October 2018, Mr G was admitted to hospital with chest pain, which had started whilst visiting the dialysis unit. His pain was thought to have been triggered by emotional stress. Mr G was currently confined to his home. Mr G was a carrier of Hepatitis B, which would require life-long monitoring. Mr G had NFCI, and his GP's notes suggested a recent worsening of the condition. Recent hospital notes stated that Mr G had Renaud's Syndrome.

31 The first MA commented that Mr G's symptoms were consistent with a diagnosis of end-stage renal failure. It was uncertain whether Mr G had Reynaud's Syndrome or there had been a misdiagnosis of NFCI.

32 The first MA's opinion was that Mr G was not fit to work in any capacity whilst he had end-stage renal failure, or whilst undergoing dialysis. If Mr G underwent a successful kidney transplantation, he would regain his health although he would need life-long immunosuppressive therapy. But it might take several years before Mr G was offered a transplant. Mr G's NFCI would limit the type of employment available to him. So, a Tier 2 award was now appropriate.

33 The same month, Veterans UK's DO accepted the first MA's opinion and awarded Tier 2 benefits, from 7 January 2019. This was subsequently internally queried and corrected to 22 July 2015.

34 In February 2020, Mr G submitted a new review request to increase his benefits from Tier 2 to Tier 3, in accord with rule D.8 (1)(a). Mr G said the chronic pain from his NFCI had recently worsened, other health conditions were contributory factors to his plight, and he was unable to work. With his request Mr G submitted a copy of Dr Haider's September 2019 report, which said Mr G was aware that there might not be many options for his NFCI condition.

35 The second MA noted the Medical Board Record, Mr G's review requests of December 2018 and February 2020, the first MA's advice of May 2019 and the available medical evidence.

36 The second MA said Mr G's main deterioration appeared to be due to his hypertension and subsequent kidney disease. In 2018, as a result of uncontrolled high blood pressure, he was found to have an enlarged heart, end stage renal failure and encephalopathy and kidney transplant and dialysis were discussed. In February 2019, the nephrologist described Mr G as well, blood pressure controlled and his renal function improving. In August 2019, the consultant stated Mr G was well, but his blood pressure was marginally high. In February 2020, kidney function tests showed an improved eGFR[4] of 27, which adjusted for Mr G's ethnicity gave an eGFR of 32. This equated to stage 3 (moderate) disease. A transplant or dialysis would not be considered until the eGFR fell below 15. The most recent gastroenterology review was in September 2020. This noted that Mr G felt generally well, no abnormal pain, itch, change in appetite or bowel motion and no weight loss. His liver function tests were normal and the viral load (Mr G being a Hepatitis B carrier) had reduced. An MRI scan of his liver in February 2020 showed no suspicious lesions. He was on four medications for his blood pressure.

37 The second MA said they could see no evidence of deterioration since the last tier review. While Mr G had chronic kidney disease, blood tests showed things had improved from 2018. With this improvement in kidney function he would not be a candidate for dialysis or a transplant. Mr G was a Hepatitis B carrier. But this was unlikely to impact on his function. His NFCI was described as mild-moderate and was unlikely to have deteriorated with time. Mr G was in university education in December 2018 and his conditions were unlikely to prevent him from completing the course.

38 The second MA advised that Mr G's conditions were unlikely to restrict his function to such severity that he would be permanently incapable of any full-time employment, therefore Tier 2 remained appropriate.

39 The Adjudicator said they had not identified any reason why Veterans UK should not have accepted the advice it received from the second MA.

40 The third MA noted the latest review of Mr G's hypertension and kidney disease from Dr Eberhard, dated 18 May 2021. The renal physician advised that Mr G felt well, had no dizzy episodes, had some peripheral oedema caused by the antihypertensive medication but his kidney function remained stable. At the time of this review, Mr G's eGFR was 25 (27 corrected) which showed an improved kidney function from the time of the Tier 2 award (eGFR 16) and a stable kidney function since the last tier review in December 2020.

41 The third MA noted that Mr G was discharged from the pain clinic on or around 16 September 2019. In a GP consultation for shoulder pain dated 16 March 2021, it was noted that Mr G was not on any painkillers.

42 The third MA said there was no recent evidence to show that Mr G's NFCI was causing any significant issues and was of the opinion that this condition was likely to

[4] Chronic Kidney disease is staged according to eGFR levels.

remain stable or to improve further. Concerning Mr G's renal function, this had improved since the Tier 2 award and was now stable. While there may be deterioration in the future, the recent improvement in eGFR was a good prognostic indicator.

43 Commenting on how Mr G's medical conditions and associated functional limitation/restriction impacted on his ability for gainful civilian employment to pension benefit age, the third MA said that currently there was no reason why Mr G's hypertension, renal impairment or NFCI would prevent him from doing full-time sedentary employment. The MA advised that Tier 1 was now appropriate and there was no evidence to support an increase to Tier 3.

44 The Adjudicator noted that Veterans UK were not bound by the advice of the MA. On this occasion, after reviewing the evidence and the third MA's opinion, the DO decided that Tier 2 remained appropriate and explained why. While the DO incorrectly referred to "for the next 20 years until pension age" (Mr G at the time was 40 and his pension benefit age under the AFPS 2005 was 65), the fact that the DO considered that Mr G was not incapable of any full-time work before age 60 (that is before Mr G's pension benefit age) meant it did not affect the outcome of the DO's decision.

45 Mr G said he had been unable to work since 2018. In and of itself, this did not mean that Veterans UK's decisions, in May 2019 and August 2021, were not properly made. A decision could only be assessed on the basis of the evidence which was, or could have been, available to the decision-maker at the time it was made. Evidence relating to Mr G's current circumstances was not available to Veterans UK at the time it took the decision to decline his application for Tier 3. So, it was not relevant to assessing whether that decision was taken in a proper manner.

46 The Adjudicator's view was that there were no grounds on which the Pensions Ombudsman would direct Veterans UK to retake its decision. So, the complaint could not be upheld.

47 The Adjudicator said if Mr G considered that his health had worsened since August 2021 he may submit a new request for a review of his tier award.

48 Mr G did not accept the Adjudicator's Opinion and the complaint was passed to me to consider. Mr G has 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 G.

Ombudsman's decision

49 Mr G says the second and third MAs only based their respective opinions on the comments of the nephrologist who described him in February 2019 as "well, blood pressure controlled and his renal function improving", but the context was not considered. Mr G asks if the nephrologist's narration was in comparison to the episode he suffered on 18 August 2018 or just taken on face value.

50 I do not agree that the second and third MAs based their respective opinions on the nephrologist's comments in 2019. Both also considered later medical evidence commenting on Mr G's renal function, hypertension and NFCI. The second MA additionally noted gastroenterology findings.

51 The weight which is attached to medical evidence is for the MA to decide. As a lay person it is not for me (or for Veterans UK as the decision-maker) to challenge any medical opinion per se, albeit Veterans UK should not accept the opinion of its MA blindly.

52 As the Adjudicator explained, it is open to Veterans UK to prefer the advice it receives from its own MAs; unless there is a good reason why it should not do so, such as an error or omission of fact, reference to irrelevant matters or a misunderstanding of the relevant rules by the MA. I have not found any reason why Veterans UK should not have accepted the opinion of the First MA or the Second MA.

53 While the third MA's opinion was that Tier 1 was now appropriate, the DO decided Tier 2 should remain, which was within the DO's remit to decide.

54 Mr G says all the predictions by the MAs turned out to be contrary to the true picture of his situation.

55 As the Adjudicator explained, a decision can only be assessed based on the evidence which was, or could have been, available to the decision-maker at the time it was made. The fact that expectations relating to a member's future capacity for work expressed at the time a decision is made are not subsequently realised does not, in and of itself, invalidate the decision. A decision is made on the balance of probabilities and there will always be an element of uncertainty about a prognosis. An assessment as to the propriety of the decision-making process should not apply the benefit of hindsight.

56 Mr G has submitted a report from Dr Khan (Consultant Cardiologist) dated 24 July 2015[5]. This is a joint medical report that was prepared for a court case between Mr G (the Claimant) and the MOD (the Defendant).

57 From the MAs reports, it is not clear that Dr Khan's report was available/considered by the MAs. Nonetheless, it is not disputed that Mr G was unfit for service, hence his medical discharge in July 2015 (a few days before and in the same month as Dr Khan's report). The MAs considered medical evidence from Mr G's doctors pertaining to his hypertension that post-dated Dr Khan's report and while Dr Khan's opinion was that Mr G's hypertension alone meant he qualified for medical discharge he was also of the opinion that Mr G was capable of civilian employment ("office- based jobs or those roles requiring only mild moderate physical effort would in my opinion be open to him"). So, on the balance of probabilities, I find that Dr Khan's report (even if it was not considered by the MAs) would not have changed the outcome. That is Mr G's Tier 1 award on medical discharge being upgraded to Tier 2.

58 As the Adjudicator said, if Mr G considers that his health has worsened since August 2021, he may submit a new request for a current review of his tier award.

[5] Extracts from this report are provided in Appendix 3.

59 I do not uphold Mr G's complaint.

Dominic Harris

Pensions Ombudsman
25 February 2025

Appendix 1

The Armed Forces Pension Scheme Order 2005 (as amended)

Rule D.5, 'Early payment of benefits: active members with permanent serious ill-health' provides:

"(1) An active member who ceases to be in service by virtue of which he is eligible to be an active member of the Scheme is entitled to immediate payment of a pension and a lump sum before reaching pension age if -

(a) in the opinion of the Secretary of State the member has suffered a permanent breakdown in health involving incapacity for any full-time employment,

(aa) the Secretary of State has received evidence from a registered medical practitioner that the member is (and will continue to be) incapable of carrying on his occupation because of physical or mental impairment, and".

(b) the member either -

(i) has at least two years' qualifying service, or

(ii) is entitled to short service benefit by virtue of section 71 of the Pension Schemes Act 1993 (basic principles as to short service benefit) because of a transfer value payment having been accepted.

(2) For the purposes of this Rule and Rule D.8 a member's breakdown in health is "permanent" if, in the opinion of the Secretary of State, it will continue at least until the member reaches pension age.

(3) For the purpose of these Rules a member's breakdown in health involves incapacity for any full-time employment if, in the opinion of the Secretary of State, as a result of the breakdown the member is incapable of any gainful full-time employment …"

Rule D.6, 'Early payment of benefits: active members with significant impairment of capacity for gainful employment', provides:

"(1) An active member who ceases to be in service by virtue of which he is eligible to be an active member of the Scheme is entitled to immediate payment of a pension and a lump sum before reaching pension age if -

(a) in the opinion of the Secretary of State the member has suffered a breakdown in health as a result of which his capacity for gainful employment is significantly impaired,

(aa) the Secretary of State has received evidence from a registered medical practitioner that the member is (and will continue to be) incapable of carrying on his occupation because of physical or mental impairment, and

(b) the member either -

(i) has at least two years' qualifying service, or

(ii) is entitled to short service benefit by virtue of section 71 of the Pension Schemes Act 1993 (basic principles as to short service benefit) because of a transfer value payment having been accepted, and

(c) the member is not entitled to a pension under rule D.5.(1) …"

Rule D.8, 'Member's requests for review of ill-health awards', provides:

"(1) This rule applies if a member -

(a) is entitled to a pension under rule D.6, or

(b) has received a lump sum under article 16 of the Armed Forces Early Departure Payments Scheme Order 2005(25) (lump sum awards: incapacity for armed forces service) ("article 16").

(2) The member may request a review of his condition under this rule -

(a) at any time before the fifth anniversary of the day on which the member became entitled to the pension or lump sum, or

(b) after that time if in the opinion of the Secretary of State the circumstances are exceptional.

(3) The request must be made by notice in writing in such form as the Secretary of State requires.

(4) If a member within paragraph (1)(a) requests a review of his condition under this rule the Secretary of State must—

(a) review the question whether the member has suffered a permanent breakdown in health involving incapacity for any employment (see rule D.5(2) and (3)), and

(b) if, he is of the opinion that he has suffered such a breakdown, determine whether—

(i) the member had suffered such a breakdown at the time when he became entitled to the pension under rule D.6, or

(ii) the condition by virtue of which he became so entitled has deteriorated so that he suffered such a breakdown later.

(5) If—

(a) on any review under paragraph (4), the Secretary of State is of the opinion that the member—

(i) has suffered such a breakdown as is mentioned in paragraph (4)(a), and

(ii) had done so at the time when he became entitled to the pension under rule D.6, and

(b) the member meets the condition in rule D.5(1)(b),

then the member's entitlement under rule D.6 ceases and rule D.5 applies as if the conditions mentioned in that rule were met at the time the member ceased to be in service by virtue of which he was eligible to be an active member of the Scheme, and accordingly the member immediately becomes entitled to payment of such an amount as is specified in paragraph (6).

…

(7) If on any review under paragraph (4), the Secretary of State is of the opinion that—

(a) the member has suffered such a breakdown as is mentioned in paragraph (4)(a), but

(b) the condition by virtue of which he became entitled to the pension under rule D.6 has deteriorated so that he suffered such a breakdown later,

then the member's entitlement to a pension under rule D.6 ceases and the member is entitled to a pension calculated in accordance with paragraph (7A) from the date on which the review was requested.

…

(8) If a member within paragraph (1)(b) requests a review of his condition under this rule, the Secretary of State must –

(a) review the question whether the member has suffered a breakdown in health as a result of which his capacity for gainful employment is significantly impaired, and

(b) if, after consultation with the Scheme medical adviser, he is of the opinion that the member has suffered such a breakdown, determine whether -

(i) the member had suffered such a breakdown at the time when he became entitled to payment of the lump sum under article 16, or

(ii) the condition by virtue of which he became so entitled has deteriorated so that he suffered such a breakdown later.

(9) If -

(a) on any review under paragraph (8), after consultation with the Scheme medical adviser, the Secretary of State is of the opinion that the member -

(i) has suffered such a breakdown as is mentioned in paragraph (8)(a), and

(ii) had done so at the time when he became entitled to payment of the lump sum under article 16, and

(b) the conditions in rule D.6(1)(aa) and (b) are met,

then rule D.6 applies from the time when the ill-health condition (as defined in paragraph 1 of Schedule 28 to the Finance Act 2004) is first met, and accordingly the member is entitled to a lump sum under that rule and to a pension under that rule payable from that time (subject to paragraph (12)).

(10) If -

(a) on any review under paragraph (8), after consultation with the Scheme medical adviser, the Secretary of State is of the opinion that -

(i) the member has suffered such a breakdown as is mentioned in paragraph (8)(a), but

(ii) the condition by virtue of which he became entitled to payment of the lump sum under article 16 has deteriorated so that he suffered such a breakdown later, and

(b) the conditions in rule D.6(1)(aa) and (b) are met,

then rule D.6 applies from the date when the ill-health condition (as defined in paragraph 1 of Schedule 28 to the Finance Act 2004) is first met, and accordingly the member is entitled to a lump sum under that rule and to a pension under that rule payable from that date (subject to paragraph (12)).

(11) If paragraph (9) or (10) applies and the lump sum paid to the member under article 16 was less than the lump sum to which he is entitled under rule D.6, the lump sum to which the member is so entitled is a lump sum equal to the difference.

(12) If paragraph (9) or (10) applies and the lump sum paid to the member under article 16 exceeded the lump sum to which he is entitled under rule D.6, then the member is not entitled to a lump sum under D.6 and the excess must be repaid."

The Armed Forces Early Departure Payments Scheme Order 2005 (as amended)

Article 16 provides:

"Lump sum awards: incapacity for armed forces service

(1) A person who ceases to be in service as a member of the armed forces is entitled to immediate payment of a lump sum if –

(a) in the opinion of the Secretary of State the person is unfit for service as a member of the armed forces because of physical or mental impairment,

(aa) the Secretary of State has received evidence from a registered medical practitioner of that unfitness,

(b) the person has at least two years' relevant service,

(c) immediately before the service ceases the person is an active member of the AFPS 2005, and

(d) the person is not entitled to payments under article 9 of the Scheme or the immediate payment of a pension or lump sum under -

(i) rule D.1 of the AFPS 2005 (retirement after reaching pension age),

(ii) rule D.5 of that Scheme (early payment of benefits: active members with permanent serious ill-health),

(iii) rule D.6 of that Scheme (early payment of benefits: active members with significant impairment of capacity for gainful employment), or

(iv) rule D.11 of that Scheme (option for members in serious ill-health to exchange whole pension for lump sum).

(2) The amount of the lump sum payable under this article is calculated by multiplying one eighth of the person's final relevant earnings by his calculation service (expressed in years and fractions of a year), except where paragraph (3) or (4) applies.

(3) If the amount calculated under paragraph (2) would be less than one-half of the person's final relevant earnings, that amount is payable instead.

(4) If the amount calculated under paragraph (2) would be more than twice the person's final relevant earnings, that amount is payable instead.

(5) This article is subject to rule D.8 of the AFPS 2005 (under which a person may ask for a review of his entitlement under rule D.6 of that Scheme and in some circumstances some of the amount paid under this article must be repaid)."

Appendix 2

Medical Evidence

A considerable volume of medical evidence has been submitted in relation to Mr G's case. It would not be practical, or helpful, to reproduce all of the material submitted. The various medical evidence has been reviewed but what follows is, of necessity, a summary of the main relevant submissions received. Medical evidence dated after the August 2021 IDRP decision has been set aside as it was not available to Veterans UK and does not pertain to Mr G's conditions around that time.

Extracts from Medical Board Record, 18 July 2014

"Principal conditions:

1. Hypertension: LCpl [G] was found to be hypertensive with BP of 180/120 a routine consultation for a mortgage application. He was started on Amlodipine the same day following discussion with the hospital and referred to the cardiology clinic…to exclude any secondary causes for his hypertension. He was found to have LV hypertrophy, otherwise investigations were normal, with no secondary cause having been found. His BP control has remained poor despite now being on quadruple therapy. When he was last seen on 16/01/2014 he was advised to keep a diary of his BP readings.

Current symptoms: BP diary shows morning levels to be around 139/88, at work 160/110 and at home later in the day the readings are usually between these two levels. He reports feeling tired with a chronic headache and sleep being disturbed by his heartbeat.

Current medication:

A…

C…

B…

B…

Ongoing rehab and treatment: Review 23/07/2014 at the cardiology clinic at…Hospital. If his BP remains high despite quadruple therapy, he may be considered for renal denervation.

2. Non Freezing Cold Injury: LCpl [G] presented to Primary Care in Camp Bastion on 16/12/2009 with painful hands, particularly his right index finger, after having been on stag for 4 hours the previous night…it took a week for the pan, numbness and tingling to his right index finger to settle. He subsequently· presented with the same symptoms following further exposure to the cold and wet in Sept 2010. He then described cold, painful and numb hands and feet. He was referred to INM and when seen on 10/1/2010 infrared thermography showed mild/moderate cold sensitisation to his right hand and feet but sparing his right index finger. He has been subsequently reviewed on 18/03/2011,

17/10/2011 and latterly 23/01/2013. His infrared thermography has remained unchanged - mild/moderate cold - sensitisation to his hand and feet.

…

Current medication: Nil

Current symptoms: Still getting some pain to his hands and feet when exposed to the cold. He reports having no particular symptoms for the past 10 months since being posted to… Ongoing rehab and treatment: He continues to use a daily foot spa, and. wearing cold weather clothing. He continues working in a thermally appropriate environment and at home has the heating on day and night all year.

…

Current employment/adaptations: Since Oct 2013 lCpl [G] has been seconded to … in a non-deployable office based role. This provides a thermally appropriate environment for him to work in. Due to his hypertension he has not been undertaking any strenuous activity. This causes him frustration as he was previously extremely fit and played football for his unit. He is currently unable to work in his CEG.

…

Individual's perspective: Although LCpl [G] wants to stay in the Army, he recognises his ability to progress his career is very limited. He reported that he had not been recommended for promotion at his last report. He has been advised previously to look at career opportunities outside the Army and plans to go to … College in Sept to gain further relevant GCSEs which will enable him to go to university…

He has received a compensation payment for his NFCI from AFCS.

Functional evaluation:

LCpl [G] is able to manage his day to day activities and indicates no limitation with walking.

…

Specific examination findings: His feet felt cold today despite it being the hottest day of the year. CR to his toes and fingers was-sluggish.

Prognosis on ongoing treatment: LCpi [G]'s hypertension remains uncontrolled and further treatment is planned. His NFCI remains unchanged despite having worked in a thermally appropriate environment for the past few years.

RECOMMENDATIONS OF THE MEDICAL BOARD

A grade of P7[6] MNO Perm is advised for his overall medical conditions as he is unable to perform the requirements of his CEG and is consistent with PAP 10 V3 Table 7. LCpl [G]

[6] Medically fit for duty with major employment limitations.

understands the implications of his grade and administrative discharge under the RECU process has been discussed…"

Summary and extracts from Hospital Transfer of Care (Discharge Summary), date of admission 23 August 2018

Diagnoses listed as:-

- Malignant Hypertension.
- Hypertensive nephrosclerosis.
- Pyelonephritis.

Procedures:

"VasCath insertion 25.09.2018 with XR to show that it is in-situ

XRay chest 20.09.2018: post NG tube insertion required for medications

MRI head 19.09.2018: Changes compatible with recent episode of hypertensive encephalopathy with additional note of small microhaemorrhages within the cerebellum.

Renal Biopsy 19.09.2018: Benign hypertensive nephrosclerosis / Malignant HT related nephropathy."

Clinical summary:

"[Mr G] was admitted on 23/08/2018 presenting with a one week history of on going headaches; he had taken paracetamol with no improvements. Additionally, he had haematuria, and vomiting. [Mr G] ceased taking his antihypertensive medication since 2015, because he was not able to tolerate them. On admission, he had no obvious abnormalities: no cough, no chest pain, no pedal oedema, and on auscultation, there were no basal crepitations.

He was stepped up to ITU and was there for a duration of 21 days. He was haemofiltrated during this time in ITU for 9 days. He has not had dialysis. Patient was sedated and intubated… ECG showed changes correlating with LVH[7]. Neurology has reviewed [Mr G], and they are happy with the current management, and there is no further input required from them.

He has been started on another antihypertensive during his admission: Moxonidine. [Mr G] also has pyelonephritis, which we are treating with co-amoxiclav… three times daily. [Mr G] had a Hepatitis B, Hepatitis C, and HIV '" screen during his stay, and [Mr G] is Hepatitis B positive; he has requested for a repeat of the Hepatitis B serology blood test, and at the time of writing this, we are waiting the results from the microbiology lab."

Addendum added, 29 November 2018:

[7] Left ventricular hypertrophy.

"[Mr G] was admitted with confusion due to malignant hypertension. He informed to the admitting team that he stopped taking tablets 2-3 years ago. Now he confirms that he stopped taking tablet in 2016. He had tablet issued with GP till 2016. He stopped getting prescription issued from GP once he stopped taking tablets.

Co-morbidities

Raynaud's Disease
Hypertension."

Extracts from Hospital Transfer of Care (Discharge Summary), date of admission 12 October 2018

"**Diagnoses** - non-cardiac chest pain

Clinical Summary
…
[Mr G] was seen in [Hospital] for chest pain. Today patient went to main dialysis unit to discuss transplant and dialysis options. When taken to unit became light-headed and reported chest pain…Never had similar thing before…Pain started gradually and became worse lasted 10 minutes and subsided after two puffs of GTN.

…

Bloods – creat 380, eGFR 16, top 34 and repeat 32

…

Reviewed by Dr Gannon – notes chest pain occurred while [Mr G] was emotionally stressed at the dialysis unit.

Good BP control.

Co-morbidities – Hypertension"

First MA's opinion, May 2019

"[Mr G] has asked for a review of his AFPS Tier 1 award. He was medically discharged on 21/7/15. The PCs were:

Hypertension

Non-freezing cold injury

You have carefully summarised the content of his appeal letter and accompanying medical evidence in Minute 4 and I shall not repeat this at length.

Essentially, he stopped taking his anti-hypertensive medications during 2015 and was admitted as an emergency with malignant hypertension and hypertensive encephalopathy on 23/8/18.

He had developed end stage renal failure secondary to poorly controlled hypertension and also pyelonephritis. The persistent high blood pressure has also caused left ventricular hypertrophy of the heart and some ischaemic changes on brain scan.

On 12/10/18 he was admitted to hospital with chest pain. This had come on while visiting the dialysis until to discuss future dialysis and possible transplantation. The pain was thought to have been precipitated by emotional stress.

[Mr G] has written that he is currently confined to his home and does not have the energy or strength to work. (His symptoms would be consistent with a diagnosis of end stage renal failure)…

I note the discharge letter dated 12/10/18 records an-eGFR of 16. An eGFR less than 10 would necessitate immediate dialysis arid this result confirms end stage renal failure.

He is also a carrier of Hepatitis Band this will require life-long monitoring. He has NFCI and the GP notes suggest a recent worsening of this condition. Recent hospital notes say he has Raynaud's Syndrome. Whether this is the correct diagnosis or there has been a misdiagnosis of the NFCI is uncertain.

Conclusions

- [Mr G] will not be fit to work in any capacity while he has end stage renal failure or while undergoing dialysis.
- If he undergoes successful kidney transplantation then he will regain his health although will require to be on life-long immunosuppressive therapy. It might take several years before he is offered a transplant. He is 38 years old and hopefully will be able to work in the future. His NFCI will limit the types of employment which will be available to him. I would therefore advise that a Tier 2 award is currently appropriate."

Dr Haider (Pain Management Consultant), letter to GP, 20 September 2019

Dr Haider said:-

- Mr G's main issue was neuropathic pain in both hands and feet following a cold injury while working in the army. This started around 2006 and had slowly worsened. In 2018, Mr G was in intensive care for about 30 days following left ventricular failure and CKD stage 5. He was a Hepatitis B carrier and also had

malignant hypertensive renal disease. Presently he took co-codamol and pregabalin, which helped only partly.

- He had had a detailed discussion with Mr G and had suggested a small increase in pregabalin over a period of time may help. Mr G was going to try to slowly increase this drug dose to see if it helped. Mr G understood that there may not be many options for his condition.

- He was discharging Mr G from the Pain Clinic with the above advice.

GP's letter, 11 September 2020

The GP said:-

- Mr G was currently being closely monitored due to kidney failure secondary to severe hypertension.

- He understood that Mr G had applied to study law and could only do this remotely because of his condition and regular specialist reviews.

- In his opinion, remote studying was a better option for Mr G in view of his serious kidney problem.

Dr Khawnekar (Consultant in Renal Medicine) to GP, 28 September 2020

Commenting on his telephone consultation with Mr G, Dr KhawneKar said:

"Today he was reasonably well at the time of review however he has been complaining of dizzy spells feeling tired mainly by the afternoon. He takes all his anti-hypertensives in the morning. He checks his blood pressure during these spells and records it in the range of 110-119 systolic which is very tightly controlled. He also complains of swelling of his left ankle and intermittent swelling of both ankles. He is on A…and D…and both are known to cause peripheral oedema although the unilateral oedema on the left leg needs to be looked into as unilateral oedema always has a local cause. I would be grateful if you could review him in your clinic to see anything further needs to be done. He is also complaining of boils on his legs intermittently. I am not sure whether he has been checked for diabetes but it would be prudent to do so…He is now doing a law degree online and is complaining of flickering of the eye so I wonder if it is related to this. I have suggested that he checks with the optometrist."

Second MA's opinion, 11 December 2020

As relevant the second MA said:

"I note at the time of the medical board his hypertension was uncontrolled despite medication. With regards to his NFCI this was described as mild-moderate cold sensitisation affecting his feet and right hand. The condition had remained stable over a period of years. The board states that he was able to manage his day to day activities and

there was no limitation on walking. He planned to go to college followed by university to do a Logistics Management course.

The main deterioration appears to have been due to his hypertension and subsequent kidney disease. He stopped medication leading to an emergency-admission to hospital and ITU stay for 30 days in 2018. As a result of his uncontrolled high blood pressure he was found to have an enlarged heart, end stage renal failure and encephalopathy. Kidney transplant and dialysis were to be discussed in 2018.

He is currently in receipt of a tier 2 AFPS award, see MA advice 14/05/2019... He advised us that his condition has got worse and requested an increase to a tier 3. His case has been reviewed recently by a MA in June & September 2020… the MA has requested to view the specialist clinic letters for the past 2 years from nephrology and gastroenterology. It was felt that more information was required on his renal disease, and whether he was planned to have a transplant. It was noted that whilst his kidney disease is a serious, his condition could be improved by a transplant if required.

There were no new letters from the nephrologist since correspondence from 2019. In February 2019 he was described as 'well' and blood pressure was well controlled. His renal function continues to improve and eGFR at the time was noted to be 26 ‘as per racial correction’. The consultant states that ‘he has made good progress although his kidney biopsy suggests he has significant scarring’. At follow-up in August 2019 again he was ‘well’ but his BP was ‘marginally’ high. ‘overall his progress from the CKD[8] point of view is satisfactory’.

His kidney function tests in September 2020 were available. These were abnormal as expected. However, his eGFR appears to have improved to some degree over time. I note the previous MA minute in May 2019 which documented eGFR as16. The latest results note eGFR is 27, however this is true for a Caucasian patient and must be multiplied by 1.159 if the patient is of African descent. I note [Mr G] is from Ghana. This would give an eGFR of 32.

Chronic Kidney disease is staged according to eGFR levels. A level of 32 is stage 3 (moderate) disease. A transplant or dialysis would not be considered until the eGFR falls below 15.

Letters were available covering his gastroenterology appointments, for which he attends due to being a Hepatitis B carrier. At his most recent review 14/09/2020 he was reviewed by telephone. He ‘feels generally well in himself’, no abdominal pain, itch, change in appetite or bowel motion and no weight loss. His liver function tests were normal and the viral load had reduced from 3.58 at his review December 2019 to 2.5 (log value). An MRI scan of his liver in February 2020 did not show any suspicious liver lesions. With regards to his renal disease there is a comment of ‘he has a past history of advanced

[8] Chronic kidney disease.

atherosclerotic renovascular disease and hypertensive neuropathy'. He is on 4 medications for his blood pressure.

From the information available I can see no evidence of any deterioration since the last tier review. The blood results show that although he continues to have chronic kidney disease things have improved to some degree from 2018 and appear to continue to do so on repeated blood tests. He would not be a candidate for dialysis or transplant with this improvement in his kidney function. He is a carrier of Hepatitis B which is unlikely to impact on his function. With regards to his NFCI this was described by the UNM[9] as mild-moderate and is unlikely to have deteriorated with time.

In his letter of 19/12/2018 [Mr G] advises that he is currently in university education, which was his plan on leaving service. It is unclear if he completed his course. His conditions would be unlikely to prevent him from doing so.

I advise that his conditions are unlikely to restrict his function to such severity that he would be permanently incapable of any full-time employment (tier 3), therefore the previous tier 2 remains appropriate."

Department of Health & Social Care, 21 February 2021

The letter is headed 'Important guidance for clinically extremely vulnerable people'. The letter pertaining to COVID-19 advises [Mr G] to shield until 31 March 2021.

GP records, 16 to 21 March 2021

Extract from 16 March 2021:

"pt reports not recieved [sic] exercises for shoulder…Resent exercises."

"pain in Rt shoulder blade-for the last few days, has numbness in Rt hand which is new no problems with power no FAST symptoms Plan: booked with physio for further assesment [sic] as has developed new symptoms in hands on the same side."

GP letter to Mr G, 13 May 2021

Letter invites Mr G to attend a free NHS Diabetes Prevention Programme.

Dr Eberhard (Renal Physician), letter to GP, 18 May 2021

Commenting on the latest telephone consultation with Mr G, Dr Eberhard said:

"[Mr G] tells me he is feeling well. He is not having any dizzy episodes. His blood pressure is quite variable. Today it was 148/93. Other times it has been lower. He has on-going issues with swelling of his inner ankles which may be exacerbated by Amlodipine and Doxazosin, both of which can cause peripheral edema. The patient has been suffering from back pain. He has been taking a painkiller for this. He is not sure which one. I have

[9] This appears to be a typo. The second MA appears to be referring to the Medical Board Record of 18 July 2014 which notes Mr G's referral to INM.

advised him not to take any nephrotoxic painkillers, particularly any non-steroidal anti-inflammatory medications such as Ibuprofen, Diclofenac/Noltaren or Naproxen may be toxic to his kidneys. I did talk to the patient about splitting his Doxazosin anti-hypertensive as previously he was getting dizzy spells when taking his 16mg once a day. However, he tells me that a trial of splitting his Doxazosin to 8mg led to headaches. and the patient felt more unwell on this. Overall, I am pleased to see his kidney function is stable. We will follow him up in 4 months' time hopefully with a face-to-face appointment depending on how the coronavirus epidemic is progressing. I am pleased to hear that he has had one of his COVID vaccinations and is due the second one shortly."

Third MA's opinion, July 2021

"The latest review of [Mr G's] hypertension and kidney disease is dated 18/5/21. This is a letter from a consultant renal physician and provides recent medical evidence. In the letter the renal consultant notes that [Mr G] is feeling well, has no dizzy episodes, has some peripheral oedema caused by his antihypertensive medication but his kidney function remains stable. At the time of this review, [Mr G's] eGFR was 25 (27 corrected) which shows an improved kidney function from the time of the tier 2 award (eGFR 16) and a stable kidney function since the last tier review in December 2020.

I have looked through the medical records since December 2020 and I note that [Mr G] was discharged from pain clinic on or around 16/9/19. In a GP consultation for shoulder pain dated 16/3/21 it was noted that [Mr G] was not on any painkillers. There is no recent evidence to show that [Mr G's] NFCI is causing any significant issues.

Mr Frimpong's NFCI does not appear to be causing any significant functional limitations and this is likely to remain stable or to improve further. [Mr G's] renal function has improved since the tier 2 award and is now stable. There may be deterioration in the future but the recent improvement in eGFR is a good prognostic indicator.

There is a likelihood of improvement in [Mr G's] NFCI. His renal function is likely to remain stable in the medium term.

As things are now, there is no reason why [Mr G's] hypertension, renal impairment or NFCI would prevent him from doing full time sedentary employment. I would advise that a tier 1 award would be appropriate now. There is certainly no evidence to support an increase in the tier 2 award."

Appendix 3

Dr Khan (Consultant Cardiologist and GP), 24 July 2015

"1.3 Summary of my conclusions

My report will demonstrate that [Mr G] has severe uncontrolled resistant hypertension with evidence of hypertensive cardiomyopathy as a result of this…His hypertension carries a high risk of serious life threatening complications that will reduce4 his predicted life expectancy considerably.

…

Issue 4: In your expert opinion, would the condition alone have been serious enough to result in the Claimant being considered for medical discharge/likely to have been medically discharged but for the NFCI and if so, when was that likely? Please explain your answer and refer to PULHEEMS guidance notes and JSP guidance?

4.19 In my opinion, the condition alone would have been serious enough to result in the Claimant being considered for medical discharge…

Issue 5: Will the Claimant's cardiovascular condition impact upon his ability to obtain civilian employment, i.e. are there any forms of employment he specifically cannot undertake, if so, when and to want extent. Please explain your answer.

4.20 Providing that [Mr G] does not sustain any complications from his severe Uncontrolled resistant hypertension, this should not impact upon his ability to obtain civilian employment for the most part.

(i) He will not however be able to undertake those jobs or roles that demand either significant physical effort (heavy lifting, labourer etc.) or those that require a defined degree of cardiovascular fitness and a particular license such as HGV driving (regulations set down by the DVLA) or becoming a pilot (CAA regulations).

(ii) On the other hand office-based jobs or those roles requiring only mild moderate physical effort would in my opinion be open to him.

(iii) Should [Mr G] at any time in the future sustain a complication from his severe hypertension, then this depending on the specific nature of the complication, this would potentially significantly alter his prospects for civilian employment. Thus for example a stroke would preclude most forms of employment."