PO-14216

Ombudsman's Determination

Applicant	Mr R
Scheme	Armed Forces Pension Scheme (**AFPS**)
Respondents	Veterans UK

Outcome

1. Mr R's complaint is upheld and to put matters right Veterans UK should review the decision not to pay Mr R's benefits early under article 3061(2).

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

Complaint summary

Complaint summary

3. Mr R has complained that his application for the early payment of his preserved benefits has not been properly considered.

Background information, including submissions from the parties

Background

4. Mr R served in the RAF until 1994. He was awarded a lump sum payment and is in receipt of the War Disability Pension. After leaving the RAF, Mr R worked for the Ministry of Defence until 2007, when his department was transferred to Electronic Data Systems. Mr R was a member of the Principal Civil Service Pension Scheme (**PCSPS**). His PCSPS benefits were paid early, on the grounds of ill health, in 2009.

5. Mr R applied for early payment of preserved pension (**EPPP**) in July 2011. He referred to two disabling conditions: lower back and knee pain, and anxiety/depressive disorder.

6. Provision for the payment of Mr R's preserved benefits is contained in Chapter 40 of the Queen's Regulations for the Royal Air Force. Article 3061(2) provides,

> "Preserved benefits will normally be payable at pension benefit age but may be paid earlier if the pensioner becomes permanently incapacitated through physical or mental infirmity from engaging in any regular full time employment.

> Early payment of entitlement shall commence from the date that a successful claim was submitted, unless the Secretary of State decides otherwise. Preserved pension benefits accrued by reference to service before 6 April 2006 shall be put into payment when the officer or airman reaches the age of 60 ..."

7. Mr R's application was declined and he appealed unsuccessfully against this decision. In July 2016, Veterans UK agreed to review their decision. This determination concerns their subsequent decision.

8. Veterans UK referred Mr R's case to one of their medical advisers who had not previously been involved in Mr R's case, Dr Gordon. In his report, dated 16 August 2016, Dr Gordon said he had examined the evidence in Mr R's case from the earliest dates. This evidence is summarised in an appendix to this Opinion. Amongst other things, Dr Gordon noted Mr R had retired in 2008 and was in receipt of a PCSPS pension. He noted this had been awarded on the grounds that Mr R was permanently incapable of carrying out his existing duties. He noted that Mr R had been diagnosed with a phobia of his workplace and the PCSPS medical adviser had been of the opinion that, even with successful treatment, he would not be able to return to that particular place of work. Dr Gordon referred to various letters from Mr R's GP, a welfare manager, a pain management consultant, and a clinical psychologist (see appendix). He noted that these letters were addressed to Mr R and opined they had been written in response to requests from him.

9. Dr Gordon noted,

> "[Mr R] has been variously diagnosed with mechanical back pain, knee pain, arthralgia and "mild nodal osteoarthritis affecting other joints". Clinical examination and radiological and serological investigation have failed to demonstrate significant pathology in [Mr R's] back or any other joint. In addition to his pain, mainly in his lumbar spine but with no radiculopathy or other neurological signs, he has significant disability, fear and avoidance of activity, anxiety and low mood and is increasingly socially isolated. In terms of attitude, at his consultation in August 2014 Dr Taylor, Pain specialist commented "[Mr R's] coping strategies appear quite passive. He is completely inactive and spends his days on the computer and goes out little"."

10. Dr Gordon went on to discuss back pain. He noted that, in most cases, the pain remits in a few weeks or months but in a proportion of cases, such as Mr R's, symptoms persist, activity declines and disability increases. He said the resultant chronic pain syndrome was described as a biopsychosocial disorder. Dr Gordon said best practice management of chronic low back pain was a holistic approach. He went on to describe what he meant by this:

> "Having discounted major pathology and undertaken any required physical, or specific mental health treatment, the approach is about coping with problems and attitudes and supports the patient in moving from passive recipient to a

> more active sharing of responsibility for his own progress.[1] The aim is to improve function, achieve better quality of life, reduced use of medication, and prevention of relapse of chronic symptoms. Physiotherapy involving hot and cold application, positioning, stretching exercises, traction, massage and ultrasound therapy and occupational therapy are important and for patients of working age, vocational rehabilitation and maintaining work or return to more suitable work, is particularly desirable. This is both because backs are intended to move and be active with as far as possible maintained activities of everyday living including paid work which provides much more than money but also company, social interaction, a sense of contribution and improved self-worth. Other treatment options might include spinal cord stimulation or intrathecal morphine pumps."

11. Dr Gordon said he accepted that, over the years, Mr R had had a range of treatment, including attendance at a pain management clinic. He said there was, however, "little evidence of a holistic ethos". He noted Mr R had been unable to fully engage with a back pain programme and that the precise details of this were unknown.

12. Dr Gordon noted Mr R had completed an EPPP form in October 2014 and had described his symptoms: limitations in mobility, unable to sit or stand for more than 10 minutes; unable to squat, bend or carry without pain or the risk of collapse; and difficulty dealing with people in noisy environments. He noted Dr Taylor had written to Mr R, in August 2014, expressing the view that, with his combination of problems and frequent flare-ups of lower back pain, the possibility of a return to any form of regular employment was unlikely. Dr Gordon noted that, in a letter to Mr R's GP at that time, Dr Taylor had noted Mr R was not distressed, had a reasonable range of lumbar spine movement (70% of normal with no tenderness), could straight leg raise to 70 degrees, and sensation, power and other reflexes were normal.

13. In his conclusions, Dr Gordon acknowledged that Mr R has chronic low back pain which is severe and disabling, together with other joint pain, anxiety and depression, fatigue, reduced levels of activity, and increased dependency. He said Mr R's management to date had focussed on a biomedical model where pain is accepted as a signal for tissue damage and there is a search for a structural cause. He suggested a trial of a holistic biopsychosocial approach and said there was little evidence of psychophysiological therapy to date. Dr Gordon said this included counselling, relaxation therapy, stress management, and biofeedback techniques. He suggested this treatment could reduce the frequency and severity of pain and referred to two studies carried out in 2011 and 2015. Dr Gordon advised that this form of treatment should be pursued and Mr R's application for EPPP reviewed on completion.

14. With regard to the weight which should be placed on the evidence from Mr R's own doctors, Dr Gordon said their role was to provide clinical information. He went on to say that the failure to support the patient's perspective risked compromising the

[1] Dr Gordon referred to two academic papers published in 2008 and 2014

doctor-patient relationship. He also said clinicians were rarely familiar with "the legislation of public compensation and occupational pension schemes" or with the need to give reasons for opinions. Dr Gordon said "Advice" should consider "not only their patient/the individual claimant but the wider context and the aim of consistent and equitable decisions across the scheme". He suggested Veterans UK should pay close attention to the clinical comments from treating clinicians but might place more weight on their own medical advisers on occasion; particularly in the case of patient solicited letters of support.

15. Veterans UK prepared a paper for a deciding officer (**DO**) to reconsider Mr R's case. They provided a copy of Dr Gordon's report and noted his recommendation that Mr R's application be rejected but reviewed once the suggested form of treatment had been completed. Veterans UK referred to Dr Gordon's comments about best practice management for Mr R's condition and that he had found little evidence of this type of treatment being undertaken. They referred to Dr Taylor's comment that Mr R had a reasonable range of lumbar spine movement (about 70% of normal with no tenderness). Veterans UK said they agreed with Dr Gordon that Mr R's application should be rejected until a trial of the suggested treatment had been completed. They said they would then invite Mr R to provide updated medical information and they would review his application.

16. The DO noted Dr Gordon's comment that clinical examination, and radiological and serological investigation had failed to demonstrate significant pathology in Mr R's back or any other joint. She also noted Dr Gordon's comment that Mr R had significant disability, fear and avoidance of activity, anxiety and low mood and was increasingly socially isolated. She then referred to Dr Taylor's comments that Mr R's coping strategies were passive, he was inactive and spent his day on the computer, and he went out little. The DO concluded,

> "The MA has given detailed consideration to the fact that [Mr R's] management has been focused on a 'biomedical model' where his pain is accepted as a signal for tissue damage and there is search for structural cause with symptomatic treatment'. I note reference to 'best practice' models for such pain treatment, which includes a holistic biopsychological approach. The MA suggests that [Mr R] supports a trial of this approach as being worthwhile first excluding cause of physical pain. The MA goes on to confirm that with these treatment modalities, the frequency and severity of chronic pain may be reduced. This clearly supports the conclusion and your recommendation … that [Mr R's] application should be rejected until trial of the suggested treatment is concluded.
>
> I also note consideration given to the decision making process within Veterans UK. Due cognisance has been given to the 'doctor/patient support required. Of note is that clinicians are rarely familiar with legislation of public compensation and occupational pension schemes, in particular of the need to give 'reasons' for opinions'. The process within Veterans UK gives consideration to the wider

> context, whilst considering each case on its own merit. I therefore support the MA conclusion that weighting is therefore not just the patient and that we correctly, for consistency and equitability may place greater significance on DBS med adviser's option [*sic*] over that of patient clinicians, and where patient has solicited letters of support."

17. Mr R wrote to Veterans UK, on 30 August 2016, saying he believed he had already provided evidence that he had had at least some of the treatment mentioned by Dr Gordon. He said, if any other treatment was either available or suitable, his doctors would have provided it. Mr R said he had undergone CBT but had to stop because of his anxiety and depression. He said he had also had counselling and been taught anti-stress techniques. Mr R said he had all the physiotherapy he could get.

Mr R's Submission

18. Mr R says Veterans UK have referred to treatments without checking whether he has already had them or whether they would apply in his case. He says he has had all available treatment through the NHS. In particular, he says he has already had counselling, physiotherapy, and cognitive behavioural therapy (**CBT**). He has explained that the latter was not completed because of difficulties with his pain, and anxiety and depression. He says Veterans UK's medical adviser has referred to treatment which he has not been offered and he questions whether this is considered suitable treatment by the NHS. He is of the view that the medical adviser failed to explain why he thought Mr R would be able to return to full time work when he has been unable to work since 2008.

19. Mr R says Veterans UK previously gave weight to the fact that his GP did not say he would never work again. He says they now give no weight to the fact that his GP has now said he will not be able to work again.

20. Mr R points out that he is already in receipt of an ill health retirement pension. He acknowledges that this is under a different pension scheme but says the scheme has the same normal retirement age and refers to never being able to work again. Mr R suggests that the difference is that he was seen by the medical adviser to the other scheme; whereas he has not been seen by Veterans UK's medical adviser. He suggests that they doubt the severity of his condition despite the medical reports he has provided, the level of war pension he was awarded, his other ill health retirement pension, and the fact that he has a blue badge.

21. Mr R has explained that Veterans UK's decision has placed great financial strain on his family. In his view, Veterans UK's approach warrants compensation for distress and inconvenience.

Adjudicator's Opinion

22. Mr R's complaint was considered by one of our Adjudicators who concluded that further action was required by Veterans UK. The Adjudicator's findings are summarised briefly below:

- The key question for Veterans UK and Dr Gordon was whether Mr R was permanently incapacitated from engaging in any regular full time employment. It is for Veterans UK to decide whether or not Mr R meets this eligibility criterion.

- It was clear that Veterans UK's decision was heavily influenced by the advice they received from Dr Gordon. It was appropriate, therefore, to consider Dr Gordon's report in detail.

- Dr Gordon's recommendation was that Mr R's application be rejected until he had tried the suggested treatment. In view of this, it was surprising that he did not consider it appropriate to ascertain in more detail what treatment Mr R had already tried; if he did not already have that information. Comparing Dr Gordon's outline of suggested treatment with the information from his own doctors suggests that Mr R had already tried many of the options. It was not clear what exactly Dr Gordon had in mind as additional treatment Mr R could try.

- Some of Dr Gordon's suggested options were not recommended by the NHS or NICE because of a lack of evidence as to their efficacy. They were, therefore, unlikely to be available to Mr R. Other suggestions appeared to be treatments of last resort and unlikely to be offered to Mr R or expected to enable someone to undertake regular full time employment.

- Dr Gordon and the DO had made the point that the doctors treating an applicant for EPPP were unlikely to be familiar with the relevant scheme rules. It would not, however, be too difficult to provide the doctors with the necessary information. There were repeated references to Mr R having solicited the reports from his own doctors. It was unlikely that Dr Gordon or the DO thought that Mr R's doctors would give anything other than a truthful response if asked whether they thought Mr R was capable of regular full time employment. They may have meant that it would be tempting to give a patient the answer the doctor thought he wanted. The same, of course, could be said of a pension scheme's doctors. Given that pension scheme members are generally encouraged to provide evidence to support an application for payment of benefits, it would be odd if that evidence were then to be discounted simply because it had been requested by the member.

- Whilst Mr R's doctors may not have been familiar with the AFPS rules, they were specialists in his condition and the appropriate treatment to be offered. Where the treatment options suggested by their medical adviser differ

markedly from that which the applicant has been offered by his treating physicians, it would be prudent for Veterans UK to be very clear as to why this is. If there was treatment available for Mr R's condition which would, more likely than not, enable him to undertake regular full time employment at some time before his normal retirement age, then he would not fulfil the eligibility criterion under article 3061(2). However, it cannot simply be a case of identifying any treatment options which have yet to be tried; the treatment should be within the range of usual options for Mr R's condition. His treating physicians are well placed to provide this information for Veterans UK; regardless of whether or not they are familiar with article 3061(2).

- It was open to Veterans UK to prefer the advice they receive from their own medical advisers. However, they should not accept that advice blindly. They are not medical professionals themselves and can only review the medical advice from a lay perspective. The same applies for the Ombudsman and his staff. The questions Veterans UK might be expected to ask of their medical advisers are only those which a reasonably informed layperson might ask.

- The evidence did not support a finding that Veterans UK had reviewed Mr R's application in an appropriate manner.

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

Ombudsman's decision

24. Mr R was happy to accept the recommendation that his case be reviewed by Veterans UK, which they were quite willing to action. However, he felt that an award for non-financial injustice was warranted.

25. This is the second complaint Mr R has brought to the Pensions Ombudsman concerning his application for early payment of his benefits on the grounds of ill health. His previous complaint was dealt with by way of an opinion from an Adjudicator to which both parties agreed. The redress recommended previously included a payment of £500 for distress and inconvenience. I have taken this into account when considering Mr R's current claim.

26. The guidance published on our website explains that not all maladministration inevitably leads to non-financial injustice and that, in any event, if the non-financial injustice is not significant, no award may be made. The particular circumstances of each case are considered. Whilst I acknowledge that this is the second complaint Mr R had had to make in relation to his application for payment of his benefits, I also note that Veterans UK dealt with the review of his case promptly and courteously. In the circumstances, I do not find that a further payment for non-financial injustice is warranted.

27. Therefore, I uphold Mr R's complaint.

Directions

28. Veterans UK shall review the decision not to pay Mr R's benefits early under article 3061(2). Before doing so, they should clarify what treatment options are usually offered for Mr R's condition and which of these he has yet to try. If there are treatment options which Mr R has yet to try, Veterans UK should obtain an opinion as to its likely efficacy. It would be advisable for Veterans UK to obtain this information from a specialist in Mr R's condition; either someone of their choice or one of his treating physicians.

29. The review shall be initiated within 14 days of this determination. Veterans UK shall provide Mr R with a decision within a further 21 days of receipt of the additional medical advice.

Anthony Arter

Pensions Ombudsman
7 December 2016

Appendix

Medical and other evidence

Dr Wijeweera (clinical fellow in rheumatology), 7 August 2013

30. In a letter to Mr R's GP, Dr Wijeweera said Mr R had had chronic mechanical back pain for the last 20 years. He said Mr R also had bilateral hip and shoulder pain, together with joint pain in his hands which had got worse over the last year. Dr Wijeweera noted Mr R had been medically retired due to his chronic back pain and was "helping his partner who is working as a child minder".

31. Dr Wijeweera noted the results of his examination of Mr R, saying there had been no tenderness over certain joints and no synovitis in any joints. He noted Mr R's left knee had been painful but he had a full range of movement. He thought Mr R's pain was likely to be mechanical, rather than an inflammatory condition, but said he had planned some investigations.

Dr King (consultant rheumatologist), 20 September 2013

32. In a letter to Mr R's GP, Dr King set out the results of recent blood tests. He said Mr R showed signs of mild nodal osteoarthritis. He said he was checking other blood test results but expected them to be normal. He mentioned x-ray and ultrasound results had been normal which he thought pointed away from inflammatory arthritis. Dr King said he had not arranged to see Mr R routinely.

Welfare Manager, 3 October 2013

33. In his covering letter with Mr R's application form, the Welfare Manager referred to a development in Mr R's health, in that there had been a recent diagnosis of osteoarthritis in both hips and the fingers of both hands. He said the diagnosis had been made by Dr King and Mr R had given his consent for Veterans UK to obtain his case notes. The Welfare Manager said he had visited Mr R on 1 October 2013 and was offering his comments based on 12 years as a Disability Employment Adviser (**DEA**).

34. The Welfare Manager said Mr R had been "noticeably tense" during their meeting. He said Mr R had had repeated episodes of chest pain and had had to change his seating position on numerous occasions because of pain. He said Mr R's wife had been asked to fetch documents from upstairs because Mr R was unable to manage the stairs safely in reasonable time. The Welfare Manager commented that it was an average day for Mr R but it had been clear to him that he was in a considerable amount of discomfort.

35. The Welfare Manager said he had discussed a return to work with Mr R. He expressed the view that Mr R would not be able to return to full-time work. He said, as a DEA, he would have recommended a period of employment rehabilitation, which was aimed at slowly introducing someone back into the working environment under

fully supported conditions. He explained that the process was often interrupted by relapses. The Welfare Manager said, in his opinion, Mr R would find such rehabilitation difficult and he could not see him moving on from there to part-time open employment. He also mentioned that the opportunities for supported employment were much reduced following the closure of the Remploy programme.

Dr Sterrick (MA), 6 December 2013

36. Dr Sterrick referred to reports dating from 2007-2009 and to the letter from the Welfare Manager. He noted that Mr R's GP now supported his application and Dr Wijeweera's letter confirmed chronic mechanical back pain, hip and shoulder pain, and worsening hand joint pain. He noted the test results referred to Dr King's letter and the conclusion that Mr R was probably suffering from osteoarthritis. Dr Sterrick said the evidence before him did not include any pain clinic input. He said it would be useful to know details of any pain clinic input and whether further specialist treatment was planned.

Dr Sissons (MA), 16 January 2014

37. Dr Sissons referred to Dr Wijeweera's letter. She said it was thought that Mr R had mild osteoarthritis. She went on to say,

> "Investigations have been normal and no specific additional treatment is indicated. [Mr R] has pain in his joints and pain and stiffness in his back. The functional effects of his back pain and mild osteoarthritis should not prevent his ability to work full time in some capacity.
>
> There does not appear to have been any significant change in [Mr R's] mental health since the last consideration of EPPP.
>
> The GP advice is noted.
>
> Taking into account the recent rheumatology findings and investigations and the previous evidence in this case, [Mr R] at the age of just 46 years is not in my view permanently incapable of partaking in full time employment due to ill health."

Mr R's GP, 4 February 2014

38. The GP said he could confirm that Mr R suffered from chronic and enduring mechanical back pain, which had been present for many years and was probably caused by repetitive stress and strain to the back. He said Mr R also suffered from secondary reactive depression and sleep disturbance. He listed the medication Mr R was taking and concluded,

> "I consider him completely incapable of work due to the pain and stiffness of his joints confirmed on rheumatological examination. The Rheumatologist considers his condition to be long standing and enduring, having been present for many decades."

Welfare Manager, 12 February 2014

39. The Welfare Manager referred to comments by Mr R that it was rare for a GP to offer a strong opinion and said he agreed. He said he could not recommend a return to full-time work for Mr R. He referred to the restrictions on Mr R's mobility resulting from his back and knee conditions, and to the effect of his high level of pain on his ability to concentrate. He said Mr R's personality was such that he would not wish to perform at less than his best and this would raise his levels of stress, which increased his pain levels and decreased his motivation. The Welfare Manager referred to Mr R's manual dexterity having become affected by osteoarthritis in his hands. He said Mr R's physical conditions were degenerative in nature which reduced his chances of achieving a worthwhile work related outcome as time went on.

Dr McLaren (MA), 13 March 2014

40. Dr McLaren said he had reviewed the letter from Mr R's GP dated 4 February 2014, the letter from Dr King dated 20 September 2013, and the Welfare Manager's second letter. He said,

> "In summary I do not feel that this evidence changes the previous decision to refuse EPPP as they demonstrate nothing to support a pathological cause for the pain.
>
> It may well be that his main problems are psychological but this does not of course mean that he does not regard himself as disabled.
>
> Nevertheless non-demonstration of pathological changes makes it very difficult to give a prognosis that the condition is permanent and I do not feel the evidence presented justifies coming to the conclusion that his disability is permanent and would therefore recommend continued refusal of EPPP."

Mr R's GP, 21 March 2014

41. In an open letter, Mr R's GP said he had seen Mr R on a number of occasions. He said Mr R had chronic back pain, for which he had recently referred him to a pain clinic. He said Mr R's back pain had been present for a number of years and, whilst he expected it to improve, he thought it would have a lifelong effect on Mr R's ability to work. The GP said,

> "[Mr R] is extremely unlikely to be able to be employed on a full time basis. He needs to attenuate his work to accommodate his chronic pain and he has fluctuations in his condition which need accounting for.
>
> In addition to chronic back pain [Mr R] has anxiety and depression. This has persisted for a number of years and is intimately related to his pain and the limitations this places on his life. I think it is likely that this will be an ongoing issue affecting the hours he can reasonably be expected to work."

Dr Taylor (consultant in pain management), 29 August 2014

42. In a letter to Mr R's GP, Dr Taylor noted Mr R had been seen by a colleague at the pain clinic in 2009. He noted Mr R's symptoms were little changed. Dr Taylor listed the treatment provided for Mr R in 2009/10. This included hydrotherapy, acupuncture, a course of treatment with the pain clinic psychologist, a review by an ESP physiotherapist and referral to a back pain rehabilitation programme. He noted Mr R had made little progress. He noted Mr R continued to suffer chronic low back pain with flare-ups about twice a month. He also noted Mr R had no sciatica, cauda equina or new red flag symptoms. Dr Taylor said Mr R occasionally had pain everywhere but did not appear to have fibromyalgia. He noted Mr R suffered from generalised anxiety disorder and depression and referred to a report from a Dr Roberts in 2008. Dr Taylor remarked Mr R's coping strategies appeared to be quite passive. He set out the results of his examination of Mr R and (amongst other things) mentioned he had a good range of lumbar spine movement with no tenderness. Dr Taylor said he thought Mr R's medication was optimal. He was uncertain what the pain clinic could offer Mr R but said he had referred him for review by their psychology team, "possibly for one of the new group therapies or the Pain Management Programme".

43. In a letter to Mr R, Dr Taylor said, having referred to the treatment undertaken in 2009,

> "Unfortunately, you made little progress with this extended course of treatments and you continued to have chronic low back pain. In addition, you have a long-term mental health problem of generalised anxiety disorder and depression with ongoing treatment from your GP. With this combination of problems and the frequent flare-ups of low back pain make, in my view, the possibility of you ever returning to any form of regular employment very unlikely i.e. you are likely to remain incapable of undertaking full time employment during the period up to the age of 60 and I would support your application for early payment of Armed Forces Pension."

Dr Braidwood (SMA), 26 September 2014

44. Dr Braidwood said she had reviewed all the notes relating to Mr R's application for EPPP in 2008 and his current application. She noted Mr R was 13 years away from his normal retirement age and had last worked in 2008. She referred to Dr Wijeweera's letter and noted Mr R had been medically retired but was helping his partner, who worked as a child minder. She noted recent rheumatology reports had ruled out an autoimmune or inflammatory arthritis and had diagnosed mild nodal osteoarthritis. Dr Braidwood said Mr R's backache had been present for over 20 years and had not led to medical retirement from the RAF. She noted Mr R complained of pain in other joints and also of stress, depression and anxiety. She said his GP summarised his active medical problems in 2013 as polyarthritis and low back pain. She said reference to mental health problems was dated 2008 and Mr R's GP had said, in October 2013, that his mental health was not impaired. Dr Braidwood

noted Mr R's medication was predominantly for pain control. She referred to Dr Taylor's letter and went on to say,

> "The pain specialist then gives his opinion that because of the lack of progress and "flare-ups" of back pain "the possibility of ever returning to any form of regular employment is very unlikely". It is not clear that the pain specialist knew [Mr R] when he attended in 2009 and the session on 29 August 2013 [*sic*] was clearly a one off review. There is no information as to what evidence was before the doctor at that visit beyond [Mr R's] given history.
>
> The test for EPPP is the SoS after consultation with the Scheme med adviser should be of the view that the member has suffered permanent breakdown of health involving incapacity for any full time employment until pension age. In this case 60 years.
>
> In Dec 2013 and again in Jan 2014 [Mr R] himself wrote to pensions confirming that all treatments ie psychiatry: orthopaedics: pain clinic were completed and had been unsuccessful. He ends the letter received on 6 Jan 2014 "My doctor has confirmed I am not expected to work again ever".
>
> Of the evidence on file provided by specialists around 2008/9 application I note especially the report of Dr A St A Roberts [see below]. [Mr R] has no life threatening/terminal disorders. I agree with Dr Roberts that his conditions are interlinked and that worsening of one leads to worsening of the others. Pain and mood are inextricably linked. [Mr R] is a young man and effective evidence based treatments and coherent approaches are available for his disorders. He however has strongly held beliefs and appear[s] to exhibit depressive rumination and has now withdrawn from any active interventions.
>
> With adequate pain relief optimisation, depression and anxiety treatment and targeted cognitive behaviour therapy [Mr R's] disability and level of function would be expected to improve significantly (that is also the view of Dr Roberts). Current best practice treatment would be expected to make a difference in six – nine months. In the context of EPPP it is also important to note that in the time interval between now and [Mr R's] 60th birthday even more effective approaches might well become available. We need also in the EPPP context to differentiate "capacity" ie ability to do something and "performance". Performance involves capacity, and ability but crucially also includes will, effort and determination.
>
> On overall evidence and with 13 years until pension age I am unable at this date to recommend EPPP."

Dr Braidwood, 14 October 2014

45. Having been asked to review her advice, Dr Braidwood said,

> "The further info includes some information already before us eg the cons rheumatologist report (Dr King dated 20 Sept 2013) excluding SLE or any other inflammatory arthritis. It is also confirmed that Dr Taylor had not seen [Mr R] on his previous referral (2008) to the Pain Clinic.
>
> The letter to the GP from Dr Taylor dated 29 August 2014 confirms that back pain flare-ups occur for no reason and are associated with muscle spasm. Dr Taylor is also of the view that FMS (fibromyalgia syndrome) is not present.
>
> Importantly Dr Taylor confirms he does not have cauda equine [*sic*], sciatica or red flag signs. Examination is reasonably normal with 70% function.
>
> Dr Taylor as you know also wrote to [Mr R] on the same day giving his opinion that it was very unlikely that he would ever return to any form of regular employment. I made reference to that report in my previous [response].
>
> I also note the remark "[Mr R's] coping strategies appear to be quite passive and he is completely inactive and spends his day on the computer and goes out little".
>
> The coping strategies eg CBT associated with Pain Clinics are not designed to eliminate pain but to help patients understand and self manage so that they can make use of whatever functional capacity is available to them.
>
> From the overall evidence, the nature of the problem, the recent examination report and documented physical functional limitations, I am not able to recommend that [Mr R] meets the EPPP criteria."

Dr St Aubin Roberts (consultant psychiatrist/rehabilitation psychotherapist), 5 March 2009

46. Dr St Aubin Roberts' report was prepared at the request of medical advisers to EDS in connection with the termination of Mr R's employment. It is a detailed 27 page report. Dr St Aubin Roberts included a summary of her conclusions in her report which is provided here.

> "It is my opinion that [Mr R] is currently disabled by the combination of chronic back pain, and anxiety disorder of moderate severity, and a depressive disorder of moderate severity. These factors interact. He has a particular thinking style, rumination, with behavioural features of repeat checking, which leads to his not being able to stop thinking about his perceived victimisation and the outcome of a tribunal and pension application. This thinking style, in my opinion, is maintaining his mixed depressive and anxiety state despite psychopharmacological treatment. He is, in my opinion, currently too disabled to work. It is my opinion that [Mr R's] disability is unlikely to improve at all until

> resolution of all work-related issues. Post-resolution of these issues, I would estimate that he could regain 30-60% of his prior functioning, particularly if he accesses some of the treatments I recommend. Even with this level of improvement, my opinion is that he would not ever be able to do his prior job again, because of his fixed beliefs about having been victimised. Even with an improved level of functioning, he would remain liable to relapse. He is likely to only feel capable of a work which is less challenging than his prior employment. It is therefore my opinion that his earning capacity in the future is likely to remain limited by his combined physical and psychological disability."

47. Dr St Aubin Roberts noted Mr R was taking an antidepressant but felt that it should be reviewed in favour of one which targeted his depressive rumination and tendency towards compulsive behaviour. She agreed that he was unlikely to benefit from counselling but recommended he receive treatment from a cognitive behaviour therapist. Dr St Aubin Roberts also recommended Mr R be referred to a chronic pain clinic. In a section entitled "Prognosis with further treatment", Dr St Aubin Roberts expressed the view that Mr R would be capable of a rehabilitation programme "to enable him to return to some form of meaningful paid employment in the future". She described this as starting with voluntary work, progressing to low-level part-time paid employment or self-employment, and finally a higher level of paid employment. She noted he was vulnerable to relapse of both chronic pain and depression.

Dr Clarke (clinical psychologist), 29 October 2014

48. In a letter to Dr Taylor, Dr Clarke said Mr R presented with widespread pain which had impacted on his quality of life. She noted he had been referred to the local pain management centre in 2010 and had undertaken some individual psychotherapy work. Dr Clarke said Mr R had reported that none of the interventions he had tried had proved particularly effective. She noted his records indicated Mr R experienced high levels of anxiety and depression, and he was currently taking antidepressants. Dr Clarke said she had discussed a variety of possible options (but did not say what these were) and Mr R had reported use of mindfulness exercises. She concluded the most appropriate intervention would be for Mr R to attend an ACT (Acceptance and Commitment Therapy) group.

Mr R's GP, 4 November 2014

49. In an open letter, Mr R's GP said,

> "I … confirm that on the 24th October 2013 I made a declaration that the above named patient is permanently (i.e. until the age of 60) in capable [sic] of undertaking <u>any</u> form of suitable full-time employment (in line with skills and trade for which they might reasonably re-train and, not taking account of local economic factors)."

Dr Clarke, 13 November 2014

50. In a letter to Mr R, Dr Clarke said,

> "… I am writing to clarify my opinion in relation to your potential to return to work. It has been documented by Dr Mark Taylor, Consultant in Pain Management, that you have received an extended course of treatment and have continued to experience chronic low back pain. I am in agreement with Dr Taylor's assessment that given the complexity of your ongoing pain, your experience of anxiety and depression, and your previous work related difficulties it is unlikely that you will return to any form of regular ongoing employment."

Mr R's GP, 19 March 2015

51. In response to Veterans UK's request for information, Mr R's GP said Mr R had chronic mechanical back and knee pain for which he took medication. He provided clarification for his entries in Mr R's application form and copies of letters from Mr R's local pain clinic. In particular, he said Mr R did have some reactionary depression. He also explained that he had not seen Mr R for three years, but he had had medical consultations in that time and provided details.

Dr Morris (MA), 14 April 2015

52. Dr Morris referred to Mr R's GP's clarification and to Dr Clarke's letter of 29 October 2014. He noted Dr Clarke had discussed a variety of treatment options and had concluded, if Mr R continued to use mindfulness exercises, it would be appropriate for him to attend an ACT group.

53. Dr Morris said any medical evidence supplied by Mr R had been considered. He said his only concern was a reference to Mr R having been referred to a military mental health treatment programme for which no further evidence had been provided. Dr Morris noted Dr Clarke's comment that it was unlikely that Mr R would return to any form of regular ongoing employment. He said she had not said that Mr R's disability was permanent. He commented that Mr R's pain might be difficult to manage, but treatment was still being considered. Dr Morris noted that this letter would not have been available to the previous MAs, but said he did not think it would have made any difference to their assessment.