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31 July 2023

Dear Miss Cartwright KC,

Thank you for your Regulation 28: Report to Prevent Future Deaths dated 05 June 2023 which detailed concerns identified during the inquest into the very sad death of Army veteran Mr Jonathan 'Jonny' Cole. I am grateful to you for your very thorough investigation.

The inquest was informed of the significant changes which have taken place over the last decade in the areas of mental health support for military personnel, transition to civilian life and assistance to veterans. I would like to focus briefly on more recent developments in each of these three areas which address the important issues you have raised.

Last year saw the publication of the 'Defence People Health and Wellbeing Strategy 2022-2027'[1] with the objective to create, promote and maintain the conditions for Defence People to live healthy lifestyles in healthy environments, reducing injury, illness and suicide as far as possible. Aligned to this effort, the first ever Armed Forces Suicide Prevention Strategy and Action Plan was published in April this year[2], detailing the strategic framework within which Defence will take further action to reduce suicide and better support those affected by it. In October 2021 the mandatory Annual Mental Fitness Brief was released, adding to the 'through life' mental resilience and stress management training available to personnel. The brief covers the themes of mental health, wellbeing and resilience and details where personnel can seek appropriate help. In 2019 we implemented a holistic transition policy, and this has recently been

[1] https://www.gov.uk/government/publications/defence-people-health-and-wellbeing-strategy-2022-to-2027
[2] https://www.gov.uk/government/publications/armed-forces-suicide-prevention-strategy-and-action-plan

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updated[3]. The policy introduced a streamlined referral process to assist service personnel leaving the military, and their immediate families, in accessing the support required.

The Office for Veterans' Affairs (OVA) works across government and with private sector organisations, charities and other public sector organisations to support and deliver services to veterans. Its 'Veterans' Strategy Action Plan'[4] sets out commitments the UK Government will deliver to support the objective of making the UK the best place in the world to be a veteran. The OVA has also worked closely with the Department of Health & Social Care and NHS England on the development and promotion of Op Courage, which was launched by the latter in 2021 to provide a broad range of specialist mental health and wellbeing care and support for service leavers, reservists, veterans and their families.

This year the MOD and OVA jointly commissioned an Independent Review of UK Government welfare services for veterans[5]. The review investigated the role, scope and breadth of UK Government welfare provision for veterans, including by the MOD under the Veterans UK banner. The report, published earlier this month, has identified several recommendations to improve welfare provision for veterans across a variety of channels. The recommendations are being closely considered and a formal response is to be published later this year.

I have provided below further details in response to the Matters of Concern raised in your report. I hope that this response will illustrate the determination held across Defence to provide the very best support to our people whilst in service and as they transition into civilian life.

Our thoughts remain with Mr Cole's family and friends.

Yours sincerely,

THE RT HON BEN WALLACE MP

[3] https://www.gov.uk/guidance/help-and-support-for-service-leavers-and-their-families
[4] https://www.gov.uk/government/publications/veterans-strategy-action-plan-2022-to-2024
[5] https://www.gov.uk/government/publications/the-independent-review-of-uk-government-welfare-services-for-veterans

Matter of Concern 1 - I have a concern as to the number and availability of psychiatrists and psychologists within the Ministry of Defence and accessible to serving personnel. This concern extends to ensuring a soldier receives access to appropriate treatment including diagnosis. Diagnosis is also important as under the Armed Forces Compensation Scheme, mental disorders must be diagnosed by a relevant accredited medical specialist, namely, a medical practitioner whose name is included in the specialist register kept and published by the General Medical Council as required by section 34D of the Medical Act 1983.

The Defence Medical Services' (DMS) mental health workforce position reflects the national and international shortage of healthcare workers that has worsened since the covid pandemic.

The current Defence workforce position for psychiatrists and psychologists is summarised in the table below. As some positions involve job shares and part time working, figures are to one decimal place, representing the number of full-time equivalent (FTE) staff.

1 in 8 (13.2%) of UK Armed Forces personnel were seen in Military healthcare for a mental health reason in 2022/23. This presents an increase compared to previous years (2021/22 = 12.5%, 2020/21 = 10.5%). 2.2% of UK Armed forces personnel were seen by a specialist mental health clinician in 2022/23, which remains consistent with previous trends.[7]

[6] Civilian In Lieu of Military. Where a military postholder is deployed or otherwise unavailable for a significant period, a suitably qualified civilian can be posted into that position to ensure continued patient care until military personnel are able to re-fill the role

[7] 20230629_MH Annual Report_O (publishing.service.gov.uk)

This picture presents a challenge to Defence. In response, the DMS has instituted a number of projects under its transformation portfolio that aim to improve the employment offer, maximise retention and ensure the workforce is efficiently used.

To improve recruitment outcomes, efforts are focussed on expanding the approach to advertising beyond the use of the NHS Jobs Platform, delivering bespoke adverts to intelligently target Mental Health professionals, including psychiatrists and psychologists. Complimenting the findings within the Haythornthwaite review[8], this relates to wider work in the recruitment attraction space on better communication of the total reward offer, maximising advertising opportunities and strengthening the Employee Value Proposition (EVP) which can improve both attraction and retention.

The Defence Health Care Recovery Group (DHRG) is a new organisation, working to HQ Defence Primary Healthcare (DPHC)[9], which will provide direct oversight and integration of Mental Healthcare (MH), Occupational Health (OH) and Rehabilitation delivery. The HQ element of DHRG reached Initial Operating Capability in Oct 2022, with a projected Full Operating Capability in Mar 2024. DHRG's role is to transform extant Mental Health Delivery Services to ensure:

a. Improved timelines for patient recovery
b. Improved patient care
c. Increased workforce satisfaction
d. Reduction in onward referrals to intermediate care
e. Improved patient satisfaction of care
f. Improved patient safety and governance

Establishment of the DHRG is an integral part of the wider Healthcare Improvement Programme (HIP) and aims to move 'referred to' services in DPHC[10] away from regional management towards a nationally managed, locally delivered model. This change will make better use of capacity and deliver standardisation of care, maximising the use of remote consultations and reducing variability in waiting times. Subordination of the Mental Health Services workforce to DHRG has already enabled full oversight of extant resources, gaps and clinical capability and therefore the ability to prioritise effort.

In conjunction with the activity above, a DMS Mental Health Service Improvement Project (MHIP) commenced in May 23 and is projected to be completed by Dec 24. It will be led by Commander DHRG and is designed to achieve the following:

a. Transform Mental Health delivery to ensure patient outcomes and responsiveness
b. Design and deliver a new Mental Health care pathway (pilot launched May 23)
c. Improve both patient and workforce access to services to enhance delivery and satisfaction

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[8] Agency and agility: Incentivising people in a new era (publishing.service.gov.uk)

[9] Headquarters Defence Medical Services is the functional lead organisation for all healthcare in Defence. The HQ DMS is led by a 3* Director General. The subordinate Defence Primary Healthcare is a 1* delivery organisation within the DMS. All non-Operational Primary Medical Care, Dental Care, Rehabilitation, Occupational Health and Mental Health is delivered by DPHC

[10] Mental Healthcare (MH), Regional Rehabilitation (RRU) and Occupational Health (OH) services

d. Standardise business processes and integrate near real time data to improve responsiveness
e. Develop a Caseload and Workforce Management Tool
f. Improve workforce agility and resilience in delivery of care

Fundamentally the establishment of the DHRG and the associated MHIP will assist DMS to optimise its use of available mental health workforce, improving access, end-user experience and staff workloads.

The final body of work of relevance to this concern is the Unified Career Management (Medical) (UCM (Med)) which has been introduced within Defence. All DMS mental health personnel were moved to this model on 01 Jul 23. This system enables DMS, through Strategic Command, to career manage the workforce across the three services, resulting in a more agile and informed approach to workforce planning which will lead to a greater ability to mutually support and proactively prioritise workforce gapping where it exists.

Matter of Concern 2 - I have a concern that the Vulnerability Risk Management Process [Suicide Vulnerability Risk Management as was] is Unit led and that DCMH clinicians do not have a greater role in influencing the Army's vulnerability risk management (VRM) process for suicidal soldiers.

The Vulnerability Risk Management (VRM) process was completely overhauled in 2014 and again in 2020. The major change in 2014 was the introduction of a Management Information System (Vulnerability Risk Management Information System (VRMIS)) as a Unit's Vulnerability Risk Management Register, moving away completely from the previous paper-based system.

Since its creation and roll-out in 2014/2015 the VRMIS specifically allows for clinicians, and other third parties who are supporting an individual, such as pastoral and welfare services, to be given read-only access to the Care Action Plan[11] (subject to the individual's explicit consent). The system and process were updated and aligned to follow a multi-disciplinary approach.

Whilst the VRM process is a command-led tool under which the Chain of Command are the lead in identifying, assessing, and managing their personnel who are considered to be vulnerable to, or at risk of suicide and self-harm behaviours, the input and involvement of medical, pastoral, welfare and other third parties are an essential requirement. The central policy, *AGAI 110*[12], acknowledges that whilst suicide and self-harm behaviour may be unrelated to mental ill health, consultation for medical advice and referral is mandatory for any individual deemed to be at risk of suicide or self-harm behaviour. Medical professionals (normally the Medical Officer or an empowered medical representative) are amongst the key personnel required to attend the initial risk conferences and subsequent formal reviews that take place whilst an individual is on the Unit's Vulnerability Risk Management Register (held on VRMIS).

[11] The CAP is a live document held securely on VRMIS which is used and maintained for the duration that the individual is considered to be at risk. It is a chronological version of events that records how the individual is being actively managed and supported

[12] Army General and Administrative Instructions, Volume 3, Chapter 110, Vulnerability Risk Management

AGAI 110 and *AGAI 57*[13] - *Army Health & Wellbeing Committees* - mandate that formal monthly reviews must take place; known as the "*Commander's Monthly Case Review*" (CMCR) these comprise of the respective Chain of Command, Medical representative/s (the Medical Officer/GP or a designate) Welfare and Pastoral personnel plus other third-party professionals involved in an individual's care. The medical attendee will usually represent the entirety of the medical function, which can include information from Specialist services, such as Departments of Community Mental Health (DCMH). This, however, does not preclude other clinicians being present at Unit level meetings by invitation/exception where required. The formal CMCRs are supplemented by "*Individual Case Management Reviews*", undertaken at a frequency to suit the requirements of a particular case and involving discussions and updates from those supporting and caring for the Service Person who has been identified at risk. *Defence Primary Health Care (DPHC) Guidance Note (G/N) 15/15* details the support which is to be provided to single service health committees by DPHC personnel. This confirms that attendance at unit health committees by the Medical Officer, GP or designate is to be 'considered the norm'. *DPHC Op Order 22/011 'Routine Firm Base Healthcare Support to Defence'* details that medical support and input to VRM conferences and reviews is priority one activity for DPHC staff, considered as urgent clinical care.

Aligned to single service policy on the management of personnel identified at risk of suicide and self-harm behaviours, Defence Medical Services (DMS) has put in place Standard Operating Procedures (SOP) for all medical personnel on the management of vulnerable patients. This is designed to promote best practice and deliver effective safeguarding procedures (*initially in G/N 07/18, superseded in 2022 by Defence Primary Healthcare Standard Operating Procedures 2022DPHCSOP03-01-002 for the Managing of Vulnerable Patients*).

This SOP strengthens the previous advice provided by DPHC in 2018 to medical facilities on the management of vulnerable patients. In particular, it directs that: all patients who are under a Chain of Command-led case conference are read-coded and alerted on DMICP[14] as vulnerable; all medical centres and DCMHs are to maintain a register and run monthly searches to identify vulnerable patients; all facilities are to hold an appropriate meeting, at least monthly, to discuss all vulnerable patients; each facility is to ensure there is a process in place for handing over patients, and identifying new ones on registration. This SOP and its intent align with both AGAI 110 - Vulnerability Risk Management and AGAI 57 - Health and Wellbeing Committees. Since 2014 with the introduction of VRMIS and the overhaul of policy, training and education has been provided to users of the VRMIS and the VRM Process as detailed in AGAI 110, specifically at career and pre-employment courses (such as the Unit Welfare Officers Course, the All-Arms Adjutants Course and the Sub Unit Commanders Management course). In addition, ad-hoc training is delivered to units as requested.

[13] Army General and Administrative Instructions, Volume 2, Chapter 57, Army Health & Wellbeing Committees

[14] The Defence Medical Information Capability Programme (DMICP), a centralised electronic record system

Matter of Concern 3a - I have a Concern about the training and experience of the Medical Advisors at Veterans UK providing advice under the Armed Forces Compensation Scheme.

The Medical Advisors are a group of doctors who sit under the operations umbrella of Defence Business Services (DBS). Some are trained in the Service Pensions Order (SPO), some in the Armed Forces Compensation Scheme (AFCS) and several are dual trained for cases which span both schemes.

As a requirement for the post of DBS Medical Advisor (MA), all employed must hold a full, unrestricted licence to practise with the General Medical Council and continue to undertake annual appraisals to maintain their revalidation certificates. This includes a requirement to undertake a minimum of 50 hours continuing professional development (CPD) activity per year relevant to the scope of the doctor's role. The MAs undertake regular in-house CPD which may be general or informed by particular case types or issues raised, both medical and legal.

Individual staff members hold various specialist qualifications, but the key factor in their recruitment is their experience and breadth of knowledge within the field of patient care and medicine.
Medical Advisors usually join the department following a successful career in some branch of clinical medicine relevant to the Armed Forces. This includes, but is not limited to, General Practice, Orthopaedics, Occupational Health, Mental Health, and Public Health. On joining they are trained in medico-legal determinations and evidence-based medicine, as they relate to the legislation covering the Armed Forces Compensation Scheme or War Pension Scheme administered by DBS. Medical Advisors give case-specific, evidence-based advice and certificates on causation and assessment and provide reasons for decisions.

DBS Medical Advisors are not involved in the clinical diagnosis, care or treatment of War Pension or Armed Forces Compensation Scheme claimants. A Medical Advisor's role is limited to providing advice and guidance based upon pre-existing medical evidence which is used to determine the level of disablement in accordance with the relevant scheme rules.

The Medical Advisor in question started in DBS on 24 Oct 2013 and provided medical advice in respect of Mr Cole's AFCS mental health claim on 10 Dec 2013. Given that the MA was ~6 weeks into the role, in terms of prevention, this response should focus on initial MA training and mentoring. After reviewing the case specific facts, DBS is confident that the approach to this case was not indicative of its current approach. Since the appointment of a Senior Medical Advisor in Dec 2022, a structured training programme has been implemented for all new AFCS Medical Advisors. This involves initial legislative training with the Policy Medical Advisor, followed by an intensive period of 3-4 weeks face to face case-based training with the Senior Medical Advisor or equivalently experienced MA. Subsequently several months of close mentorship occurs by an experienced MA, including reviewing each decision made to ensure correct decision making and a consistent approach, whilst continuing to provide ongoing guidance and training.

Following careful assessment of their training progress made to date, if deemed appropriate, the newly trained MA is then allocated a dedicated mentor for the scheme on which they trained, and as such is able to easily access advice, guidance and further training as required.

Considering that this medical advice was provided in Dec 2013, in addition to a more structured and supportive initial training programme for new MAs, the following measures have also been implemented more generally since that time:

- Monthly peer AFCS case-based discussion groups which allow the MAs to ensure consistency via benchmarking and identify issues that may require further policy guidance.

- In house CPD sessions. For example bringing in specialists from Defence Medical Services to upskill MAs in relevant medical conditions, such as non-freezing cold injury or PTSD. The MAs are also encouraged to join the Civilian Medical Practitioner CPD sessions which are also relevant to the MA role.

- Having a single point of contact for complex case queries/case discussion, providing less of a barrier for MAs to seeking advice/reassurance in respect of queries.

- Improved identification of overall MA training needs; utilising various methods including quality monitoring outcomes, tribunal outcomes, opportunistically, via complaints and through customer/colleague feedback. This feeds into the in-house MA training discussed above.

- Making sure all MAs have access to necessary medical resources, for example DMICP and ensuring Athens accounts[15] are maintained to ensure access to up-to-date medical evidence.

- Since early 2023 DBS is now performing an increased number of validation checks on completed MA quality monitoring files and performing improved analysis of the quality monitoring outcomes. This is being fed back into the in-house MA CPD programme.

It is acknowledged in the case of Mr. Cole that the MA was new to the role and required more support and guidance, and that this was a shortcoming which DBS has recognised and worked hard to address. As detailed above, there have been significant improvements in MA training and support since this decision was made in 2013 and it is hoped that this response provides reassurance in this regard to HM Coroner and the family and friends of Mr Cole.

Matter of Concern 3b - I have a Concern about the rejection of claims for PTSD under the Armed Forces Compensation Scheme if there is not a formal diagnosis

[15] An authentication system that acts as a key to unlock access to resources for eligible health and care staff. An account gives access to NHS-funded online books, journals, databases, evidence sources and e-learning

by a consultant psychiatrist or psychologist but evidence of PTSD within medical records from other medical professionals.

The Armed Forces Compensation Scheme legislation (available at: The Armed Forces and Reserve Forces (Compensation Scheme) Order 2011 (legislation.gov.uk)) specifies that mental disorders must be diagnosed by a clinical psychologist or psychiatrist at consultant grade; this is the case for all mental disorders, not only PTSD. The requirement for a consultant level diagnosis has been considered multiple times by the Independent Medical Expert Group (IMEG) as part of their reports on mental health, and on each occasion found to be appropriate. IMEG is an advisory non-departmental public body sponsored by the Ministry of Defence that advises the Minister for Defence People, Veterans and Service Families on medical and scientific aspects of the Armed Forces Compensation Scheme and related matters.
Their responsibilities include:

- investigating the issues on which advice is requested;
- reaching conclusions and making recommendations based on evidence;
- providing evidence comprising independent, published, peer-reviewed scientific and medical literature; and
- consulting other experts and inviting interested parties to submit relevant research (but IMEG does not commission research)

A summary of IMEG considerations is outlined below.

In 2013 IMEG considered the need for a formal diagnosis at this level as part of their second report, in the section entitled “Who should make the diagnosis?”. This report concluded that diagnosis should be by consultant level psychiatrist or clinical psychologist. The report is available here: IMEG Report 2 Mental Health (publishing.service.gov.uk).

In early 2016 a quinquennial review, or QQR, was conducted of the Armed Forces Compensation Scheme to make sure that the scheme remained fit for purpose and displayed the flexibility to adapt to changing conditions and environments. This was an independent review. Overall the QQR concluded that the AFCS remained on track and fit for purpose, with some areas needing improvement. IMEG considered issues raised in the QQR as part of their fourth report, including mental health, and concluded that “Diagnosis remains very important and should continue to be made by a psychiatrist or clinical psychologist at consultant level.” The report is available here: IMEG report 4 AFCS QQR issues (publishing.service.gov.uk).

IMEG further considered mental health in their fifth report, published in 2020. This reviewed the conclusions reached in 2013 as part of their second report. IMEG concluded that: “Because of the classification complexities and uncertainties discussed above and the need for rigour and consistency in diagnosis, both in clinical and compensation terms, we continue to recommend clinical diagnosis at consultant level.” The report is available here: IMEG Report 5 Review of 2013 IMEG Second Report on Mental Health (publishing.service.gov.uk).

There is ongoing work to keep the requirement for a consultant level psychiatrist or clinical psychologist under review and ensure it remains an appropriate requirement for mental health claims. A further quinquennial review of the Armed Forces Compensation Scheme has been conducted which will comment on this matter when published; a copy will be made available on gov.uk and provided to HM Assistant Coroner for Derby and Derbyshire. Additionally, IMEG are again reviewing mental health as part of their seventh report, expected in early 2024. Once complete, a copy of their report will be published on gov.uk and provided to HM Assistant Coroner for Derby and Derbyshire.