



House of Commons
Defence Committee

**The Armed Forces
Covenant in Action
Part 5: Military
Casualties, a review of
progress**

Fourth Report of Session 2014-15



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to the report*

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The Defence Committee

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Summary

The wars in Afghanistan and Iraq have drawn the British Armed Forces into its most intense fighting since the Korean War. The British military has displayed great courage and gallantry throughout the period, hundreds have lost their lives and thousands have been seriously wounded. British society has a unique debt of gratitude, and an obligation to look after citizens who have risked their lives for their country. This report analyses the support currently provided for military casualties.

Our 2011 inquiry into military casualties found that the Ministry of Defence (MoD) provided first class medical treatment and rehabilitation for wounded and injured personnel on operations and back in the UK. However, we were concerned about the longer term support for those developing severe and life-limiting, physical, mental health or neurological problems in later life. We were also concerned that more needed to be done to improve the mental health support for serving personnel, reservists and veterans and to support bereaved families and the families of severely injured personnel. This inquiry was designed to chart the progress of the MoD in these specific areas.

Armed Forces personnel as a whole suffer similar rates of mental health problems to the general population. But those deployed in combat roles exhibit twice the usual rates of post-traumatic stress, and reservists exhibit twice the rates of regulars. The MoD has made progress in developing programmes to support service personnel following traumatic incidents. But it has not yet identified why reservists are facing particular problems or developed solutions to the problems reservists face. Personnel are seeking support for mental health problems earlier than in the past, and we are concerned that the Armed Forces may lack the resources to deal with the increased demands.

The mental health of Armed Forces personnel is intrinsically linked to two major problems in the Armed Forces. Hazardous levels of alcohol consumption are the norm in the Armed Forces, regardless of Service or gender. Urgent action is needed to reduce the harm caused by the abuse of alcohol to Armed Forces personnel and their families. Too many members of the Armed Forces appear to believe that alcohol is integral to group cohesion or believe that alcohol is an appropriate way of coping with a return from a military deployment.

Although Armed Forces personnel have a lower rate of criminal offending than the general population, the rate for violent incidents is substantially higher, particularly amongst those who have previously been deployed in combat roles and those who misuse alcohol. There has been no research as to the incidence of domestic violence amongst Armed Forces personnel. The MoD needs to understand better the links between deployment, alcohol misuse and violent behaviour especially domestic violence.

There is a shocking backlog in the processing of claims for War Pensions and for the Armed Forces Compensation Scheme. We are also concerned that the demand from serving personnel and veterans for support from the Defence Recovery Capability already exceeds supply and that veterans need more support navigating the overlapping

bureaucracy of the health system. Despite assurances from the MoD and the Department of Health, we are concerned that, as operations in Afghanistan and Iraq fade from the public's mind, the necessary long-term support for those injured physically and psychologically will not be maintained. The MoD, in conjunction with the Health Service, has introduced a number of measures to support those with mental health problems and amputees but other conditions also require this focus. It is too early to judge the success of these measures, but the MoD should monitor the results of its work and report the outcomes in its annual report on the Armed Forces Covenant.

1 Introduction

1. The wars in Afghanistan and Iraq have drawn the Armed Forces into their most intense period of fighting since the Korean War. Many members of the Armed Forces have been killed or seriously injured in action. From the start of the mission in Afghanistan in 2001 to 31 July 2014, 453 members of the Armed Forces and civilians have been killed and a further 614 seriously injured or wounded.¹ In Iraq from January 2003, 136 Armed Forces were killed as a result of hostile action and a further 222 seriously injured or wounded.² An unknown number of personnel have suffered mental health problems following deployment, including post-traumatic stress disorder (PTSD), and alcohol misuse. Many more personnel have been wounded or injured or fallen sick as a result of military service not on deployment, for example, on training. In the five years from 1 April 2008 to 31 March 2013, some 51,300 personnel have been categorised as wounded, injured or sick, of whom three per cent were reservists. Table 1 shows the numbers of wounded, injured or sick by Service and rank.

Table 1: Armed Forces Personnel, wounded, injured or sick April 2008 to March 2013

Service	Officer		Other Ranks		Total	
	All	Operational	All	Operational	All	Operational
Naval Service	1,030	75	5,082	689	6,112	764
Army	3,554	481	32,396	6,792	35,950	7,273
RAF	1,876	119	7,346	640	9,222	759
Total	6,460	675	44,824	8,121	51,284	8,796

Source: Ministry of Defence³

The Armed Forces and the Ministry of Defence (MoD) have a responsibility to ensure that Armed Forces and civilian personnel are provided with the best treatment and support, including rehabilitation and mental health support, and that their families are supported.

2. We pay tribute to all the British personnel, both military and civilian, who are currently serving or have served on operations in Iraq, Afghanistan, and elsewhere but, in particular, to those who have lost their lives, and the many more who have sustained life-changing injuries as a result of these conflicts. We express our gratitude for the vital contribution made by the families of Armed Forces personnel.

3. The charitable sector has made a huge contribution of resources and expertise to the support and wellbeing of Armed Forces personnel and veterans, and their families. This contribution should be recognised by the Armed Forces, the MoD, Parliament and the public. We are also grateful to the many charities who have engaged constructively with our inquiry and provided written and oral evidence.

1 [Ministry of Defence– Defence statistics](#) on casualties in Afghanistan

2 [Defence Committee Report *The Armed Forces Covenant in Action? Part 1: Military Casualties Seventh Report 2010-12, HC 762*](#) British Casualties - Iraq

3 MoD ([MIL027](#))page 25

Scope of the inquiry

4. In our 2011 report on military casualties⁴, we commended the MoD for providing first class medical treatment and rehabilitation both in theatre and back in the UK. However, we questioned whether the support for wounded personnel would be sustainable over the long term and we were concerned about the number of former personnel who might go on to develop severe and life-limiting, physical, mental health or neurological problems in later life. We doubted whether the Government fully understood the likely future demands and related costs. Our report also found that more needed to be done to improve the mental health support given to serving and reservist personnel, in particular with regard to alcohol misuse. We also recommended that more be done to support the families of injured personnel.

5. We have followed the progress of work introduced by the MoD further to support the recovery of personnel and have examined the approaches taken by the NHS and the Devolved Administrations to the support given to wounded, injured or sick Armed Forces personnel discharged from the Services. In this inquiry, we have charted the progress the MoD has made in implementing our earlier recommendations and considered new emerging questions. In particular, we have examined the following issues:

- Mental health care for Armed Forces personnel, particularly following deployment on operations;
- Support for families of deployed personnel, for those bereaved and for families of severely injured personnel;
- Arrangements for the supported recovery of wounded, injured or sick personnel;
- Continuing long-term support for wounded, injured and sick personnel after discharge from the Armed Forces, including from the NHS and the Devolved Administrations; and
- The MoD's relationship with the charitable sector and its role in supporting serving and discharged personnel.

6. We took oral evidence from a number of external sources: the King's Centre for Military Health Research (KCMHR); the Royal British Legion; Combat Stress; SSAFA; and Help for Heroes. On the Government side, we took evidence from Air Marshal Paul Evans, the Surgeon General, Admiral Simon Williams, Assistant Chief of Defence Staff (Personnel and Training), Caroline Pusey, Head of Service and Veterans' Welfare MoD, and Surgeon Captain John Sharpley, Defence Consultant Adviser on psychiatry; Jon Rouse, Director of Social Care, Local Government and Care Partnerships, Department of Health; and Kate Davies, Head of Public Health, Armed Forces and their Families and Health and Justice, NHS England. Anna Soubry MP, Minister for Defence Personnel, Welfare and Veterans, and Dr Dan Poulter MP, Parliamentary Under-Secretary for

4 [Defence Committee Report *The Armed Forces Covenant in Action? Part 1: Military Casualties* Seventh Report 2010-12, HC 762](#)

Health also appeared before us. In addition, we received written evidence from the MoD, the Department of Health, NHS England, the Devolved Administrations, charities and individuals all of which are available on the Defence Committee website.⁵ We also note the February 2013 Welsh Affairs Committee on support for veterans in Wales.⁶

5 [Defence Committee website](#)

6 [Welsh Affairs Committee Report, Support for Armed Forces Veterans in Wales, HC131 Second Report of 2012-13](#)

2 Mental health of Armed Forces personnel

Background

7. In our previous inquiry into military casualties, we found that the MoD did not have a complete understanding of the mental health needs of serving personnel or veterans. We recommended that the MoD identify the extent of mental health problems in the Armed Forces, including post-traumatic stress disorder (PTSD) and alcohol misuse. We were also concerned about the higher incidence of mental health problems in reservists who had been deployed. We concluded that mental health was an area we needed to follow up with the Armed Forces and the MoD.⁷

8. In general, the mental health of the Armed Forces is good, and it is important that the public and Parliament recognise this fact. But, Service personnel remain particularly at risk from certain conditions. Professor Simon Wessely, Director of the King's Centre for Military Health Research told us:

[...] in general, the mental health of the armed forces remains remarkably robust, all things considered in terms of what has been going on in the last 10 years and the nature of the post. It is important that the general public get that fact. This is not a crisis that we are facing, a catastrophic failure in morale or a tidal wave of problems. But [...] we know that there are particular groups who are particularly at risk, and particular problems that are perhaps more prevalent in the armed forces than in the rest of the population. Plus, of course, being in the armed forces does not make you immune from the same problems that afflict all of us.⁸

Incidence of mental health problems

9. The MoD has commissioned extensive research from the King's Centre for Military Health Research into the impact of deployment on the mental health of Armed Forces personnel. The Centre has conducted two large cohort studies of some 10,000 personnel deployed to Iraq or Afghanistan and those not deployed. The studies were reported in 2006 and 2009.⁹ The Centre has since been commissioned to undertake a further cohort study following up these individuals, with the inclusion of additional Armed Forces personnel to increase the sample size. In addition to written questionnaires, this study will involve interviewing and collecting more detailed clinical information from a subset of the sample, 1,500 to 1,800 Armed Forces personnel.¹⁰

7 [Defence Committee Report *The Armed Forces Covenant in Action? Part 1: Military Casualties* Seventh Report 2010-12, HC 762](#)

8 Q1

9 [King's Centre for Military Health Research: A fifteenth year report, September 2010](#)

10 Q52

10. Professor Wessely and Professor Nicola Fear, Director of KCMHR, told us that the cohort studies indicated a level of common mental disorder amongst Armed Forces personnel of some 20 per cent including 11 per cent suffering from depression and some three to four per cent experiencing post-traumatic stress disorder (PTSD), both in line with rates in the general population.¹¹ However, personnel deployed in combat roles, reservists and individuals whose cumulative length of deployment was 13 or more months in any three year period exhibited higher rates of PTSD at six to seven per cent.¹²

11. The majority of personnel who reported symptoms of PTSD in the KCMHR studies had not asked for medical treatment on return from conflict zones. The KCMHR is currently undertaking research for the US Government as to the value of post-deployment screening. Professor Wessely described it thus;

We previously showed that screening for mental health problems before people deploy was ineffective. It basically doesn't work. It is much more interesting to see whether screening people when they come back, when they may have developed mental health problems—as opposed to predicting—has more utility. We are in the middle of the first ever such trial in the world, doing post-deployment mental health screening of more than 10,000 people, and that is ongoing. The results of that will definitely have an impact on policy one way or the other.¹³

Stigma

12. We asked Professor Wessely about the problems of stigma associated with Armed Forces personnel seeking help for mental health problems. He said that stigma was a problem in the general population as well as in the Armed Forces but that the level had been reducing in the Armed Forces.¹⁴ Indeed, he argued that more people in the Armed Forces sought help than in the general population—he estimated that 40 per cent of those who needed help in the Armed Forces had asked for it compared to an estimated 25 per cent in the civilian population.¹⁵ He noted that the degree of stigma was dependent largely on circumstances, explaining that the stigma associated with seeking help when in theatre was much greater than when at home:

It is as though when people are on deployment, they really are very task-orientated, they want to know they can rely on their mates, so it is not the right time to be emoting and talking about your personal problems. Then, when they come back, it drops quite dramatically and it is a good time for talking about these things. So it is important not to see it as an innate quality that people have. In the military context, there are times when you can

11 Q52

12 Q3

13 Q40

14 Q19

15 Q20

understand that and you can see why it might be so, so I think we have to have a more nuanced view of stigma.¹⁶

Treatment of regular Armed Forces personnel

13. Armed Forces personnel can access Defence Medical Services (DMS) mental health care support through their local medical centre which can refer them to one of the 16 UK Defence Community Mental Health teams (DCMH) or one of the five overseas departments.¹⁷ If required, inpatient care has been provided under contract by South Staffordshire and Shropshire Healthcare NHS Foundation Trust since 2009.¹⁸ Mental health support is available on operations from field mental health teams.

14. In 2008, the Armed Forces introduced a non-medical response to traumatic events, starting with the Royal Marines, called Trauma Risk Management (TRiM). TRiM is now the responsibility of the single Services and is delivered by trained peers not mental health professionals. The MoD told us that TRiM was judged by commanders to contribute to operational effectiveness as it ensured a timely and front line response to the needs of Service personnel exposed to traumatic events.¹⁹ In addition, since 2009 all Armed Forces personnel undergo a mandatory period of decompression on return from operations. Decompression provides time for personnel to readjust before returning to family life in the UK.²⁰

Increased number of personnel seeking mental health support

15. The number of military personnel being treated for mental health problems has increased as has the rate of patients diagnosed with a mental disorder. Between 2007-08 and 2012-13, the number of new cases requiring care from Defence Community Mental Healthcare (DCMH) increased by a third (5,000 to 6,700) and the number of patients diagnosed with a mental disorder rose from 3,500 to 5,100 (45 per cent increase). The number of consultations conducted by the DCMH rose despite the reduction in the size of the Armed Forces over this period.²¹ These figures do not include those personnel being treated by their GP. The MoD told us that the complexity and seriousness of the cases being treated had also increased as illustrated by the increase in the number of appointments per patient and the rise in the number of personnel medically discharged from the Armed Forces with a diagnosis of PTSD.²²

16. The MoD told us that the increase in those seeking help might be partially due to the success of anti-stigma campaigns and TRiM, although it could also indicate an absolute

16 Q19

17 MoD ([MIL0027](#)) page 2

18 MoD and Department of Health ([MIL038](#))

19 MoD ([MIL0027](#)) page 6

20 MoD ([MIL0027](#)) page 6

21 MoD and Department of Health ([MIL038](#))

22 MoD and Department of Health ([MIL038](#))

increase in levels of mental illness.²³ The increase could also be due to personnel presenting earlier with mental health problems than in the past. Professor Wessely said that there had been a big drop in the length of time before personnel sought help and that this might be a good thing. He further said:

[...] there is no doubt that within the Defence Medical Services and the charity sector, people are presenting earlier than they used to. Combat Stress, for example, used to say that it was 12 to 14 years before people would present. Now that is certainly not the case. Now we know it may be up to two years, so there has been a big drop in the length of time it takes before people will either come and get help or, as happens more often, be told to get help by their spouse or whatever.

[...] It might be a mark of the fact that some of the stigma campaigns and the outreach programmes are having an effect. We will have to see, and the longitudinal study that we are doing will help to separate out these various themes, but we should not leap to the conclusion that because the defence services are seeing more cases, something has gone wrong in theatre. It might well be that this is something we should be pleased about.²⁴

17. Following the 2005 Strategic Defence and Security Review, the MoD increased the number of personnel providing mental health support by 25 including an additional 13 psychologist posts. The total number of defence mental healthcare staff across UK and overseas is approximately 250,²⁵ and the MoD is currently looking at recruiting additional mental health professionals and developing pilot schemes to exchange staff with the NHS to transfer skills.²⁶

18. We welcome the introduction of the Trauma Risk Management system and the MoD's work in reducing the stigma attached to seeking help for mental health problems. We also welcome the fact that personnel are seeking help for mental health problems earlier than in the past. The Armed Forces have seen a significant increase in the number of personnel requiring treatment by the Defence Community Mental Healthcare Teams without a proportional increase in the number of staff. Given evidence that Service personnel are coming for mental health support sooner than in the past and while they are still serving, pressure on existing resources will only increase. In response to this Report, the MoD should inform us of its plans to deal with the increased volume of work and tell us how quickly it can ramp up its support for personnel in the event of any further acceleration in the number of personnel coming forward for help.

23 MoD and Department of Health [\(MIL038\)](#)

24 Q53

25 MoD and Department of Health [\(MIL038\)](#)

26 MoD and Department of Health [\(MIL038\)](#)

Reservists

Higher numbers of reservists report mental health problems

19. Reservists experience higher levels of reported mental health problems than regulars, experiencing double the rate of PTSD post-deployment compared to regulars in all roles and continuing to show higher rates five years after deployment. When asked about the higher incidence of mental health problems, Surgeon Captain Sharpley said that although reservists had a higher rate of PTSD, they had a lower risk of alcohol misuse and, therefore, the totality of the mental health problems of reservists were broadly equivalent to those of regular personnel.²⁷ Rear Admiral Williams told us that the culture of the command chain needed to change to be more effective at dealing with mental health problems, in particular to encourage personnel to seek support. He also said that this change had to be extended to ensure that those who work with the Reserve Forces were aware of the problems faced by reservists on their return from deployment.²⁸

20. Air Vice Marshal Murray of SSAFA said that reservists were often isolated on return from deployment:

Young soldiers understand where to get help from; Reservists—this goes back to the isolation point—don't really understand, and nor do their families. They don't really know how to hook into and how to get support from the Army, the Air Force and the Navy, which is there if they need it, but it is about getting into it. They are also pretty independent people running pretty independent lives, which is a strength. But when things go wrong, they can go horribly wrong and they are on their own.²⁹

21. In its cohort study, the KCMHR asked reservists how they dealt with reintegration back into civilian life. Professor Fear said that the cohort study looked at:

reintegration back into civilian life—how they coped with socialising with their civilian friends and their families, but also with reintegrating back into their civilian employment. We found that those Reservists who struggled—who had problems readjusting—were more likely to report mental health problems across the board, particularly PTSD and common mental disorders.³⁰

22. We asked Professor Wessely what needed to be done to improve mental health support for reservists. He stressed that any solution had to involve informal support:

[...] The implications of what we are saying are fairly obvious all round, but these are very difficult things to do in reality. It is not just formal social support that you can deliver. You could deliver increased welfare services

27 Q167

28 Q167

29 Q124

30 Q10

and provide more counsellors and more psychologists and all those things, but the evidence shows that just as important—some people think more important—are the informal networks that you cannot create because they come naturally. They are about mates being bonded together.³¹

23. In our last Report on military casualties in December 2011, we recommended that the MoD identify the factors leading to the difference in the rates of PTSD between reservists and regulars. The MoD is in the process of commissioning two pieces of research related to the mental health of reservists. The first one will explore the factors which determine why reservists are more at risk of mental health problems on return from combat operations and will assess the awareness of reservists of mental healthcare and support services. The MoD described the second project as follows:

KCMHR research indicated that Reserves post deployment normalisation and reintegration experiences were different to that of their Regular counterparts. The requirement was identified to develop a Post Operational Stress Management (POSM) programme tailored to Reservists differing needs.

This research programme will look to provide recommendations on the most appropriate POSM programme for improving Reservists reintegration and normalisation experiences and as a consequence improve their mental health outcomes.³²

Neither of these pieces of research have yet been formally commissioned but the MoD expect them to report in March 2015.

24. The MoD has introduced some specific support for demobilised reservists with mental health problems but it is still limited. Professor Fear said:

We evaluated the Reserves mental health programme and showed that the individuals who were going through that were having good outcomes, so that was shown to be effective.³³

25. The higher incidence of mental health problems developing in reservists deployed to Iraq and Afghanistan has been known for some considerable time. Given our earlier recommendation in 2011 that it investigate the factors contributing to that higher incidence, we are disappointed that the MoD is still in the process of commissioning this research. This has meant that the MoD has yet authoritatively to identify or to address these issues and provide support specifically tailored for reservists. This is of great concern to the Committee given that the importance of identifying and addressing the particular problems facing reservists is increased by the growing dependence on Reserve Forces in Future Force 2020.

31 Q14

32 MoD and Department of Health [\(MIL038\)](#)

33 Q40

Alcohol misuse

26. The MoD told us that KCMHR research “found that the misuse of alcohol in the military is substantially higher than that seen in the civilian population, particularly among 16 to 19 year olds, with males drinking over twice the hazardous levels and females over three times”.³⁴ In addition, Professor Fear told us that male NCOs and Officers are more likely to die from alcohol-related causes than other occupational groups within the general population.³⁵

27. The MoD described its policy on alcohol consumption as shown in Box 1 below. It stressed that it had breathalysing and discipline procedures for personnel with safety critical duties.

Box 1: MoD policy on alcohol consumption

While social drinking can play a part in developing group cohesion within the military culture, the MOD recognise the benefits of this must be balanced against misuse which could be hazardous to the individual, families or colleagues and ultimately operational capability. Therefore the MOD strategy has a twin track approach of education (routine awareness campaigns and health fairs) and regulation (for example discipline procedures and breathalysing for those on safety critical duties), with medical and welfare support for those who require it, including intervention and rehabilitation programmes. The strategy works on the principle that alcohol misuse is preventable and recoverable, and even those who are alcohol dependent can be helped.

The single Services are responsible for delivering through-life alcohol prevention programmes designed to raise awareness of the dangers of excessive alcohol misuse, including how to drink within safe limits; additional training is also provided for those in command positions. Each Service approaches the through-life framework principle in accordance with their needs, resulting in variations in programme delivery. For example the Royal Navy delivers lectures every one or three years, dependent on age, while the Army runs health fairs and bespoke alcohol presentations. The single Services all take a firm stance against misuse and manage it through a process of counselling, administrative and disciplinary action. They promote, through awareness campaigns and education, the sensible use of alcohol in accordance with government guidelines, in order to develop a culture of positive attitude and behaviour towards health and wellbeing. Their aim is to rehabilitate individuals as quickly as possible so that they remain operationally effective. Responsibility for a successful rehabilitation lies with both the individual and the support services. Nevertheless, there are those individuals who, despite chain of command and medical support, combined with an extensive treatment and rehabilitation programme, cannot be rehabilitated; in these rare instances, these individuals are discharged from the Services.

Source: Ministry of Defence³⁶

28. In our previous Report on military casualties, we expressed concerns that it was unclear whether the MoD regarded the misuse of alcohol as part of a pattern of reprehensible behaviour which required discouragement or a manifestation of stress which required treatment or a combination of both.³⁷ We recommended that the MoD carry out a study into what was driving the misuse and abuse of alcohol and what more could be done to change behaviour.³⁸

29. In October 2012, the MoD commissioned research to explain the high rates of alcohol consumption in the Armed Forces and the disparity in consumption between military

34 MoD ([MIL0027](#)) page 4

35 Q57

36 MoD ([MIL0027](#)) page 4

37 [Defence Committee Report The Armed Forces Covenant in Action? Part 1: Military Casualties Seventh Report 2010-12, HC 762](#)

38 [Defence Committee Report The Armed Forces Covenant in Action? Part 1: Military Casualties Seventh Report 2010-12, HC 762](#)

and civilian populations and to recommend improvements in the management and prevention of alcohol misuse in the Armed Forces. This study concluded in August 2014 and confirmed the findings of the KCMHR research that hazardous levels of alcohol consumption are the norm in the Armed Forces, regardless of Service or gender. The study reached some other worrying conclusions, in particular, that alcohol misuse continues to rise and is associated with criminal offences and violent behaviour causing problems to families and communities. It also pointed to an “attitudinal and cultural ambiguity regarding alcohol, it is considered by many to be a positive catalyst of group cohesion and to help Armed Forces personnel deal with the aftermath of deployment”.³⁹

30. The study made recommendations under the categories of prevention, intervention and treatment. The recommendations included limiting the availability of alcohol on Armed Forces premises and increasing its price; education of personnel; intervention for those with recognised alcohol problems; and better treatment options including the employment of alcohol misuse specialists. In addition, the study made overarching recommendations on the need to develop a clear alcohol policy highlighting clearly key approaches and responsibilities and a major campaign to ensure all officers are committed to reducing alcohol consumption across the Armed Forces.⁴⁰

31. We questioned the charities as to whether some Armed Forces personnel were resorting to alcohol to help them with mental health problems, Bryn Parry, co-founder of Help For Heroes, said:

What we are seeing is that all those who have had some life-changing injuries, so that they can no longer do the job that they wanted to do, are presenting with some mental condition. They have concerns. They are not sleeping, they have anxieties or depression, and they are turning to alcohol and so on.⁴¹

32. We welcome the MoD’s acceptance of our previous conclusion that it needed to recognise the seriousness of the problem of alcohol consumption in the Armed Forces and that it has strengthened its response to the problem. However, we remain concerned that the MoD’s response has not had any noticeable impact on the level of excessive and binge drinking in the Armed Forces. We are not convinced that sufficient focus has been given to dealing with the problem at every level of the chain of command. We also question whether the MoD has examined whether excess alcohol consumption may, in some Service personnel, be masking other mental health problems.

33. We are disappointed that the MoD took well over a year to commission research into the drivers of excessive alcohol consumption. The conclusions of the study are very worrying. Clearly, urgent action is needed to tackle the harm caused by the abuse of alcohol to both Armed Forces personnel and their families. In its response to this Report,

39 MoD further evidence ([MIL045](#))

40 MoD further evidence ([MIL045](#))

41 Q115

the MoD should tell us how it intends to implement the study's recommendations and in what time frame.

34. The MoD should determine a comprehensive strategy and plan to tackle alcohol misuse, identifying how it intends to change the culture within the Armed Forces and identifying practical measures to reduce consumption including, if necessary, reviewing pricing policies and availability of alcohol on bases. The plan should incorporate the recommendations of the study on excessive alcohol consumption. It should also include performance measures which will indicate whether the plan is working in reducing excessive alcohol consumption.

Violence

35. The KCMHR has undertaken research on offending behaviour, linking data on Armed Forces personnel from its longitudinal cohort study to criminal records. The results showed that those who are serving or have served in the Armed Forces have a lower overall offending rate than the general population. Professor Wessely said:

[...] those who served in the forces have an overall offending rate that is lower than the general population. When you think about the fact that, as is known, the forces recruit some people from very disadvantaged backgrounds—some of whom already have criminal offences, and they may well have gone on to acquire more—that tends to speak to the idea that, overall, offending goes down when you join the forces.⁴²

However, rates for violent offending are higher. Lifetime violent offending (ranging from threats of violence to serious physical assault or worse) was more common among male Service personnel—11 per cent compared to 8.7 per cent in the general population. A pre-Service history of violence, younger age and lower rank were the strongest risk factors for violent offending. Men who were deployed to Iraq or Afghanistan with direct combat exposure were 53 per cent more likely to commit a violent offence than men who served in a non-combat role on operations. Witnessing traumatic events on deployment also increased the risk of violent offending. Alcohol misuse, PTSD, and high levels of self-reported aggressive behaviour on return from deployment were also found to be strong predictors of subsequent violent offending.⁴³

36. Professor Wessely said that rates of violent offending were higher in those who had been deployed:

The exception is violence, and it is clear that that goes up. It is particularly clear that that goes up in the obvious groups—those who have previously offended, etc., with social deprivation and so on—but equally it goes up in those who have been in combat. So, for those in the teeth arms—in the infantry arms—who have been deployed and been in combat, it goes up.

42 Q66

43 [King's Centre for Military Health Research paper](#) UK military personnel at risk of violent offending March 2013

Remember that generally in life violent offending goes down. That is a specific deployment effect and it is massively compounded by alcohol and somewhat compounded by PTSD. If you are asking me honestly, I would say that the most significant negative effect of military service is in the rates of violence, but overall rates of offending are lower and overall there are fewer veterans in prison than you would expect from their size in the population. So it is a very specific effect.⁴⁴

37. Increases in violent offending behaviour are linked to deployment in combat roles and subsequent misuse of alcohol and other risk taking behaviour. The MoD should identify those most at risk of such offending and put in place measures to assist these personnel to manage the aftermath of deployment in combat roles better.

Domestic violence

38. Domestic violence has a profound effect on families. The MoD told us that the Armed Forces do not tolerate domestic violence. It also said:

Service personnel who are themselves experiencing violence and Service family members who are victims of violence have a comprehensive range of sources of help and information including single-Service welfare providers, welfare and personnel staff, Families' Federations and help-lines.⁴⁵

The MoD wrote to us about the detailed policies on responding to domestic violence and supporting the victims of domestic violence led by each of the three Services.⁴⁶

39. The research on violent offending discussed above did not separately identify domestic violence although Professor Wessely said that he thought domestic violence was also likely to be higher than the general population.⁴⁷ The KCMHR is currently undertaking a study of over one thousand children of military fathers on the impact of military life. Professor Fear described it thus:

[...]. We have got over 600 fathers who have been recruited into our study, so we have collected information from them on their health and well-being and on their family structure, their relationship with their partner or ex-partners and children and their view on the social, emotional and behavioural development of their own children.

Through the fathers, we have access to the mother or mothers of their children, and we ask the mother the same questions about their mental health and well-being, their relationship with the father and the children and their views on the children's development from an emotional and social perspective. For those children who are 11 and older, we have contacted

44 Q66

45 MoD further evidence ([MIL041](#)) page 4

46 MoD further evidence ([MIL041](#)) page 5

47 Q77

them directly and collected information from them, asking them, “What’s it like having a father in the Military—the good things and not-so-good things?” We also ask them the same questions about their own development.⁴⁸

This study has yet to report.

40. We asked the MoD what it was doing to track incidents of domestic violence. It told us that it had “seen no evidence that suggests domestic violence is a greater problem with the Service community than in the civilian community”.⁴⁹ The MoD has limited information on the number and nature of incidents of domestic violence in the Armed Forces, and, in particular, in the Reserve Forces nor does it know how many of these incidents happen as a result of deployment in combat roles.⁵⁰

41. The MoD needs to understand better the links between deployment on combat operations, alcohol misuse and domestic violence. The MoD must be more proactive at all levels and should re-examine its policies on domestic violence and develop plans to intervene to prevent domestic violence or, at least, reduce the incidence of domestic violence by Armed Forces personnel. These plans should deal with both regulars and reservists.

48 Q76

49 MoD further evidence ([MIL041](#)) page 4

50 MoD further evidence ([MIL041](#))

3 Support for families

Families of injured or killed Armed Forces personnel

Support following a bereavement or serious injury

42. In its memorandum, the MoD detailed the support the Armed Forces give to the families of personnel in general, on deployment and on return from deployment.⁵¹ It described its policy as:

As with all members of the public Service families can call on the full range of Government services external to the MOD. The department does not seek to replicate these services in the UK. However, we have long recognised how important families are in supporting our personnel to fulfil their Service commitments and thus we have put in place additional support structures to help address the challenges created by Service life. Nevertheless, we do seek to generate resilience in families, which leads to better family outcomes, and to avoid creating a dependency culture.⁵²

It also told us that there had been little fundamental change to its welfare model since the Committee's 2011 inquiry.⁵³

43. When asked about the impact of caring for an injured family member, Sue Freeth, Royal British Legion, pointed to a recent US Report on military caregivers⁵⁴ noting that this research:

[...] actually looks at the needs of what they call the care-giving community to the military injured. [...] We do not have that kind of data available to us at the moment. We have the data and the experience from those of us involved in individual cases. I think there are some interesting features in there and I would be very surprised if they were not similar here. A much younger age group of people are affected. Their partners are often parents; they are at work, and in their 20s and 30s, not their 40s and 50s. There are some specific issues about this legacy group. We need to work hard to make sure that they know they can come forward for support and that they get the kind of support they are looking for.⁵⁵

Reviews of support for families

44. In our last report on military casualties, we found that the MoD did not always provide the best care to bereaved families or those where the family member or someone

51 MoD ([MIL0027](#)) pages 17 to 22

52 MoD ([MIL0027](#)) page 17

53 MoD ([MIL0027](#)) page 17

54 [Rand Report Hidden Heroes: America's military caregivers March 2014](#)

55 Q130

known to the family was severely injured. The impact of such an event can be widely and deeply felt. We urged the MoD to look at the support services it provided for the families of Armed Forces personnel and, in particular, their children.⁵⁶ The MoD told us that, following the Committee's recommendations, it had commissioned independent research to "examine the support experiences and needs of families of the wounded, injured and sick". This research has yet to report but the MoD told us that early indications were:

- Families affected by injury and illness are more vulnerable to experiencing difficulties and have unique needs and challenges;
- Little research has been conducted in the UK Armed Forces;
- The wider family find it harder to locate services and support; and
- There have been large improvements in the last few years but improvements can still be made with regards to families' psychological, emotional, practical and transition needs.⁵⁷

45. The MoD also commissioned a piece of work from SSAFA on the support given to bereaved families. Air Vice Marshal Murray said:

[...] We have been commissioned by the MOD to do an independent piece of work, talking to the families we look after to get their views about the experiences they have had—good, bad and indifferent. [...] It is a very candid report, and we will give it back to the MOD and it can do what it wants with it. As a general point, the support that the families get now compared with perhaps 10 years ago is much, much better.⁵⁸

The SSAFA study found that overall the support to military bereaved families is generally good and of a high standard. However, it recommended that support for children and for adult siblings should be increased and that information about the resources available should be more effectively communicated to families.⁵⁹

46. We asked Air Vice Marshal Murray about the support given to members of the wider family. He replied:

We provide support, bizarrely enough, to everybody but the wife. We work closely with them, but the wife is looked after by separate charities—Army, Air Force and Navy widows' groups. As for the rest of the family—the broader family—do you know what? We don't really look too closely as to what "the family" really means. We look after people who need help. It might be partners or girlfriends. I was up in Glasgow recently with 250 families and

56 [Defence Committee Report *The Armed Forces Covenant in Action? Part 1: Military Casualties* Seventh Report 2010-12, HC 762](#)

57 MoD ([MIL0027](#)) page 21

58 Q126

59 MoD further evidence ([MIL045](#)) on the SSAFA Report on support for bereaved families

there were some quite diverse families. One doesn't ask too much. If they are in pain and they need support, they get it.⁶⁰

47. Bryn Parry drew attention to the families of those wounded:

[...] it is not only the bereaved families who need help. We have more than 1,500 loved ones who belong to our support group for people who are in relationships with the wounded, injured or sick. We are here to talk about the wounded, injured or sick. We have talked a lot about mental health and bereavement, but there are a lot of issues to do with these people—again, to do with the point about Reservists—who are finding it very hard to live with their loved one who has now changed and is experiencing all sorts of mental conditions and issues, and needs to be part of a fellowship, particularly when they are Reserves or anybody recovering at home in isolation. That is an issue we are concerned about.⁶¹

The families of reservists

48. We asked if the families of reservists had difficulty in accessing support. Air Vice Marshal Murray said:

[...] When the Reservists know about us, we can support them, but again it is a question of knowing about them. When they are bereaved, people will gather around very quickly and the regiment will gather round very quickly, but some of them are not really a full member of the regimental family, so they can be forgotten about a bit. Some regiments are better than others. I am not saying that it is a two-tier process. There is not a deliberate two-tier process but, again, the people are in the community. They do not hook naturally into the military and their surviving families do not naturally hook into it. They don't know where to go to get that support, so we are working very hard to get that information out.⁶²

49. We are disappointed that the MoD has taken so long to act on the recommendation in our December 2011 Report to review the support it offers families. Families need improved support, in particular, the families of reservists who find it harder to identify sources of support than regulars. The MoD should provide us with its study of the support to the families of wounded, injured and sick personnel as soon as it is available. It should also tell us how it intends to implement the recommendations of the SSAFA report on support to bereaved families and the above report. We call on the MoD to use the reports it has commissioned as the basis for a revision to its policy for the support of families.

60 Q127

61 Q127

62 Q125

4 Support for the recovery of wounded, injured or sick personnel

Defence Recovery Capability

50. The Defence Recovery Capability (DRC) is a set of residential facilities and activities designed to provide support to wounded, injured and sick personnel (WIS) to enable them to return to service or to prepare them for medical discharge from the Armed Forces. DRC support is co-ordinated with hospital treatment and medical rehabilitation. The establishment of the DRC was a joint initiative of the MoD, Help for Heroes, the Royal British Legion and other charities. The contribution made by Help for Heroes and the Royal British Legion represents the largest single charitable donation to the Armed Forces. The MoD described the DRC as follows:

While the care of WIS personnel rests with the single Service chain of command, that provision has been brought under the policy umbrella of the DRC and significant progress has been made in the development and delivery of facilities, and the command and care provision for WIS personnel. Of note, the planned Personnel Recovery Centres have been built and opened; a Veteran's Entry Protocol has been introduced and an RAF Personnel Recovery Unit established in June 2012. The DRC is underpinned by substantial financial investment by both the MOD and its principal partners H4H and RBL, this represents the largest single charitable donation to the Armed Forces in British history. The DRC reached full operating capability on 11 June 2013.⁶³

51. The MoD told us that Command was an essential component of recovery and that the single Services retained full responsibility for wounded, injured or sick personnel until they are discharged.⁶⁴ The co-ordination of these arrangements by each of the three Services and the provision of recovery centres for personnel undergoing recovery is shown in Box 2 below.

63 MoD ([MIL0027](#)) page 8

64 MoD ([MIL0027](#)) page 9

Box 2: Recovery arrangements for the three Services

Service	Arrangements
Naval Service	<p>The Royal Navy and Royal Marines deliver recovery support to personnel who are long-term medically downgraded or have complex welfare or discipline issues through the Naval Service Recovery Pathway (NSRP). This encompasses individual Recovery Cells in each Naval Base, Career Management Cells in both Naval Air Stations and Recovery Troops in 40, 42 and 45 Royal Marines Commando Units.</p> <p>Naval Service Recovery Centre. The NSRP Hasler Company, based in HMS DRAKE Plymouth, provides the command, management and care for personnel recovering from the most severe and complex service-limiting injuries, and those recovering from serious illness. Support from Help for Heroes (H4H) enhanced the Parker VC accommodation block and Endeavour Recovery Centre which are optimised to ensure that individuals achieve their maximum recovery potential. Assigned personnel have access to multi-disciplinary assessment and treatment according to need and, through well-established service level agreements, direct and prioritised access to adjacent NHS care. Assigned personnel are expected to reside in Hasler Company to ensure that their care can be optimised.</p>
Army	<p>All WIS Army personnel are covered by the Army Recovery Capability (ARC) and will have access to any routinely provided or additional resource that may be provided through the DRC on a prioritised needs basis. The Army have established eleven regionally based Personnel Recovery Units (PRU) throughout the UK and in Sennelager, Germany. The role of the PRU is to provide specialised recovery focussed command and care for the most complex and medium-to-long term Army WIS personnel. They also provide regional coordination and specialist recovery advice for all WIS personnel who remain under command of their parent Army organisations.</p> <p>Army Personnel Recovery Centres. The Army, working with H4H and RBL have established Personnel Recovery Centres (PRCs) in, or near to, major Army garrisons at Edinburgh, Catterick, Colchester, Tidworth and Sennelager in Germany. This enables the PRCs to take advantage of the full range of existing welfare, medical, rehabilitation, education and resettlement facilities located in the garrisons. All centres have been designed to provide a conducive military environment within which the Army can deliver bespoke core recovery courses and other supporting activities to enable WIS personnel to recover in line with their Individual Recovery Plan. The PRCs cater for both day and residential attendees who must be self-medicating and independently mobile. The centres also offer a temporary secure base/ sick at home address for those individuals who have no family home to go to, or whose family circumstances or accommodation make residence at home impractical and where there is no appropriate garrison or civilian alternative. PRCs are centres of excellence to be used at the right point in an individual's recovery, when they in effect become the soldier's place of work. Care is taken not to create a dependency on the excellent facilities but to use them as a step to achieving an independent, self-reliant outcome.</p>
Royal Air Force	<p>Bespoke recovery arrangements are made by an individual's parent unit or, depending on need, the RAF's Personnel Recovery Unit based at HQ Air Command who co-ordinate the recovery process, drawing on PRC facilities provided by both the NSRP and ARC.</p>

Note: Recovery Centres provide residential facilities for personnel undergoing recovery activities as well as facilities for day attendees; they are not hospitals or rehabilitation centres.

Source: *the Ministry of Defence*⁶⁵

52. Help for Heroes has pushed for the Defence Recovery Centres to support veterans in addition to currently serving personnel⁶⁶ and the MoD told us that an 'entry protocol' for veterans had recently been developed.⁶⁷ There is as yet little information about the take up of this opportunity by veterans. We asked whether reservists got equal access to the DRC.

65 MoD (MIL0027) pages 9-10

66 Qq 132 and 149

67 MoD (MIL0027) page 8

Bryn Parry told us that they had an equal right to use the DRC but found it more difficult to get access particularly after they had been demobilised.⁶⁸

Capacity

53. In its response to our 2011 report, the MoD admitted that it would not reach its target for the capacity of the Army Recovery Capability on time.⁶⁹ Some wounded, injured or sick personnel are allocated a Personnel Recovery Officer (PRO) to help co-ordinate their recovery or medical discharge and gain access to the DRC. There has been a shortfall in capacity of the Army Recovery Capability which is dependent on the number of PRO who are in limited supply. The required capacity of the ARC was based on a throughput of 1,000 wounded, injured and sick personnel with a staff to personnel ratio of 1:15. The MoD subsequently found that a ratio of 1:12 was necessary and that the number of personnel requiring the services of a PRO was 1,700 at March 2014, of whom only 800 had a PRO.⁷⁰

54. There was some debate within the DRC providers about whether to centralise recovery services to make more efficient use of resources or to provide a more distributed service allowing those likely to be medically discharged to remain at home during their recovery period. Bryn Parry said:

The reality is that the personnel recovery officer therefore travels to see the soldier, who is normally at home, so a lot of their time is spent on the road. If we could better resource or better utilise and centralise our resources, the expertise could be centralised and the resident or the candidate could be brought to the expertise.⁷¹

However, Sue Freeth told us that:

[...] There are always going to be people who would prefer to recover at home and to dip in and out of the recovery centres. They will not necessarily always want to stay away from home, particularly if they spend long postings away from home. In fact, their recovery is probably better supported by enabling them to stay as close as possible to the community where they are going to be residing and living as they spend more time away from the armed forces and start to move away.⁷²

55. Admiral Williams said that the MoD had deliberately gone for a distributed system for the DRC as the best way to support the recovery of personnel, some of whom will be leaving the Services. He added:

We believe that if you force them all into a centre, then it may not be the optimal thing for them, because you take them away from, perhaps, family

68 Q139

69 [Government Response to the Armed Forces in Action? Part : Military Casualties, Tenth Special Report, 2010-12 HC1855](#)

70 MoD ([MIL0027](#)) page 11 and MoD and Department of Health ([MIL038](#)) section 2

71 Q134

72 Q137

and friends and other support. Most particularly, you may take them away from the very place that they are going to conduct their recovery transition from the service to the outside.⁷³

Evaluation of the DRC

56. The MoD, in conjunction with its charitable partners, carried out a review of the DRC one year after it achieved full operating capability to consider its current position and future development. On 23 May 2014, the Defence Recovery Steering Group chaired by the Assistant Chief of Defence Staff (Personnel and Training) agreed a number of outcomes including the need for the Army to increase the number of Army PROs; the need for an external assurance framework which would be commissioned from Ofsted; the importance of effective case management; and access to a common information system.⁷⁴

57. The shortfall in the capacity of the Defence Recovery Centres has meant that some wounded, injured or sick serving personnel have not been able to benefit from them and reservists, in particular, have found it difficult to access them. We welcome the opening up of the Centres to veterans but recognise that this will also increase demand. Whilst we welcome the Army's decision to increase the number of Personnel Recovery Officers, we doubt that this increase will be sufficient. In response to this Report, the MoD should outline both its estimates of expected demand on the Defence Recovery Capability from serving personnel, reservists and veterans and its estimates of the additional resources, in particular, numbers of staff, needed to meet those demands and also clarify whether staff will be provided by the MoD or the charitable sector.

58. The MoD should inform us of the latest progress in implementing the recommendations of its review of the Defence Recovery Centres. In particular, it should tell us how many additional Personnel Recovery Officers have been appointed, and when and how the new evaluation and assurance scheme for the Defence Recovery Centres will be implemented.

Provision of medical care to Armed Forces personnel

59. Primary health care for Armed Forces personnel is provided by the MoD, that is, the Defence Medical Services. Secondary health care is provided by the NHS except for injuries sustained on operations where medical services are provided by the MoD in theatre and the Queen Elizabeth Hospital in Birmingham and the Defence Rehabilitation Centre at Headley Court in Surrey. Headley Court also provides rehabilitation services for Service personnel with non-combat injuries. The MoD set out the healthcare responsibilities in Table 2 below.

⁷³ Q181

⁷⁴ MoD further evidence ([MIL045](#)) on the evaluation of the Defence Recovery Capability

Table 2: Responsibilities for the Healthcare of Armed Forces personnel in the UK

	Primary Healthcare	Secondary acute and community Healthcare	Community Mental Health	MOD Enhanced Pathways
Service Personnel	DMS	NHS ¹	DMS	DMS
Families registered with the DMS	DMS	NHS	NHS	N/A
Families registered with the NHS	NHS	NHS	NHS	N/A
Mobilised Reservists	DMS	NHS ¹	DMS	DMS
Non-Mobilised Reservists	NHS ²	NHS	NHS ³	N/A
Veterans	NHS	NHS	NHS ³	N/A

Notes:

1. The vast majority of secondary care services are funded and delivered by the NHS. The MOD has a contracted in-patient mental health service (a lower threshold is required for military admissions) and provides our own inpatient rehab capability at Defence Medical Rehabilitation

2. The Reserve Forces White Paper in July 2013 directed that Reservists should have access to MOD funded occupational health services. This will be managed by Defence Primary Health Care; it will include both rehabilitation and Mental Health advice.

3. Generally NHS but access to the Veterans and Reservists Mental Health Programme located at the MOD Department of Community Mental Health in Chetwynd Barracks, Chilwell.

Source: Ministry of Defence⁷⁵

Replacement for Headley Court Rehabilitation Centre

60. In our previous inquiry on military casualties, we found the quality of care and support at the Defence Medical Rehabilitation Centre at Headley Court to be very good. We were hugely impressed by the courage, hard work and determination of those injured on operations to recover and, if possible, to return to active service. Headley Court was instrumental in providing support to those so injured. We sought assurance from the MoD that Headley Court would continue to be adequately resourced.⁷⁶ In its response, the Government told us that it would continue to invest in Headley Court to provide first-class rehabilitation services and was considering the creation of a Defence and National Rehabilitation Centre (DNRC) using private funding.⁷⁷ On 10 July 2014, the Secretary of State for Defence announced that the MoD would transfer the Headley Court facility to the new DNRC when it opens in 2017. Construction work will start in 2015.⁷⁸ The new Centre is to be collocated with a civilian national rehabilitation centre. The Surgeon General, Air Marshal Paul Evans, said:

Thanks to the Duke of Westminster's initiative and his generosity, and that of other benefactors, a new state-of-the-art medical rehabilitation centre will provide our injured troops with a remarkable place to recover and begin rebuilding their lives.

The new centre will build on the legacy of the Defence Medical Rehabilitation Centre at Headley Court and the significant support it has

75 MoD and Department of Health ([MIL038](#))

76 [Defence Committee Report The Armed Forces Covenant in Action? Part 1: Military Casualties Seventh Report 2010-12, HC 762](#)

77 [Government Response to the Armed Forces in Action? Part 1: Military Casualties, Tenth Special Report, 2010-12 HC1855](#)

78 HoC Deb, 10 July 2014, [cols 29-30WS](#)

received from many forces charities, including Help for Heroes, the Royal British Legion and SSAFA. It will also provide the bedrock of the capability development for musculoskeletal injuries for the next 20 or so years.⁷⁹

61. The Defence Medical Rehabilitation Centre at Headley Court has been a valuable resource for those injured in the Armed Forces. We welcome the announcement of a new Defence and National Rehabilitation Centre and commend the generosity of those charities and individuals who have committed to fund the Centre. In response to this Report, the MoD should tell us what its financial and other commitments to the establishment will be over the next ten years. The MoD should also inform us of the results of its negotiations with the trustees about the future of Headley Court.

Chavasse report

62. In June 2014, Professor Tim Briggs, President of the British Orthopaedic Association presented his report (called the Chavasse Report) on the need for enhanced support for serving personnel including reservists and for veterans with musculoskeletal conditions.⁸⁰ In a forward to the report, Air Marshal Paul Evans, Surgeon General said:

Military Training is by necessity arduous and it is therefore not surprising that musculoskeletal injury is the greatest cause of secondary care referral for Service personnel, although patients are managed whenever possible by rehabilitation delivered by the Defence Medical Services within the Defence Medical Rehabilitation Programme. The veteran population is also at increased risk of earlier presentation of musculoskeletal problems as a result of the arduous nature of military training and operational exposure that they have undertaken during their Service career. Moreover, the greater reliance on Reservists will place additional pressure on the NHS to deliver timely access to elective orthopaedic care and rehabilitation if the Government's direction to increase the use of Reservists in the future is to be delivered. The Defence Medical Services are therefore committed to working with NHS England and the Devolved Administrations to deliver optimal orthopaedic care for Service personnel, Reservists and veterans.⁸¹

63. The report made a number of recommendations designed to provide high quality, timely and musculoskeletal healthcare service for all Armed Forces personnel in active service, volunteer reserves and those retired. This would require agreement and co-operation across the different sectors of NHS and the provision of advice and information to Armed Forces personnel and veterans.⁸²

79 [MoD press release 10 July 2014](#)

80 [The Chavasse Report: Raising the Bar](#)

81 [The Chavasse Report: Raising the Bar](#)

82 [The Chavasse Report: Raising the Bar](#)

64. The Government should tell us how it intends to respond to the conclusions and recommendations on the treatment of musculoskeletal conditions raised in the Chavasse Report for serving personnel, reservists and veterans.

Lost Voices Report

65. The Royal British Legion published a report on hearing loss in the Armed Forces in August 2014.⁸³ The report makes recommendations to better support Service personnel and veterans with hearing loss and tinnitus, and to encourage a healthier attitude to hearing protection amongst younger members of the Armed Forces.⁸⁴

66. The Government should tell us how it intends to respond to the recommendations on the support of Service personnel and veterans with hearing loss and tinnitus and on the prevention of hearing damage in younger members of the Armed Forces as set out in the Royal British Legion Report on hearing problems in the Armed Forces.

Armed Forces Compensation Scheme

67. The Armed Forces Compensation Scheme (AFCS) replaced the earlier War Pensions Scheme which runs concurrently with the AFCS for older veterans. A description of the Scheme is given in Box 4.

83 [Lost Voices A report by the Royal British Legion](#)

84 [Lost Voices A report by the Royal British Legion](#)

Box 4: The Armed Forces Compensation Scheme

Under the Armed Forces Compensations Scheme (AFCS) each claimed injury, illness (including mental illness) is investigated to see if it was predominantly caused by service whether on operations or while training or maintaining fitness. If so, it will then be matched against prescribed descriptors in the scheme's tariff system, which contains common disorders affecting the Armed Forces population. Each descriptor has a tariff level, which indicates how much compensation is to be paid. All descriptors attract a lump sum award of £1,200 to £570,000. The most serious conditions also attract a Guaranteed Income Payment, which is a life-long, tax-free addition to the pension to compensate for lost civilian earning potential. There are additional rules for multiple injuries and interim awards for claimants whose injury is clear, but whose recovery is not. AFCS also pays death benefits to surviving adult dependants and children.

Average clearance times for those claims registered with the Service Personnel and Veterans Agency between 6 April 2005 and 31 March 2013 were:

- Injury/illness claims - 125 days (min=0 days, max=2,225 days)
- Survivors' claims - 69 days (min=0 days, max=1,502 days)
- Reconsiderations - 72 days (min=0 days, max=965 days)
- Appeals - 370 days (min=0 days, max=2,243 days)

These times do not include the time taken to get medical information and medicals.

Source: Ministry of Defence⁸⁵

68. We were told that there had been significant delays in agreeing both lump sum payments and guaranteed income payments.⁸⁶ The MoD provided us with the monthly number of ongoing claims for the AFCS and the WPS from 2009–10 to 2013–14, see Tables 3 and 4 below. The number of claims for AFCS peaked in February 2013 and for WPS in June 2013.

Table 3: Armed Forces Compensation Scheme ongoing claims

	2009–10	2010–11	2011–12	2012–13	2013–14
April	2278	3091	2842	4545	6390
May	2058	3112	3058	4683	6505
June	2204	3181	3446	4901	6516
July	2297	3272	3714	5192	6079
August	2428	3132	4035	5654	6051
September	2406	3147	4183	5557	5653
October	2387	3272	4042	5721	5071
November	2409	3185	4211	6030	4372
December	2439	2898	4016	6516	4224
January	2586	2735	4128	6624	3882
February	2848	2812	4192	6665	3712
March	2987	2841	4125	6525	3345

Source: Ministry of Defence⁸⁷

85 MoD ([MIL0027](#)) page 15

86 MoD further evidence ([MIL041](#))

87 MoD further evidence ([MIL041](#))

Table 4: War Pension Scheme ongoing claims

	2009–10	2010–11	2011–12	2012–13	2013–14
April	5026	3457	3994	6447	9595
May	5116	3487	4091	6618	9739
June	4928	3530	4352	6619	9589
July	4960	3722	4585	7388	9557
August	4763	3565	4783	7302	9538
September	4423	3735	4924	7074	9476
October	4293	3893	5135	7482	8893
November	4141	3863	5081	7470	8790
December	3872	3627	4785	8468	8311
January	3540	3548	4977	8617	7838
February	3578	3658	5533	8879	7644
March	3455	3697	5774	9210	7741

Source: Ministry of Defence⁸⁸

69. In response to our follow up questions about the capacity of the Service Personnel and Veterans Agency, now Veterans UK,⁸⁹ the MoD said it had expected the number of claims to fall but that instead the schemes had come under further pressure for the following reasons:

- The quinquennial review into the AFCS conducted by Lord Boyce caused all the 12,000 cases previously approved to be reviewed. This caused backlogs in prospective cases.
- The number of AFCS claims has continued to rise at an average of 10% per annum since the scheme opened in 2005. It is a generous and well-publicised scheme. The publicity generated by the Boyce Review caused a further growth in claims.
- For WDP [War Disablement Pension] the recent reductions in the numbers of regulars in the armed forces, supported by the Armed Forces Redundancy Programme, has brought in more WDP claims than had been anticipated. These would more typically have come at a later point if the individual had stayed in service longer.
- People are living longer lives in society generally and under WDP pensioners may claim for deterioration of their accepted condition and for new conditions. There is no restriction as to how often and how many times they may claim.
- A general rise in the compensation culture in society.⁹⁰

88 MoD further evidence ([MIL041](#))

89 [In April 2014, the Service Personnel and Veterans Agency merged with Defence Business Services to become Veterans UK](#)

90 MoD and Department of Health ([MIL038](#))

70. The MoD told us that the following actions had reduced the level of outstanding claims in AFCS by 50 per cent and WDP by 35 per cent:

- Additional (up to) 51 temporary staff to tackle backlogs
- The provision of significant amounts of overtime, which has had a high take-up
- Support from other parts of DBS [Defence Business Services] by utilising spare capacity there
- Improvements to the computer systems that support the claims process
- Significant internal efficiencies that have been reinvested into delivering additional capacity⁹¹

71. Despite the assurances provided by MoD that the processing times had improved and backlogs reduced, we understand that serving personnel and veterans are still experiencing long delays in having their claims processed. We recognise that the backlog of cases awaiting award by Veterans UK has fallen but we are concerned that the throughput is still too slow. In response to this Report, the MoD should set out how it intends to reduce the time taken to adjudicate on claims under the Armed Forces Compensation Scheme and the War Pension Scheme.

91 MoD further evidence ([MIL041](#))

5 Longer term sustainability of support

Ensuring wounded, injured and sick veterans get the right support

72. Thanks to the excellent medical services in theatre and afterwards, many more Armed Forces personnel have survived serious battlefield injuries than ever before. These higher survival rates and the resultant complex medical needs of those survivors have serious implications for the individuals and the Health Service.

Long term impact on personnel severely injured

73. The Surgeon General told us that the MoD was setting up a 20 year longitudinal study of the impact of severe injuries on a sample of some 600 personnel:

That will mean that we then have a cohort with a control group set aside that we can follow through for the next 50 years, if we want to, in terms of the effect of amputation [...] on things such as the cardiovascular system, social well-being and the psychological effect. We will follow those people through and see what will be required, or not required, in the future.⁹²

74. The study will consider the medical and psychosocial outcomes of battle casualties from the Afghanistan war. It will look at a wide range of health measures including cardiovascular disease; obesity; osteoarthritis; mental health; long term quality of life; and occupational outcomes. It will be commissioned and led by the Surgeon General and his team.⁹³

75. We welcome the establishment of a longitudinal study looking at the long-term impact of injuries sustained in operations in Afghanistan. We will continue to take an interest in the progress of this long term study, its conduct and its management.

Physical health

Disablement centres–Murrison report

76. Following the second Murrison Report on a better deal for military amputees, the Department of Health established nine specialist disablement centres in England with a budget of £15 million over three years. Veterans can, however, choose to attend a local clinic if they wish. Alongside the creation of the disablement centres, a Veterans Prosthetic Panel was put in place to consider applications from veterans for prosthetic components. To the end of January 2014, the Panel had approved some 174 applications at a cost of £627,000 in 2012-13 and £470,000 in 2013-14.⁹⁴ BLESMA, previously known as the British Limbless Ex-Service Men's Association, welcomed the implementation of

92 Q189

93 MoD and Department of Health ([MIL038](#))

94 MoD ([MIL0027](#))

the Murrison Report but told us that there was inconsistent provision across the nine disablement centres which threatened confidence in the system.⁹⁵

Wheelchairs

77. Problems have emerged with the provision of wheelchairs for veterans.⁹⁶ The MoD and the Department of Health told us that they recognised the importance of the issue and that the number of people requiring wheelchairs would increase; Air Marshal Paul Evans, the Surgeon General said:

We do not know; we could find that several of the people—50% [of those with prosthetic limbs]—are in wheelchairs within 10 years of leaving the service. That is the sort of information we need to know. One hopes that, by giving them independence and the ability to function and get employment—maybe not in the military—that is the best we can do to get them to a point to deliver something useful for their lives ahead. That is obviously really important.⁹⁷

Kate Davies, NHS England said that more research on the long term impact of living with disabilities was needed:

Alongside that, in the first year we have agreed centrally to do some research on long-term living with disabilities and the impact of that, particularly for men and women. That is also about the long-term impact and how disability works with independent living. That research will have an advantage for the civilian population. That research was led by the sustainability element that we need to be aware of as part of commissioning and supporting that work that we are doing together.⁹⁸

Support for the mental health of veterans

78. As discussed in Part 2, the Armed Forces do not suffer more mental health problems than the general population but the Royal British Legion pointed out that there were concerns for the mental health of veterans. These include:

Across all age groups of Service personnel and amongst some groups of veterans, rates of alcohol misuse, including alcohol dependency, appear to be worryingly high. Some groups, such as those with pre-enlistment vulnerabilities, Reservists, and those exposed to combat, are at a significantly heightened risk of developing PTSD. Early Service leavers are a vulnerable group, with heightened rates of suicide. And, although the numbers surveyed were small, injured personnel or veterans may also be at an elevated risk of developing PTSD. Further research on larger samples could establish

95 BLESMA [\(MIL30\)](#)

96 BLESMA [\(MIL30\)](#)

97 Q190

98 Q191

whether this is an enduring trend. Overall, mental health outcomes for veterans and Armed Forces families—including the families of the WIS—remain poorly understood, as both groups have been under-researched.⁹⁹

79. In implementing the recommendations of the first Murrison report “Fighting Fit” on mental health support for those who have left the Services, the MoD, working with the charitable sector and the Department of Health, NHS England and the Devolved Administrations, has introduced a number of measures:

- The introduction of a mental assessment at discharge medicals;
- Access to the DCMHs for up to six months after discharge;
- The introduction of 10 veteran mental health teams across England;
- An e-learning package for GPs on the healthcare needs of veterans and their families;
- A Combat Stress and Rethink 24 hour mental health helpline for veterans funded by the Department of Health;
- The ‘Big White Wall’, an online support and self-help for veterans and serving personnel; and
- The Veterans Information Service run by the Service Personnel and Veterans Agency and linked to the Royal British Legion knowledge base allowing direct access to sources including if necessary crisis care.¹⁰⁰

80. We remain very concerned about the long term impact of deployment in Iraq and Afghanistan on those personnel who were injured physically or psychologically. Other aspects of Service life may also have a long term impact on the health of veterans. However, there are issues which need to be tackled now; these include provision for those requiring musculoskeletal treatment and wheelchairs and those suffering hearing loss.

81. We are not aware whether the MoD has made concerted and comprehensive efforts to keep in touch with people discharged from the Armed Forces due to life-changing injuries. The MoD should tell us how it intends to remain in contact with such discharged personnel to ensure that it can monitor whether individuals are receiving the support they deserve.

82. It is too soon to judge the long-term effectiveness of the measures to address the mental health needs of veterans. The MoD with the Department of Health should monitor the provision of mental health support to veterans and remedy any shortcomings identified. It should include the results of this monitoring in the annual report on the Armed Forces Covenant. The MoD should also monitor the implementation of the improved services for

99 Royal British Legion ([MIL020](#))

100 MoD ([MIL0027](#)) pages 3 - 4

amputees, act on any shortcomings and again report the results in the annual report on the Covenant.

83. Despite assurances from the MoD and the Department of Health, we are still worried that, as operations in Iraq and Afghanistan fade from the public eye, the necessary long term support for those injured will not be maintained. In response to this Report, the Government should make explicit its continued support for those damaged physically or psychologically in the service of the country.

Access to NHS services

84. Health services are provided to veterans through the NHS in England, Scotland, Wales and Northern Ireland. In principle, if their injury is related to service in the Armed Forces, veterans can get priority treatment, although as we found in our previous inquiry, this policy is not well understood by GPs or by veterans.¹⁰¹

85. The MoD Transition Protocol is an established practice designed to ensure the effective transition of health and social care of injured Service leavers to local public providers. The MoD told us that there was regular and close co-operation between the MoD, the Department of Health, NHS England and the Devolved Administrations to ensure that the protocol was working successfully.¹⁰² It is not clear that the protocol is working effectively for all those leaving the Services especially for those who are not in a Personnel Recovery Unit. The protocol requires personnel to register early with a GP in the area in which they intend to settle.¹⁰³

86. We asked the MoD whether it had resolved the problem of the transfer of medical records to the NHS when personnel leave the Armed Forces. The MoD told us that, in conjunction with the NHS across the UK, it had introduced a new system in December 2013:

When a service leaver registers with a civilian GP the individual's NHS record has a letter enclosed which informs the GP of their status as a veteran, that they have been issued with a summary of their care whilst in service, and how the GP can obtain their military medical record if necessary.

Although this system is only some four months old, the NHS Primary Care Support Service in Preston who have been dealing with the process of transfer of records from an NHS perspective have reported they are happy with the process and how it is working. They do not hold the figures for how many requests for records have been made and it is too early to state whether or not the system is a success but we will continue to monitor it closely.

101 [Defence Committee Report *The Armed Forces Covenant in Action? Part 1: Military Casualties* Seventh Report 2010-12, HC 762](#)

102 MoD and Department of Health [\(MIL038\)](#)

103 MoD and Department of Health [\(MIL038\)](#)

It is our intention to develop this new system further in due course to allow for a summary of in-service care to be included in the NHS record when it is sent to the civilian GP.¹⁰⁴

87. *The system intended to improve the transfer of the medical records of Armed Forces personnel leaving the Services has been in operation for less than a year. The MoD told us it will be monitoring performance closely. The MoD should provide us with a progress report on the success or otherwise of the system and the timetable for making the improvements that it was planning.*

88. The problems experienced by veterans in getting their medical needs met by the NHS are possibly greater than those experienced by recent Service leavers. The complexity of the healthcare arrangements with the Department of Health, NHS England and the Devolved Administrations were forcibly brought home to us during our inquiry. We took written evidence from the Devolved Administrations and oral evidence from the Department of Health and NHS England and from Ministers at the MoD and the Department of Health followed by further written evidence.¹⁰⁵ The MoD and the Department of Health have recently established a partnership board involving NHS England and the Devolved Administrations in Wales, Scotland and Northern Ireland. They intend that this Board will help ensure consistent access to health services across the UK.¹⁰⁶ Jon Rouse pointed out that health was delegated to local bodies and that “one person’s postcode lottery is another person’s localism. He further said:

[...] there is some really interesting and bespoke provision that is being developed in localities that you would not get if you had just a single national blueprint that was rolled down from on high. So there is a balancing act. We do need to ensure that there is consistency of standards, but by the same token we need to ensure that localities, linked to their community covenants, are able to develop localised responses as well.¹⁰⁷

89. *We have heard a great deal about the multiplicity of governance arrangements for healthcare and the processes for liaison between the MoD, the Department of Health, NHS England and the Devolved Administrations. We do not believe that these arrangements ensure that veterans get appropriate treatment for their needs and that this treatment is consistent across the whole of the UK. The Government should explain how the MoD’s recently created Partnership Board with the Department of Health, NHS England and the Devolved Administrations will ensure that serving personnel and veterans are receiving appropriate and consistent treatment wherever they live.*

104 MoD and Department of Health ([MIL038](#))

105 MoD and Department of Health ([MIL038](#)), MoD further evidence ([MIL041](#)), NHS England ([MIL024](#)) and Department of Health ([MIL042](#))

106 MoD further evidence ([MIL041](#))

107 Q163

Conclusions and recommendations

Mental health of Armed Forces personnel

1. We welcome the introduction of the Trauma Risk Management system and the MoD's work in reducing the stigma attached to seeking help for mental health problems. We also welcome the fact that personnel are seeking help for mental health problems earlier than in the past. The Armed Forces have seen a significant increase in the number of personnel requiring treatment by the Defence Community Mental Healthcare Teams without a proportional increase in the number of staff. Given evidence that Service personnel are coming for mental health support sooner than in the past and while they are still serving, pressure on existing resources will only increase. In response to this Report, the MoD should inform us of its plans to deal with the increased volume of work and tell us how quickly it can ramp up its support for personnel in the event of any further acceleration in the number of personnel coming forward for help. (Paragraph 18)
2. The higher incidence of mental health problems developing in reservists deployed to Iraq and Afghanistan has been known for some considerable time. Given our earlier recommendation in 2011 that it investigate the factors contributing to that higher incidence, we are disappointed that the MoD is still in the process of commissioning this research. This has meant that the MoD has yet authoritatively to identify or to address these issues and provide support specifically tailored for reservists. This is of great concern to the Committee given that the importance of identifying and addressing the particular problems facing reservists is increased by the growing dependence on Reserve Forces in Future Force 2020. (Paragraph 25)
3. We welcome the MoD's acceptance of our previous conclusion that it needed to recognise the seriousness of the problem of alcohol consumption in the Armed Forces and that it has strengthened its response to the problem. However, we remain concerned that the MoD's response has not had any noticeable impact on the level of excessive and binge drinking in the Armed Forces. We are not convinced that sufficient focus has been given to dealing with the problem at every level of the chain of command. We also question whether the MoD has examined whether excess alcohol consumption may, in some Service personnel, be masking other mental health problems. (Paragraph 32)
4. We are disappointed that the MoD took well over a year to commission research into the drivers of excessive alcohol consumption. The conclusions of the study are very worrying. Clearly, urgent action is needed to tackle the harm caused by the abuse of alcohol to both Armed Forces personnel and their families. In its response to this Report, the MoD should tell us how it intends to implement the study's recommendations and in what time frame. (Paragraph 33)
5. The MoD should determine a comprehensive strategy and plan to tackle alcohol misuse, identifying how it intends to change the culture within the Armed Forces and identifying practical measures to reduce consumption including, if necessary, reviewing pricing policies and availability of alcohol on bases. The plan should

incorporate the recommendations of the study on excessive alcohol consumption. It should also include performance measures which will indicate whether the plan is working in reducing excessive alcohol consumption. (Paragraph 34)

6. Increases in violent offending behaviour are linked to deployment in combat roles and subsequent misuse of alcohol and other risk taking behaviour. The MoD should identify those most at risk of such offending and put in place measures to assist these personnel to manage the aftermath of deployment in combat roles better. (Paragraph 37)
7. The MoD needs to understand better the links between deployment on combat operations, alcohol misuse and domestic violence. The MoD must be more proactive at all levels and should re-examine its policies on domestic violence and develop plans to intervene to prevent domestic violence or, at least, reduce the incidence of domestic violence by Armed Forces personnel. These plans should deal with both regulars and reservists. (Paragraph 41)

Support for families

8. We are disappointed that the MoD has taken so long to act on the recommendation in our December 2011 Report to review the support it offers families. Families need improved support, in particular, the families of reservists who find it harder to identify sources of support than regulars. The MoD should provide us with its study of the support to the families of wounded, injured and sick personnel as soon as it is available. It should also tell us how it intends to implement the recommendations of the SSAFA report on support to bereaved families and the above report. We call on the MoD to use the reports it has commissioned as the basis for a revision to its policy for the support of families. (Paragraph 49)

Support for the recovery of wounded, injured or sick personnel

9. The shortfall in the capacity of the Defence Recovery Centres has meant that some wounded, injured or sick serving personnel have not been able to benefit from them and reservists, in particular, have found it difficult to access them. We welcome the opening up of the Centres to veterans but recognise that this will also increase demand. Whilst we welcome the Army's decision to increase the number of Personnel Recovery Officers, we doubt that this increase will be sufficient. In response to this Report, the MoD should outline both its estimates of expected demand on the Defence Recovery Capability from serving personnel, reservists and veterans and its estimates of the additional resources, in particular, numbers of staff, needed to meet those demands and also clarify whether staff will be provided by the MoD or the charitable sector. (Paragraph 57)
10. The MoD should inform us of the latest progress in implementing the recommendations of its review of the Defence Recovery Centres. In particular, it should tell us how many additional Personnel Recovery Officers have been appointed, and when and how the new evaluation and assurance scheme for the Defence Recovery Centres will be implemented. (Paragraph 58)

11. The Defence Medical Rehabilitation Centre at Headley Court has been a valuable resource for those injured in the Armed Forces. We welcome the announcement of a new Defence and National Rehabilitation Centre and commend the generosity of those charities and individuals who have committed to fund the Centre. In response to this Report, the MoD should tell us what its financial and other commitments to the establishment will be over the next ten years. The MoD should also inform us of the results of its negotiations with the trustees about the future of Headley Court. (Paragraph 61)
12. The Government should tell us how it intends to respond to the conclusions and recommendations on the treatment of musculoskeletal conditions raised in the Chavasse Report for serving personnel, reservists and veterans. (Paragraph 64)
13. The Government should tell us how it intends to respond to the recommendations on the support of Service personnel and veterans with hearing loss and tinnitus and on the prevention of hearing damage in younger members of the Armed Forces as set out in the Royal British Legion Report on hearing problems in the Armed Forces. (Paragraph 66)
14. Despite the assurances provided by MoD that the processing times had improved and backlogs reduced, we understand that serving personnel and veterans are still experiencing long delays in having their claims processed. We recognise that the backlog of cases awaiting award by Veterans UK has fallen but we are concerned that the throughput is still too slow. In response to this Report, the MoD should set out how it intends to reduce the time taken to adjudicate on claims under the Armed Forces Compensation Scheme and the War Pension Scheme. (Paragraph 71)

Longer term sustainability of support

15. We welcome the establishment of a longitudinal study looking at the long-term impact of injuries sustained in operations in Afghanistan. We will continue to take an interest in the progress of this long term study, its conduct and its management. (Paragraph 75)
16. We remain very concerned about the long term impact of deployment in Iraq and Afghanistan on those personnel who were injured physically or psychologically. Other aspects of Service life may also have a long term impact on the health of veterans. However, there are issues which need to be tackled now; these include provision for those requiring musculoskeletal treatment and wheelchairs and those suffering hearing loss. (Paragraph 80)
17. We are not aware whether the MoD has made concerted and comprehensive efforts to keep in touch with people discharged from the Armed Forces due to life-changing injuries. The MoD should tell us how it intends to remain in contact with such discharged personnel to ensure that it can monitor whether individuals are receiving the support they deserve. (Paragraph 81)
18. It is too soon to judge the long-term effectiveness of the measures to address the mental health needs of veterans. The MoD with the Department of Health should monitor the provision of mental health support to veterans and remedy any

shortcomings identified. It should include the results of this monitoring in the annual report on the Armed Forces Covenant. The MoD should also monitor the implementation of the improved services for amputees, act on any shortcomings and again report the results in the annual report on the Covenant. (Paragraph 82)

19. Despite assurances from the MoD and the Department of Health, we are still worried that, as operations in Iraq and Afghanistan fade from the public eye, the necessary long term support for those injured will not be maintained. In response to this Report, the Government should make explicit its continued support for those damaged physically or psychologically in the service of the country. (Paragraph 83)
20. The system intended to improve the transfer of the medical records of Armed Forces personnel leaving the Services has been in operation for less than a year. The MoD told us it will be monitoring performance closely. The MoD should provide us with a progress report on the success or otherwise of the system and the timetable for making the improvements that it was planning. (Paragraph 87)
21. We have heard a great deal about the multiplicity of governance arrangements for healthcare and the processes for liaison between the MoD, the Department of Health, NHS England and the Devolved Administrations. We do not believe that these arrangements ensure that veterans get appropriate treatment for their needs and that this treatment is consistent across the whole of the UK. The Government should explain how the MoD's recently created Partnership Board with the Department of Health, NHS England and the Devolved Administrations will ensure that serving personnel and veterans are receiving appropriate and consistent treatment wherever they live. (Paragraph 89)

Formal Minutes

Wednesday 15 October 2014

Members present:

Rory Stewart, in the Chair

Mr James Gray

Derek Twigg

Mrs Madeleine Moon

Draft Report (*The Armed Forces Covenant in Action Part 5: Military Casualties, a review of progress*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 89 read and agreed to.

Summary agreed to.

Resolved, That the Report be the Fourth Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

Written evidence was reported to the House for publishing with the Report in addition to that ordered to be reported for publishing on 21 January, 12 and 25 February, 5, 11 and 18 March, 8 April and 2 July 2014.

[Adjourned till Tuesday 21 October 2014 at 2.00 p.m.]

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the Committee's inquiry page at [The Armed Forces Covenant in Action? Part 5: Military Casualties - UK Parliament](#).

Tuesday 21 January 2014

Question number

Professor Sir Simon Wessely, Director, King's Centre for Military Health Research, and **Professor Nicola Fear**, Director, King's Centre for Military Research

[Q1-89](#)

Tuesday 1 April 2014

Sue Freeth, Director of Operations, Royal British Legion, **Air Vice-Marshal David Murray**, Chief Executive Officer, SSAFA, **Bryn Parry**, Co-founder and Chief Executive, Help for Heroes, **Peter Poole**, Director of Strategic Planning and Partnerships, Combat Stress

[Q90-149](#)

Air Marshal Paul Evans, Surgeon General, MOD, **Rear Admiral Simon Williams**, Assistant Chief of Defence Staff (Personnel and Training), MOD, **Caroline Pusey**, Head of Service and Veterans' Welfare, MOD, **Surgeon Captain John Sharpley (RN)**, Defence Consultant Adviser in Psychiatry, MOD, **Jon Rouse**, Director General, Social Care, Local Government and Care Partnerships, Department of Health, and **Kate Davies**, Head of Public Health, Armed Forces and their Families and Health and Justice, NHS England

[Q150-198](#)

Tuesday 29 April 2014

Anna Soubry MP, Minister for Defence Personnel, Welfare and Veterans, Ministry of Defence, and **Dr Dan Poulter MP**, Parliamentary Under-Secretary of State for Health

[Q199-323](#)

Published written evidence

The following written evidence was received and can be viewed on the Committee's inquiry web page at [The Armed Forces Covenant in Action? Part 5: Military Casualties - UK Parliament](#). MIL numbers are generated by the evidence processing system and so may not be complete.

- 1 [Jonathan Morgan](#) (MIL 0002)
- 2 [Northern Ireland Department For Social Development](#) (MIL 0004)
- 3 [Professor Sir Simon Wessely And Dr Nicola Fear - written evidence](#) (MIL 0005)
- 4 [British Society Of Rehabilitation Medicine](#) (MIL 0008)
- 5 [Ssafo](#) (MIL 0007)
- 6 [British Society Of Rehabilitation Medicine](#) (MIL 0009)
- 7 [Bridge Across Service Into Civilian](#) (MIL 0012)
- 8 [Cobseo](#) (MIL 0013)
- 9 [The Ripple Pond - written evidence](#) (MIL 0016)
- 10 [Combat Stress - written evidence](#) (MIL 0018)
- 11 [D Giemza-Pipe Ma](#) (MIL 0019)
- 12 [The Royal British Legion](#) (MIL 0020)
- 13 [Royal College Of Physicians](#) (MIL 0021)
- 14 [Scottish Government](#) (MIL 0022)
- 15 [Forceswatch](#) (MIL 0023)
- 16 [Nhs England](#) (MIL 0024)
- 17 [Northern Ireland Executive](#) (MIL 0026)
- 18 [Ministry Of Defence](#) (MIL 0027)
- 19 [Major \(Rtd\) Terry Roper](#) (MIL 0028)
- 20 [Naval Families Federation](#) (MIL 0029)
- 21 [BLESMA - The Limbless Veterans](#) (MIL 0030)
- 22 [Help For Heroes](#) (MIL 0031)
- 23 [RAF Benevolent Fund And RAF Association](#) (MIL 0032)
- 24 [ABF - The Soldier's Charity](#) (MIL 0033)
- 25 [Welsh Government](#) (MIL 0034)
- 26 [Ministry Of Defence And The Department Of Health](#) (MIL 0038)
- 27 [NHS England](#) (MIL 0039)
- 28 [Raf Families Federation](#) (MIL 0040)
- 29 [Ministry Of Defence](#) (MIL 0041)
- 30 [Department Of Health](#) (MIL 0042)
- 31 [Ministry of Defence](#) (MIL 0044)
- 32 [Ministry Of Defence](#) (MIL 0045)

List of Reports from the Committee during the current Session

All publications from the Committee are available on the Committee's website at [Defence Committee - publications - UK Parliament](#).

The reference number of the Government's response to each Report is printed in brackets after the HC printing number.

Session 2014–2015

First Report	MoD Main Estimates 2014-15	HC 469 (<i>HC 681</i>)
Second Report and First Joint Report	Scrutiny of Arms Exports and Arms Controls (2014) First Joint Report of the Business, Innovation and Skills, Defence, Foreign Affairs and International Development Committees of Session 2014–15	HC 186
Third Report	Towards the next Defence and Security Review: Part Two: NATO	HC 358 (<i>HC 755</i>)
Fourth Report	The Armed Forces Covenant in Action Part 5: Military Casualties, a review of progress	HC 527
Fifth Report	Armed Forces (Service Complaints and Financial Assistance) Bill	HC 508