

SECTION 16.2

SUPPORT FOR INJURED SERVICE PERSONNEL AND VETERANS

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Introduction

1. This Section addresses:

- the arrangements for providing medical care to Service Personnel;
- the provision of medical care and welfare support for seriously injured Service Personnel and their families; and
- the support provided for veterans.

2. The welfare support provided to Service Personnel and their families is addressed in Section 16.1.

3. The preparations made for repatriating the bodies of those who lost their lives serving on Op TELIC, how their deaths were investigated, and the support provided for bereaved families are addressed in Section 16.3.

4. The decision to deploy to Helmand province in Afghanistan, and the implications of that decision, are addressed in Section 9.

System for providing medical care for Service Personnel

5. The healthcare system in the UK comprises three tiers:

- Primary care is provided at the first point of consultation, including by General Practitioners (GPs).
- Secondary care is provided by medical specialists who do not usually have first contact with patients, including in a hospital. It includes acute care.
- Tertiary care is specialised consultative healthcare, for example for cancer management.

6. Primary care for Service Personnel in the UK and Service base areas overseas is provided by the MOD's Defence Medical Services (DMS).¹

7. Secondary care for Service Personnel is generally provided within the National Health Service (NHS).

8. Following the closure of military hospitals in the 1990s, the Government established five MOD Hospital Units (MDHUs) within NHS Trusts. MDHUs are not discrete military wards or units, but comprise medical Service Personnel (including substantial numbers of Reservists) integrated into a host NHS Trust. MDHUs:

- provide accelerated access for elective referrals of Service Personnel, to meet operational requirements; and
- allow medical Service Personnel to develop and maintain their skills.

¹ Seventh Report from the House of Commons Defence Committee, Session 2007-2008, *Medical Care for the Armed Forces*, HC327.

- 9.** In April 2001, the MOD established the Royal Centre for Defence Medicine (RCDM) within the University Hospital Birmingham Foundation Trust (UHBFT), as “a centre of military medical excellence, with academic, teaching and clinical roles”.
- 10.** During the period covered by the Inquiry, the main receiving centre for casualties evacuated from operational theatres was RCDM Selly Oak (one of the hospitals within the UHBFT).²
- 11.** If Selly Oak was unable to cope with the flow of casualties, the Government could activate the Reception Arrangements of Military Personnel (RAMP) plan, engaging the wider NHS in the treatment of military casualties.
- 12.** Military patients requiring further rehabilitation once released from hospital might be referred to the Defence Medical Rehabilitation Centre (DMRC) at Headley Court in Surrey, the principal medical rehabilitation centre run by the Armed Forces.³ DMRC Headley Court also accepted direct admission from hospitals, and most combat casualties were referred directly to DMRC Headley Court from RCDM Selly Oak.
- 13.** DMRC Headley Court provided both physiotherapy and group rehabilitation for complex musculo-skeletal injuries, and neuro-rehabilitation for brain-injured patients.
- 14.** Operation TELIC was the first major military operation after the closure of the military hospitals in the 1990s. Many medical Service Personnel were therefore withdrawn from NHS Trusts, and military casualties were treated in NHS Trusts.
- 15.** Tertiary care for Service Personnel is provided by the NHS.
- 16.** From 2002, the MOD reconfigured its mental health services to focus on community rather than in-patient services, including by establishing 15 military Departments of Community Mental Health (DCMH) throughout the UK to provide out-patient mental healthcare for Service Personnel.⁴
- 17.** From 2004, in-patient mental healthcare was provided by The Priory Group of hospitals, through a contract with the MOD.
- 18.** Those changes were in line with NHS best practice, which held that individuals should be treated in as normal an environment as possible, close to their units, families and friends.
- 19.** The Ex-Services Mental Welfare Society (generally known as Combat Stress) runs three short-stay residential treatment centres for men and women who have served in

² Seventh Report from the House of Commons Defence Committee, Session 2007-2008, *Medical Care for the Armed Forces*, HC327, paragraph 21.

³ Paper MOD, 28 June 2010, ‘Medical Input to Ainsworth Brief’.

⁴ Seventh Report from the House of Commons Defence Committee, Session 2007-2008, *Medical Care for the Armed Forces*, HC327.

the Armed Forces or the Merchant Navy. The MOD meets the cost of fees charged by Combat Stress for “remedial treatment” at the three centres.⁵

20. Veterans’ healthcare is generally provided by the NHS. Charities and welfare organisations also play an important role.

Medical care during the combat phase of operations

Planning and preparing to provide medical care

21. In July 2002, the MOD defined three options for a UK contribution to US-led military operations in Iraq:

- Package 1 – an “in-place support package” using forces already in the region;
- Package 2 – an “enhanced support package” comprising Package 1 with additional air and maritime forces; and
- Package 3 – a “discrete UK package” based on deployment of an armoured division, in addition to the forces in Package 2.⁶

22. Those three options provided the broad framework for discussions within the UK Government until the end of 2002.

23. A Strategic Medical Estimate was prepared for the MOD’s Strategic Planning Group on 1 September 2002.⁷ The Estimate – which assumed an entry into Iraq from Turkey – set out the expected number of Role 3 hospital admissions from an operation in Iraq, as a basis for medical planning:

- 157 (best case) to 241 (worst case) battle casualties;
- 152 (best case) to 212 (worst case) casualties from chemical warfare;
- 15 percent of those exposed to biological warfare; and
- 34 Disease and Non-Battle Injuries (DNBI) a day.

24. The Estimate stated that 55 individuals a week would require medical evacuation back to the UK.

⁵ [Paper MOD, 29 June 2010, ‘Veterans Mental Health’.](#)

⁶ [Letter Watkins to Rycroft, 26 July 2002, ‘Iraq’.](#)

⁷ [Minute MOD \[junior official\] to Iraq Inquiry \[junior official\], 22 June 2010, ‘Iraq Inquiry – Request for Evidence’.](#)

Structure of medical support to operations

Military medical support was organised in four tiers, on the basis of the medical capabilities and resources available:

- Role 1 (broadly equivalent to Echelon 1 for maritime forces) medical support was integral or allocated to a small unit, and included the capabilities for providing first aid, immediate lifesaving measures, and triage.
- Role 2 support was normally provided at larger unit level, and included pre-hospital care.
- Role 3 support was normally provided at Division level and above. It included specialist diagnostic resources, and specialist surgical and medical capabilities. Support would usually be provided in field hospitals and (as Echelon 3) in hospital ships.
- Role 4 support was the definitive hospital and rehabilitative care of patients. That would usually be provided in the UK.⁸

25. General Sir Kevin O’Donoghue, Deputy Chief of Defence Staff (Health) (DCDS(H)) from September 2002 to 2004, told the Inquiry that medical planning was “quite advanced” by the time he took up post.⁹ Staffing plans were in place and gaps in medical equipment and supplies had been identified, although approval had not yet been received to begin procurement to fill those gaps.

26. On 31 October, Mr Blair agreed that the UK should offer Package 3 to the US on the same basis as Package 2, for planning purposes.¹⁰

27. In early December, an MOD official invited Mr Geoff Hoon, the Defence Secretary, to agree that the MOD should hold detailed talks with the Department of Health (DoH) on the withdrawal of Regular and Reserve medical personnel from the NHS, and on the reception of casualties under the RAMP.¹¹ Package 3 would require around 2,000 medical personnel, of whom approximately 60 percent would be Reservists. The majority of those Reservists would be working within the NHS; their withdrawal would have a “local impact”. DoH was pressing the MOD for details on the withdrawal of medical Reservists.

28. The official also advised that the procurement of medical equipment through the Urgent Operational Requirement (UOR) mechanism to support Packages 0 (Special Forces only) and Package 1 was under way. The Treasury was expected to authorise procurement of medical equipment to support Package 2 shortly. The MOD’s Directorate of Capability, Resources and Scrutiny (DCRS) had not yet approved the business case

⁸ NATO, *Logistics Handbook*, October 1997.

⁹ Public hearing, 14 July 2010, pages 4-5.

¹⁰ [Letter Wechsberg to Watkins, 31 October 2002, ‘Iraq: Military Options’.](#)

¹¹ Minute PS/VCDS to PS/Secretary of State [MOD], 6 December 2002, ‘Medical Support to Operations against Iraq’.

for the medical equipment to support Package 3; that approval, and the subsequent Treasury authority to commence procurement, was needed as soon as possible.

29. The official advised that in “about three months time” the DMS would have “minimised medical risk by being properly equipped in mission critical areas”.

30. On 11 December, Gen O’Donoghue told the Chiefs of Staff that the DoH had been engaged on Iraq planning, and had responded “positively and pragmatically”.¹²

31. The DCRS agreed the business cases for the medical modules (packages of equipment and supplies) to support Package 3 on 16 December.¹³ The modules were expected to achieve “full capability in theatre” on 15 March 2003.

32. At the beginning of 2003, in the light of continued uncertainty on whether Turkey would agree to the use of its territory by Coalition ground forces, the focus of UK military planning shifted from the North to the South of Iraq (see Sections 6.1 and 6.2).

33. The Permanent Joint Headquarters (PJHQ) assessed that the shift made the UK medical mission “less demanding in terms of supporting manoeuvre”.¹⁴ A revised Estimate specified that the Role 3 medical support required:

- the Royal Fleet Auxiliary (RFA) Argus, as the Primary Casualty Receiving Facility (PCRF), with 100 beds;
- two 200-bed field hospitals deployed;
- a third 200-bed field hospital in reserve;
- casualty staging flights through Cyprus; and
- the augmentation of the Princess Mary Military Hospital in Cyprus.

34. RFA Argus deployed on 15 January and was operational in the North Arabian Gulf by mid-February.

35. Mr Alan Milburn, the Health Secretary, wrote to Mr Hoon on 10 March to inform him that the DoH was ready to activate the RAMP, when required.¹⁵

36. Mr Hoon was advised by PJHQ on 14 March that an “effective medical capability”, scaled to the expected number of casualties, was now operational in theatre.¹⁶ Arrangements were also in place for the aeromedical evacuation of casualties to the UK.

¹² Minutes, 11 December 2002, Chiefs of Staff meeting.

¹³ Minute MOD/DCRS [junior official] to APS/SoS [MOD], 31 January 2003, ‘Possible Operations against Iraq UOR List, 31 January 2003’.

¹⁴ Report PJHQ, July 2003, ‘Operation TELIC 1 – Medical Post Operation Report’.

¹⁵ Letter Milburn to Hoon, 10 March 2003, ‘Military Deployment to the Middle East: the NHS’s Responsibilities’.

¹⁶ Minute PJHQ [junior official] to PS/SoS [MOD], 14 March 2003, ‘Op TELIC – Casualty Treatment and Management Arrangements’.

37. Gen O’Donoghue told the Inquiry that by 19 March, when military operations against Iraq began, there remained some “shortfalls” in medical modules:

“We had worked out what equipment we needed. We were allowed to discuss that informally with industry in, I think, mid-November. We weren’t allowed to place the orders until early to mid-December, which we did with £34m/£35m worth of UORS, and those came in between then and March.

“Some items may not have arrived by March, but they came fairly shortly afterwards and we topped up the modules.”¹⁷

38. Sections 6.3 and 13 describe the development and approval of UOR business cases within the MOD and discussions with the Treasury on funding UORs. A mechanism for funding UORs was agreed between Mr Hoon and Mr Brown on 23 September; the mechanism did not require individual UORs to be agreed by the Treasury. Mr Hoon agreed that the MOD could begin discussions with industry on the provision of UORs on 2 December.

39. Brigadier Alan Hawley, Commander Medical of the Joint Force Logistic Command during Op TELIC 1 (which covered the initial combat phase of military operations in Iraq), told the House of Commons Defence Committee in October 2003:

“From where I was, no one informed me of any clinical care that was compromised by a lack of equipment. I have to say that it was very tight.”¹⁸

40. Brig Hawley assessed that a number of factors had combined to produce that “rather tight, fraught situation”, including the late release of money for UORs, a new process for building medical equipment modules, and a change in responsibility for medical supply from the medical to the logistical Command.

41. Vice Admiral Ian Jenkins, Surgeon-General from 2002 to 2006, agreed with Brig Hawley’s assessment:

“... I can categorically assure you that clinical outcomes [during Op TELIC 1] were uncompromised. Yes there were problems with supply, equipment and everything else, mobilisation of Reserves, support ... but the clinical outcomes were first class. I can put my hand on my heart and say that nobody suffered inappropriately because of a lack of medical requirement.”¹⁹

¹⁷ Public hearing, 14 July 2010, page 7.

¹⁸ Defence Committee, *Examination of Witnesses (Questions 1176-1179)*, 22 October 2003, Q 1211.

¹⁹ Defence Committee, *Examination of Witnesses (Questions 1176-1179)*, 22 October 2003, Q 1217.

42. Lieutenant General Louis Lillywhite, the Director General of Army Medical Services from 2003 to 2005 and Surgeon General from 2006 to 2009, told the Inquiry that cost had not been an issue in providing medical care:

“As far as care on operations are concerned, it is effectiveness that counts, not cost-effectiveness. As far as providing care for Servicemen was concerned, I was – I personally, and I have to say Ministers supported me – did not allow cost to be an issue. If it was required, it was provided.”²⁰

43. A July 2003 MOD report on Op TELIC 1 stated that the medical component of the deployment was fully staffed, with 2,800 medical staff including 760 Reservists.²¹ Trained psychiatric staff were also deployed.

Arrangements for supporting mental health

44. Lt Gen Lillywhite described for the Inquiry, the Armed Forces’ general approach to identifying and tackling mental health issues at the beginning of Op TELIC:

- using initial and subsequent training to identify individuals with less ability to withstand stress, and to help prepare people to withstand stress;
- training commanders to identify issues as early as possible; and
- deploying field psychiatric teams to help identify those “who had true psychological disability, that ... needed care and evacuation or simply support and return to duty”.²²

45. Prior to deployment on Op TELIC, Royal Navy and Army units received a pre-deployment presentation by a psychiatrist or community psychiatric nurse (or non-medical personnel if medical personnel were unavailable).²³ As the RAF deployed as individuals rather than formed units, it produced an equivalent booklet for all deploying personnel.

46. The Services also prepared post-deployment stress prevention packages, comprising two handouts and a post-operational psychological briefing.

47. MOD demobilisation policy at the beginning of Op TELIC required that:

- At the end of an operational tour but while still in theatre, all individuals should attend a presentation and be given an information leaflet covering post-traumatic stress reactions and the problems that might be encountered on returning home to families. Families should be offered a presentation and information leaflets on the possible after-effects of an operational deployment.

²⁰ Public hearing, 20 July 2010, page 73.

²¹ Ministry of Defence, *Operations in Iraq: First Reflections*, July 2003.

²² Public hearing, 20 July 2010, pages 54-55.

²³ Minute DMSD/MOD to USoS [MOD], 2 April 2003, ‘Op TELIC – Personnel Repatriated for Medical Reasons’.

- All personnel should undertake a period of “normalisation”, lasting two to three days, before taking post-operational tour leave. It would usually be spent on routine duties. This requirement stemmed from the MOD’s assessment that:
 - The immediate release of personnel after an operational tour could be a contributory factor to the likelihood of developing post-conflict syndromes.
 - Personnel should be given time to deal with issues raised by combat in the company of those who understood and had shared those experiences.²⁴

48. This policy applied to Reservist as well as Regular Personnel.

49. Lieutenant General Anthony Palmer, Deputy Chief of the Defence Staff (Personnel) (DCDS(Personnel)), wrote to General Sir Mike Jackson, Chief of the General Staff, on 23 April 2003, advising:

“At this morning’s Op COS meeting you mentioned concerns among some of the deployed Personnel that their return to the UK was being delayed because of the requirement for a period of ‘normalisation’ ...

...

“Ultimately the implementation of the overall policy guidance lies with PJHQ and the FLCs [Front Line Commands] ... However, the lessons learned from the last Gulf Conflict in particular have demonstrated how important it is – not least in terms of demonstrating due diligence – that we are rigorous in adopting formal procedures to reduce the risks and incidence of psychological illness.”²⁵

Delivery of medical care

50. The MOD reported in July 2003 that more than 4,000 British patients had been treated in British field hospitals, and over 800 evacuated to the UK by air, during the deployment and combat phases of Op TELIC.²⁶ The majority of those patients had suffered disease and non-battle injuries.

51. Around 200 Iraqi Prisoners of War and 200 Iraqi civilians had also been treated in British medical facilities.

52. The number of admissions to Role 3 hospitals during Op TELIC 1 are set out in the table below.²⁷

²⁴ Paper DFRC/MOD, 16 April 2003, ‘Operation TELIC – Demobilisation’.

²⁵ Minute DCDS(Pers) to CGS, 23 April 2003, ‘Op TELIC – Normalisation’.

²⁶ Ministry of Defence, *Operations in Iraq: First Reflections*, July 2003.

²⁷ [Minute MOD \[junior official\] to Iraq Inquiry \[junior official\], 22 June 2010, ‘Iraq Inquiry – Request for Evidence’](#).

Table 1: Admissions to Role 3 hospitals during Op TELIC 1

	Expected number of admissions ²⁸	Actual number of admissions
Battle casualties	157-241	81
Casualties from chemical warfare	152-212	0
Casualties from biological warfare	15 percent of those exposed	0
Disease and Non-battle Injuries	34 a day	31 a day
Medical evacuations	55 a week	90 a week

53. In July, PJHQ assessed that medical support during Op TELIC had been “a success by any measure”.²⁹ The aeromedical evacuation of casualties (by VC 10 to Cyprus then by civilian aircraft to the UK) had been particularly effective.

54. PJHQ reported that some evacuated Service Personnel were nursed in NHS hospitals without other military patients and had therefore lacked “peer support”.

55. The issue of treating injured Service Personnel in NHS hospitals, and on civilian wards, would come to prominence in 2006.

56. Lt Gen Lillywhite told the Inquiry that in the early part of Op TELIC, the MOD did not have the data to make an objective assessment of the effectiveness of emergency care.³⁰ Analysis of data relating to later phases of Op TELIC indicated that UK medical support was achieving a significantly greater than expected survival rate.

57. Gen O’Donoghue told the Inquiry that the DMS drew two major lessons from its experience during the invasion:

- It needed more Regular medical Personnel, to take account of the limited time that any individual could spend in theatre given their NHS commitments and the need to retain “medical dexterity”.
- UORs allowed DMS to respond to particular threats and secure the latest equipment, but it needed more equipment and supplies “on the shelves” ready to deploy.³¹

58. Lt Gen Lillywhite described a number of changes in the provision of medical care after Op TELIC 1.³² During Op TELIC 1, the MOD generally used armoured ambulances to move casualties from aid posts to medical regiments and a mixture of ambulances and helicopters to get from (Role 2) medical regiments to hospital. From Op TELIC 2, the military generally used helicopters to move from the point of wounding or the aid post to hospital.

²⁸ As defined in the 1 September 2002 Strategic Medical Estimate. Figures for battle casualties and casualties from chemical warfare represent best and worse case estimates respectively.

²⁹ Report PJHQ, July 2003, ‘Operation TELIC 1 – Medical Post Operation Report’.

³⁰ Public hearing, 20 July 2010, pages 14-16.

³¹ Public hearing, 14 July 2010, pages 16-17.

³² Public hearing, 20 July 2010, pages 22-23.

59. Lt Gen Lillywhite told the Inquiry that he had not experienced any problems in securing sufficient helicopters for those medical moves.

Support for injured Service Personnel and their families

60. The number of casualties and aeromedical evacuations relating to Op TELIC are set out in the table below.³³ The figures for 2003, 2004 and 2005 reflect military casualties only; the figures for 2006 onwards reflect military and civilian casualties.

Table 2: Casualties and aeromedical evacuations relating to Op TELIC

Year	Casualties			Aeromedical evacuations
	Total	Very Seriously Injured or Wounded	Seriously Injured or Wounded	
2003	46	14	32	
2004	45	14	31	
2005	20	5	15	
2006	32	11	21	701
2007	69	24	45	603
2008	9	5	4	433
2009	1	0	1	234
Total	222	73	149	1,971

Establishing a Military Managed Ward at Selly Oak hospital

61. MOD Ministers and senior military officers made regular visits to injured Service Personnel, both in the UK and Iraq.³⁴

62. Mr Blair made a private visit to RCDM Selly Oak in February 2005.

63. Mr Des Browne, the Defence Secretary, visited RCDM Selly Oak on 15 August 2006.

64. Lt Gen Freddie Viggers, the Adjutant General, visited RCDM Selly Oak on 21 August.³⁵ He reported on 22 August that:

- The quality of clinical care was excellent.
- Morale among military medical staff was “fragile”, due to under-manning, the joint military/civilian structure, and the physical environment.
- Wounded soldiers wanted to be looked after in a military environment “within which they can be with their mates, be looked after by named military nurses

³³ DASA, [undated], *Op TELIC Casualty and Fatality Tables: 1 January 2003 to 31 July 2009*. The figure for 2009 is to 31 July 2009. Casualty figures exclude casualties due to natural causes.

³⁴ Minute Batchelor to PS/SoS [MOD], 13 August 2006, ‘Preparatory Brief for Visit to RCDM HQ on Tuesday 15 Aug 06 of the Rt Hon Des Browne MP Secretary of State for Defence’.

³⁵ Minute AG to DCDS (Health), 22 August 2006, ‘Visit to Royal Centre for Defence Medicine (RCDM) – 21 August 2006’.

and be treated like soldiers (including security)". Enhancing the military environment was "essential" for soldiers' physical and psychological recovery.

- It was iniquitous that soldiers being treated at the RCDM Selly Oak lost their entitlement to the Operational Welfare Package (OWP) and some other allowances. The OWP would provide much of the support (including TVs, DVDs and telephone calls) that were currently being provided from "assorted non-public funds" or paid for by the soldiers themselves.

65. Lt Gen Viggers identified a number of immediate actions, including:

- informing wounded personnel what the MOD was planning to do to create a military environment;
- starting to create that military environment, by putting soldiers together in one area of a ward; and
- extending the OWP to patients.

66. On 23 August, General Sir Timothy Granville-Chapman, Vice Chief of Defence Staff (VCDS), reported that Mr Browne had given him a "very thorough de-brief" on his 15 August visit to RCDM Selly Oak.³⁶ Key points included:

- Mr Browne was "very seized" with the need for injured personnel to recover in a military environment, and was clear that a "military ward solution" was needed.
- Mr Browne was "very much behind" Lt Gen Viggers' recommendation that the OWP should be extended to injured personnel.

67. The following week, the MOD's Service Personnel Board (SPB) considered a package of financial and non-financial measures which aimed to replicate the effects of the OWP for in-patients, whether at the RCDM or elsewhere.³⁷ The SPB was advised that, although the package was "work in progress", Gen Granville-Chapman was clear that the proposal "cannot bear the delay inherent in the usual staff circulations".

68. The package, which included the payment of Incidental Expenses to in-patients and an extension to the Dangerously Ill Forwarding of Relatives (DILFOR) scheme, was agreed and implemented by the end of September.³⁸

69. The extension of the DILFOR scheme provided for two close family members to visit the permanent residence of a hospitalised Service person, so that they could support the family members there. The DILFOR scheme was extended again in 2008

³⁶ Minute VCDS to DCDS(Pers), 23 August 2006, 'SoS Visit to Headley Court and RCDM'.

³⁷ Paper MOD, 31 August 2006, 'Welfare Support for Service In-Patients'.

³⁸ Minute Randall to Fleet-NLM DACOS PPA, 27 September 2006, 'Extension of DILFOR Travel Arrangements to the Families of Service Personnel who are Hospitalized'; Minute Randall to Fleet-NLM DACOS PPA, 27 September 2006, 'Payment of Incidental Expenses to Service Personnel who are Hospitalized'.

to allow multiple journeys to and from a hospital if the family was unable to remain at the bedside.³⁹

70. In early October, there was considerable press coverage of alleged verbal abuse of military patients at Selly Oak hospital by members of the public.⁴⁰

71. On 24 October, the SPB assessed that action to establish a Military Managed Ward (MMW) at RCDM Selly Oak was “well in hand”, and that:

“Security had been the biggest issue, and a weekly meeting was now in place between the local police (who have security primacy), MOD Police, RCDM and NHS Staffs.”⁴¹

72. General Sir Richard Dannatt made his first visit to RCDM Selly Oak as Chief of the General Staff (CGS) in December.⁴² He reported to Air Chief Marshal Jock Stirrup, Chief of the Defence Staff, that while progress was being made, the “whole ‘system’ for dealing with those wounded on operations, once back in the UK, has been allowed to sink to such a woefully inadequate level that the task to rebuild it ... is huge”. He identified two underlying problems:

- RCDM was principally focused on delivering trained medical staff, rather than treating the wounded.
- The MOD had implicitly accepted that the NHS level of care was “good enough” for Service Personnel. That was reasonable for clinical care, but not for other issues such as the nurse to patient ratio, access to specialist units, and food.

73. Gen Dannatt concluded that efforts to establish an MMW needed to be re-invigorated and, more fundamentally, that the MOD should “operationalise” Selly Oak as a Role 4 military medical facility.

74. The MMW reached Initial Operating Capability in December 2006 and Full Operating Capability in July 2007, when it comprised 39 medical Service Personnel (compared with 12 in summer 2006):

- 11 orthopaedic nurses;
- 15 general nurses; and
- 13 healthcare assistants.⁴³

75. Gen Dannatt visited the MMW at Selly Oak on 22 June 2007 and reported that it was “at last moving in the right direction”.⁴⁴ Clinical care, welfare support and administration were better led and co-ordinated, and there was a greater sense of

³⁹ Paper MOD, June 2010, ‘Operational Welfare Enhancements as at June 2010’.

⁴⁰ *Daily Mail*, 5 October 2006, *Calls for ‘military-wards’ to protect troops from abuse*.

⁴¹ Minutes, 24 October 2004 Service Personnel Board meeting.

⁴² Minute Dannatt to CDS, December 2006, ‘CGS Visit to RDCM Selly Oak: 6 December 06’.

⁴³ [Paper MOD, 28 June 2010, ‘Medical Input to Ainsworth Brief’](#).

⁴⁴ Minute Dannatt to VCDS, 26 June 2007, ‘Visit to Selly Oak – 2 Jun 07’.

urgency, although “we should not take any satisfaction in reaching what is only the basic level of care that our wounded servicemen deserve”.

76. The challenge now was to ensure that clinical, welfare and administrative support was delivered to injured personnel in a holistic manner wherever they were in the healthcare system.

77. In February 2008, the House of Commons Defence Committee described the clinical care for Service Personnel injured on operations as “second to none”.⁴⁵ The Committee commented, however, that “many of the improvements ... are relatively recent, and there has been a great deal of change over the past 18 months. The MOD should not be complacent: they have had to learn important lessons and it is now clear that the picture at Selly Oak was not always so positive.”

78. Specific issues cited in the report included the provision of toiletries and basic clothing for Service Personnel, travel assistance for the families of injured Service Personnel, and accommodation for the relatives of parents. The report stated that improvements were taking place, but “some of the slack had been taken up by welfare organisations”.

79. Mr Adam Ingram, Minister for the Armed Forces from 2001 to 2007, told the Inquiry:

“It became very clear early on that there was a problem at Selly Oak. It wasn’t the question of the quality of the medical care. It was the fact that they were in mixed [military/civilian] wards. You had soldiers who had been attended to by civilian nurses, civilian doctors and in the next bed there may well be a civilian injured person or old person.

“That became a big issue. My instinct initially was ... that if I was injured, I just wanted the best medical care ...

“But, as a result of a number of visits, Ministerial visits, it became abundantly clear we needed to do other things. So progressively, the number of military personnel, in terms of the medical care, changed ...”⁴⁶

80. Lt Gen Lillywhite told the Inquiry:

“It quickly became apparent that returning casualties actually wanted to be looked after by the military ...

“Although at no stage ... was the clinical care of casualties coming back from Iraq compromised, there was an unhappiness amongst the patients themselves and their relatives about the lack of military involvement in both their care, although actually much more so in their welfare support.

⁴⁵ Seventh Report from the House of Commons Defence Committee, Session 2007-2008, *Medical Care for the Armed Forces*, HC327, pages 3 and 13.

⁴⁶ Public hearing, 16 July 2010, page 49.

“So there was a period when the plan, which was working, was not in accord with what people had expected or wanted. So that led to a significant period of adverse press and internal adverse press as well, whilst both the medical services, but even more so the chain of command, organised themselves to actually provide that military bubble around the care in the hospital.”⁴⁷

81. Lt Gen Lillywhite told the Inquiry that, while establishing a “military bubble” – such as the MMW – around a military patient did not improve the quality of clinical care, “one should not underestimate the beneficial impact upon recovery, upon family dynamics, and upon psychological wellbeing of actually being content”.⁴⁸ He added that the importance of continuing to provide a military bubble during treatment was one of the main lessons learned by DMS and the MOD from Iraq.

Improvements at Headley Court

82. The facilities at DMRC Headley Court had been significantly enhanced by the end of Op TELIC, including through:

- the opening of a Complex Rehabilitation and Amputee Unit in June 2006: a contract was let to a private company that manufactured individually tailored prosthetics on site;⁴⁹
- construction of a 30-bed temporary ward annex, which was brought into use in May 2007;⁵⁰
- construction of a 58-bed staff and patient accommodation block (Wood House) in January 2009; and
- the opening of the Centre for Mental and Cognitive Health, to provide mental health and clinical psychology services, in spring 2009.

83. In May 2008, Ministers announced £24m in capital funding over four years for a Headley Court development programme. Over the first two years, this funding was mainly applied to the MOD contribution to the “Help for Heroes” rehabilitation complex (which was officially opened in June 2010) and a utilities upgrade for the whole site.

84. Lt Gen Lillywhite told the Inquiry that, while Headley Court was a “centre of excellence”, it was also “the greatest area of risk in actually managing casualties”.⁵¹ The first risk area was its capacity:

“We were seeing far more cases that needed in-patient care in beds than we had ever seen probably since Korea ... and the capacity of Headley Court was not sufficient to have met it. Luckily, the building programme, the temporary ward, the

⁴⁷ Public hearing, 20 July 2010, pages 33-34.

⁴⁸ Public hearing, 20 July 2010, pages 35-36.

⁴⁹ Seventh Report from the House of Commons Defence Committee, Session 2007-2008, *Medical Care for the Armed Forces*, HC327.

⁵⁰ [Paper MOD, 28 June 2010, ‘Medical Input to Ainsworth Brief’.](#)

⁵¹ Public hearing, 20 July 2010, pages 39-40.

relationships with the local planning authority, enabled us just to keep ahead of the surge. A close run thing, I think, but we kept ahead of the surge.”

85. The second risk area was the building itself:

“Headley Court is a fine listed building, which had in essence for many years treated sports injuries, complex sports injuries, but not open wounds. What we have started doing in this conflict is starting rehabilitation ever earlier, with significant success. But it posed risk in the type of surroundings that they were being managed in, in that Headley Court was not set up to look after cases that were open wounds or complex medication that required ongoing non-rehabilitation specialist care.”⁵²

86. The Inquiry visited Headley Court in October 2010, and spoke to a number of members of staff and Iraq veterans. Members of staff told the Inquiry that it would be helpful if they were given more forewarning about deliberate operations with potential for high casualties.

87. In early October 2006, Gen Dannatt directed Major General Mark Mans, the Deputy Adjutant General (DAG), to lead an assessment of in-Service welfare provision to see where improvements could be made.⁵³ Gen Dannatt directed that the assessment should include discussions with the Soldiers, Sailors, Airmen and Families Association (SSAFA) on bringing back SSAFA Social Workers.

88. Maj Gen Mans replied to Gen Dannatt on 30 November, recommending that he should:

- invite the SSAFA to:
 - provide short-stay hostels for families at Selly Oak and Headley Court;
 - provide additional support for vulnerable Service leavers;
 - provide enhanced support for Service parents of children with disabilities and special needs; and
 - provide enhanced adoption services;
- enhance the current Army Welfare Service (AWS) structure with additional Civil Service Social Workers and Welfare Workers; and
- invite DCDS(Personnel) to organise a “wide-ranging, tri-Service, Ministerially-led” conference to increase understanding of welfare and healthcare support to the ex-Service community.

89. Maj Gen Mans advised that the AWS, like the rest of the Army, was “running hot”. The “heavy burden” of operational commitments and increased casualties had led to a 20 percent increase in the AWS’s workload over the past year. Using Civil Service (rather than SSAFA) Social Workers would give the AWS access to an established and

⁵² Public hearing, 20 July 2010, pages 40-41.

⁵³ Minute DAG to CGS, 30 November 2006, ‘Welfare and Aftercare’.

trained delivery network with a national footprint. SSAFA could be best deployed to provide support on discrete activities to specific groups.

90. Lt Gen Mans advised colleagues in December 2006 that Gen Dannatt considered it was timely to hold a wide-ranging conference on welfare and aftercare provision for Service leavers and veterans, “[a]gainst a background of changing operational imperatives, high commitment levels and evolving welfare demands, as well as a steadily declining knowledge and consciousness amongst the public and in the media of military needs and expectations during and after service”.⁵⁴

91. The Tri-Service Welfare Conference was held in April 2007.⁵⁵

92. Gen Dannatt wrote in his autobiography that although no major decisions were taken at the conference, “all those present were left in no doubt that those of us at the top of the organisation [the MOD] knew what the problems were, understood them, and had a determined commitment to tackle them”.⁵⁶

The role of charitable organisations

In the UK, charitable organisations have traditionally played an important role in providing care to Service Personnel and veterans, often working closely with the MOD, the NHS and the private sector.

Lt Gen Lillywhite told the Inquiry that the MOD welcomed the involvement of charitable organisations (although it might not always agree with their approach):

“They all have a desire to actually progress the care of Servicemen ... and they actually contribute significantly to; one, promoting the cause of particularly the ex-Servicemen; secondly, they are quite good at challenging us on what we are doing or not doing; and thirdly, they often bring a degree of expertise or approach that we might not otherwise have recognised.

“... it is a complex relationship but they are an essential part, in my view, of our society in terms of actually ensuring that veterans in particular, but to a lesser extent, serving soldiers, get the appropriate care that they require.”⁵⁷

In his autobiography, Gen Dannatt described how, in 2007, charitable organisations became increasingly involved in military medical and welfare issues, as the number of casualties in Iraq and Afghanistan grew and the “fragility of the ... arrangements for our seriously injured become painfully apparent”.⁵⁸ That fragility related not to clinical care, which was excellent, but to the broader support that was available to injured personnel and their families.

⁵⁴ Paper Mans, 20 December 2006, ‘Army Welfare and Aftercare Conference Victory Services Club, London on Mon 16 Apr 07’.

⁵⁵ Minute MOD [junior official] to PS/Minister for Veterans [MOD], 5 June 2007, ‘Veterans Forum – 15th June 2007’.

⁵⁶ Dannatt R. *Leading from the Front*. Bantam Press, 2010.

⁵⁷ Public hearing, 20 July 2010, pages 70-72.

⁵⁸ Dannatt R. *Leading from the Front*. Bantam Press, 2010.

Gen Dannatt wrote that the increasing involvement of charitable organisations was, in his view, not a response to “a challenge thrown down by the Government, merely evidence that the nation was beginning to get behind its soldiers and their families”.

Handling complex cases

93. Lt Gen Lillywhite told the Inquiry that survival rates improved significantly over the course of Op TELIC.⁵⁹ He also highlighted the increasing number of Service Personnel with “complex injuries” that would be seen in civilian life extremely rarely, and for which civilian medical and social services have not been set up to manage.

94. Lt Gen Lillywhite also told the Inquiry that since the start of the Iraq conflict, the MOD had taken a more flexible approach to determining the appropriate date for discharge, which now depended on the individual’s circumstances.⁶⁰ He described that to be “a compassionate response to ... very, very serious injuries and sometimes family situations”.

95. A particular challenge was managing the transfer of care from the military system to the NHS, when an individual with complex injuries was discharged.⁶¹ The military system was holding onto casualties for longer, and in some cases to a point where it did not have all the capability required to care for the individual. However, at that same point, the NHS was not set up to provide the comprehensive care that was required.

Lt Gen Lillywhite commented:

“So arranging that care package requires individual persuasion, discussion, debate, with the local authorities in the place where that individual is at home. Of course, the issue of funding can then come into it ...

“So the ongoing care of the complex casualty is throwing up issues that we have not seen before.”

96. Lt Gen Lillywhite suggested that individuals with complex injuries should be treated by the Government as a group with specific clinical needs, in recognition of their service and on clinical grounds to enable specialist care to be arranged and provided more consistently.⁶² He subsequently stated:

“I had general agreement when I was in office that that was what was required, but it needs giving effect to, and there are ongoing issues that can be only addressed

⁵⁹ Public hearing, 20 July 2010, page 41.

⁶⁰ Public hearing, 20 July 2010, pages 52-53.

⁶¹ Public hearing, 20 July 2010, pages 47-49.

⁶² Public hearing, 20 July 2010, pages 41-42.

in my view by treating them as a group ... for example, giving them the advanced prostheses in the future, giving them access to new techniques that are becoming available as a result of research.”⁶³

Clinical developments during Op TELIC

The MOD told the Inquiry that it had identified five major “lessons” from the provision of medical care during Op TELIC, and had incorporated those lessons into its medical procedures.⁶⁴ The lessons were:

- Novel haemostatics. Experience during Op TELIC showed that control of catastrophic bleeding in the first 10 minutes after wounding led to a significant improvements in mortality and morbidity rates. New blood clotting agents, the Combat Applied Tourniquet, and an improved First Field dressing were introduced to arrest the flow of blood more effectively.
- Medical Emergency Response Teams (MERTs). Experience during Op TELIC led to the creation of Immediate Response Teams (IRTs), to deliver medical care at the point of wounding. The concept was developed into MERTs, which deliver consultant-led, pre-hospital emergency care.
- The introduction of a more capable “ground evacuation platform” (based on the Mastiff) which improved soldiers’ confidence in the casualty evacuation chain and significantly improved the delivery of medical care during evacuation.
- The introduction of digital imaging which allowed casualties to be diagnosed more quickly and more accurately.
- The development of an enhanced system for capturing medical data from all parts of the operational medical chain which improved casualty care and treatment regimes.

The Inquiry asked Lt Gen Lillywhite what the MOD had learned from Op TELIC about trauma care.⁶⁵ Lt Gen Lillywhite highlighted three areas:

- how to save life at the point of injury, including through the use of haemostatic dressings and massive transfusion protocols;
- how to sustain the quality of life of seriously injured individuals into the long term; and
- pain management.

Lt Gen Lillywhite added that those advances, and others, were being transferred to civilian medicine.

⁶³ Public hearing, 20 July 2010, page 92.

⁶⁴ [Minute MOD \[junior official\] to Iraq Inquiry \[junior official\], 22 June 2010, ‘Iraq Inquiry – Request for Evidence’.](#)

⁶⁵ Public hearing, 20 July 2010, pages 24-27.

Support for mental health

Research into the physical and psychological health of Operation TELIC personnel

97. Following a meeting of the Veterans Task Force on 10 April 2003, and as major combat operations in Iraq continued, Dr Lewis Moonie, the Parliamentary Under Secretary of State for Defence, discussed with MOD officials the value of initiating a long-term study of the health of Op TELIC veterans.⁶⁶

98. In early May, an MOD official asked Dr Moonie to agree that the UK Government should support a large-scale programme of research on the physical and psychological health of personnel deployed on Op TELIC.⁶⁷ The cost could not yet be precisely estimated, but could be around £3m.

99. The official commented that the UK Government had moved “far too late” to initiate research programmes after the 1990/1991 Gulf Conflict, leading to a loss of trust from veterans and the public:

“By the time we [the Government] responded concern was widespread and the idea of a ‘Gulf War Syndrome’, for which there is still no scientific evidence, had taken root.

“We therefore need to act early this time and put in place as soon as possible a robust programme of research ... and respond as necessary.”

100. Dr Moonie agreed that recommendation.⁶⁸

101. The MOD subsequently commissioned the King’s Centre for Military Health Research (the King’s Centre) at King’s College London to undertake a large-scale epidemiological study into the physical and psychological health of personnel deployed on Op TELIC.⁶⁹ The “primary objectives” of the study were:

- to assess the physical and psychological health of personnel deployed on Op TELIC in comparison with personnel not deployed on Op TELIC; and
- to ascertain whether an “Iraqi War Syndrome” had emerged following deployment, similar to the Gulf War Syndrome.

⁶⁶ Minute PS/USofS [MOD] to Hd GVIU, 11 April 2003, ‘Op TELIC: Studies of Returning Service Personnel’.

⁶⁷ Minute MOD [junior official] to PS/USofS [MOD], 1 May 2003, ‘Op TELIC – Research into Possible Health Effects Post-Conflict’.

⁶⁸ Minute PS/USofS [MOD] to Hd GVIU, 6 May 2003, ‘Op TELIC – Research into Possible Health Effects Post-Conflict’.

⁶⁹ King’s Centre for Military Health Research, 2006, *The Iraq Study 2003 – 2006: Monitoring the Physical and Psychological Health of Personnel Deployed on Operation TELIC 1 (Op TELIC 1): Key Results from Stage 1*.

102. Secondary objectives included:

- to compare the health of Regular and Reservist Personnel; and
- to assess risk-taking behaviours (alcohol consumption and risky driving) in personnel deployed on Op TELIC.

103. In December 2003, the MOD published a report on lessons it had drawn from operations in Iraq.⁷⁰ The report provided a brief update on the King's College work, and concluded that "to date, we are not aware of any unusual pattern of ill-health in returning personnel".

104. The initial findings of the King's College research were published in May 2006.

Over-Arching Review of Operational Stress Management

The MOD completed its Over-Arching Review of Operational Stress Management (OROSM) in September 2004, and a second phase covering Training and Communications Strategies in April 2005.

The OROSM defined six steps in operational stress management:

- pre-service entry beliefs and attitudes;
- in-service training and promotion courses for career development;
- pre-deployment;
- operational deployment;
- post-operational recovery; and
- on discharge from the Armed Forces.

Implementation and delivery of operational stress management within that framework remained the responsibility of the individual Services.

The OROSM clearly identified operational stress management as a management, rather than a medical, responsibility.

Decompression

105. Over the course of Op TELIC, in addition to the requirement for a period of "normalisation" at the end of an operational tour, commanders increasingly opted for their units to undertake a formal period of decompression at the end of an operational tour, as part of post-operational stress management.⁷¹

106. Decompression involved "placing groups into a structured and – critically – monitored environment in which to begin winding down and rehabilitating to a normal, routine, peacetime environment". Any individual considered to be vulnerable to any form

⁷⁰ Ministry of Defence, *Operations in Iraq: Lessons for the Future*, December 2003.

⁷¹ Minute DCDS(Pers) to VCDS, July 2007, 'Decompression'.

of post-operational stress should be identified, so that the appropriate support could be provided as the individuals passed through the demobilisation process.⁷²

107. The MOD assessed that decompression was best suited to formed teams and units.⁷³ Where possible, units should include individual augmentees (including Reservists) in their decompression arrangements. In the cases of individuals who were not available for the decompression period, the “clinically relevant” elements of the decompression process could be covered by pre-departure briefings and the subsequent normalisation period.

108. For Army units on Op TELIC, decompression usually took place in Cyprus over a period of 36 hours.

109. The first formal period of decompression took place in 2004, at the end of Op TELIC 3.⁷⁴

110. By July 2007, the MOD’s policy was that formed units should have a period of decompression unless a formal application to opt out had been agreed by the chain of command.⁷⁵ Air Marshal (AM) David Pocock, the Deputy Chief of Defence Staff (Personnel), advised Gen Granville-Chapman that, in the absence of evidence of “clinical efficacy”, the policy was based on the “military judgement” that decompression promoted adjustment and re-integration into a normal environment.

111. In August 2010, the MOD produced an analysis of Op TELIC from a Land perspective.⁷⁶ The analysis stated that many units reported that individual augmentees and members of the TA could “fall between the cracks” and not carry out decompression. Some units reported that members of the TA could not remain with the unit during normalisation when it took place in the unit’s barracks, and therefore went home.

112. The MOD concluded:

“... a debate remains to be had about whether the main effort for Reservists should be to return them to civilian life as quickly as possible or extend their period in mobilised service to effect full normalisation ... What is vital is to ensure that all TA Personnel are given adequate transition back to civilian life, and this includes important information on where to get assistance if he/she needs it. POSM [Post-Operational Stress Management] must continue through their chain of command.”

⁷² Minute DCDS(Pers) to MA/USoS [MOD], December 2006, ‘Management of Personnel Returning from High Intensity Operations’.

⁷³ Minute DCDS(Pers) to VCDS, July 2007, ‘Decompression’.

⁷⁴ Minute DCDS(Pers) to MA/USoS [MOD], December 2006, ‘Management of Personnel Returning from High Intensity Operations’.

⁷⁵ Minute DCDS(Pers) to VCDS, July 2007, ‘Decompression’.

⁷⁶ Report Land Command, 31 August 2010, ‘Operations in Iraq: An Analysis from a Land Perspective’.

Variations in the level of support after an operational deployment

113. The Inquiry heard from a number of veterans and witnesses that the level of support received by personnel returning from Op TELIC varied significantly.

114. The Inquiry asked Lieutenant General Sir Alistair Irwin, Adjutant General from 2003 to 2005, whether he was aware of that variation and, if so, what was done to address it.⁷⁷ He told the Inquiry:

“... we were aware that there were varying standards ... That was obviously a worry because, where the standard was good, that was fine. Where the standard was not good, then something clearly needed to be done about it.

“So there was a constant interchange between my people, who were producing the advice, the guidance, the policy, and the people who were actually delivering these things, which were ... the welfare staffs ... the field Army and the chain of command.

“... there was, amongst us all collectively, a desire to deliver as good a product as we could for those who needed it but, when it boils down to it, when you have a complex machine that consists of over 100,000 individual people, you can be absolutely certain, no matter what it is that you do, that there will be people who one way or another don't live up to the standard required.

“So much to the regret of all of us involved, there were unquestionably people who weren't looked after as well as they should have been. There is no doubt about that and each one of them represents, in some degree or another, a failure.

“I hope, though ... without in any way wanting to sound complacent about it, that that number was probably relatively small.”

115. Lt Gen Irwin agreed that those individuals were more likely to have returned to environments without significant military support around them, including Reservists returning to civilian life and Regular Personnel living away from barracks.

116. Vice Admiral Peter Wilkinson, Deputy Chief of Defence Staff (Personnel) from 2007, told the Inquiry:

“Certainly, when we started the campaign, we were much more adept at looking after the large, formed units than we were on those individuals who had either gone out as single staff or on an augmentee basis.

“I think, as we have gained greater experience of the operation and of the likely pressures on the troops, then we have become more adept and more proactive at looking after their likely needs.”⁷⁸

⁷⁷ Public hearing, 21 July 2010, pages 29-31.

⁷⁸ Public hearing, 19 July 2010, page 24.

First reports from the King's Centre study

117. Professor Simon Wessely and Professor Christopher Dandeker presented the early findings of the King's Centre study to the 25 May 2005 meeting of the Service Personnel Board (SPB).⁷⁹ The record of the meeting reported:

"The initial observations suggest that for Regulars, there was no Iraqi War syndrome, no increases in general mental health problems and PTSD [Post-Traumatic Stress Disorder], or increases in alcohol intake. These observations were different to Op GRANBY [the 1990/1991 Gulf Conflict]. For Reservists, there have been increases in general mental health problems and a doubling of PTSD, but no increase in alcohol intake."

118. Two papers from the King's Centre study into the physical and psychological health of personnel deployed on Op TELIC were published in May 2006.

119. The first paper concluded that for Regular Personnel, deployment to Iraq had not, so far, been associated with significantly worse health outcomes, apart from a modest effect on multiple physical symptoms.⁸⁰ There was, however, evidence of a clinically and statistically significant effect on the health of Reservists, in relation to PTSD symptoms, multiple physical symptoms, and general perceptions of health.

120. The second paper concluded that there had been no substantial increase in symptomatic ill-health amongst members of the Regular Armed Forces who had taken part in the invasion of Iraq, and there was no pattern suggestive of a new syndrome.⁸¹ That finding was in contrast to the situation after the 1990/1991 Gulf Conflict, when a substantial increase in symptomatic ill-health had been observed.

121. On 16 May, Mr Tom Watson, the Parliamentary Under Secretary of State for Defence, set the conclusions of the papers and the Government's response in a written statement to Parliament:

"... a small but measurable number of Reservists (when compared either with Regulars who did deploy or Reservists who did not deploy) are showing some increased health effects as a result of deployment – particularly for common mental disorders (such as anxiety, depression and stress), post traumatic stress disorder and fatigue. It remains the case, though, that the reported rates of indicators of common mental ill-health for both Reservists and Regulars are broadly of the same order as found in the general UK population."⁸²

⁷⁹ Minutes, 25 May 2005, Service Personnel Board meeting.

⁸⁰ Hotopf et al. The health of UK military Personnel who deployed to the 2003 Iraq war: A cohort study. *The Lancet* **367**: 1731-1741 (2006).

⁸¹ Horn et al. Is there an 'Iraq War Syndrome'? Comparison of the health of UK Service Personnel after the Gulf and Iraq wars. *The Lancet* **367**: 1742-1746 (2006).

⁸² House of Commons, *Official Report*, 16 May 2006, column 43WS.

122. Mr Watson described the issue of Reservists' mental health as the "key finding" of the study, advised that the Government was already monitoring the issue closely and looking at possible solutions, and announced that the Government would introduce an enhanced post-operational mental health programme for recently demobilised Reservists later in the year.

123. Lt Gen Lillywhite told the Inquiry that there might be several reasons why Reservists might suffer more from mental health issues:

- less preparatory training throughout their careers than Regular Personnel;
- a less supportive environment for the families of Reservists than for Regular Personnel;
- a less robust selection process; and
- an absence of "ongoing support from their peers" when Reservists left the military environment and returned to civilian life.⁸³

124. The King's Centre study was extended in 2006 into a second phase (2007 to 2010), and broadened to include all subsequent Iraq deployments and deployments to Afghanistan.⁸⁴

Reserves Mental Health Programme

125. In November 2006, in response to the findings of the King's Centre study, the MOD launched the Reserves Mental Health Programme (RMHP), to provide enhanced mental healthcare to current and former Reservists who had been demobilised since 1 January 2003 following deployment on an overseas operation.⁸⁵

126. The RMHP provided a mental health assessment and, if appropriate, out-patient treatment at one of the MOD's Departments of Community Mental Health (DCMHs). In-patient treatment was provided through the NHS.

127. The MOD assessed that there could be, in the worse case, a "backlog" of 680 individuals (who had been demobilised since 1 January 2003 and who had concerns over their mental health), who would be referred to the RMHP when it launched.⁸⁶ Thereafter the RMHP was expected to receive 75 referrals a year.

128. A 2011 study concluded that the RMHP was an effective method of treatment for those who accessed it.⁸⁷

⁸³ Public hearing, 20 July 2010, pages 60-61.

⁸⁴ [Paper MOD, 29 June 2010, 'Veterans Mental Health'](#).

⁸⁵ Surgeon General's Policy Letter 28/06, 21 November 2006, 'Reservists Mental Health Programme'.

⁸⁶ Paper MOD, 25 August 2006, 'Recently Demobilised Reservists Mental Health Project: The Proposal and Business Process'.

⁸⁷ N Jones et al. A Clinical Follow-up Study of Reserve Forces Personnel Treated for Mental Health Problems Following Demobilisation. *Journal of Mental Health* **20** (2011).

Concerns over mental health issues, late 2006

129. Section 16.1 describes the concerns of General Sir Richard Dannatt, Chief of the General Staff (CGS) from August 2006, that the Army was “running hot” and the military covenant was out of balance.⁸⁸

130. Gen Dannatt visited Iraq in late September 2006.⁸⁹ His report to Air Chief Marshal Jock Stirrup, Chief of the Defence Staff (CDS), highlighted the psychological welfare of Service Personnel as one area where action was required:

“I was concerned to hear that there had been 99 referrals to the Field Mental Health Team from 20 Bde alone during their tour. This number seems high, though I suspect as people start returning to Iraq (or Afghanistan) for the third or fourth time it will not be atypical. I am aware ... that we do not equip our soldiers as well as we might during their pre-deployment training for the combat stress of operations. I am discussing this with AG [the Adjutant General, Lt Gen Viggers], and we will shortly be taking steps to improve our commanders’ understanding of, and ability to deal with, psychiatric casualties in theatre. I will ensure that this work informs DCDS(Personnel)’s Overarching Review of Operational Stress Management.

“I am less sanguine, however, about what happens to psychological casualties evacuated back to UK – in the case of 20 Bde about 20 individuals. As I understand it, once in the UK these casualties are managed by The Priory, a civilian contractor, for psychiatric treatment. Not only do we tend to lose track of these casualties thereafter, but I feel intuitively that rustication from a military environment is hardly the best way to treat all but the very worst of our stress casualties. Indeed, experience from recent major conflicts tells us that soldiers suffering from combat stress are best treated in as military an environment as possible. Once the psychological props of discipline, esprit de corps, ethos and humour are removed, the road to recovery for stress casualties grows that much longer. Now that we have decided, quite rightly, to run RCDM Birmingham on more military lines,⁹⁰ we should at least ask ourselves similar questions over our care of psychiatric casualties.”

131. Gen Dannatt subsequently tasked Major General Mark Mans, the Deputy Adjutant General (DAG), to address those concerns.⁹¹

⁸⁸ Letter Dannatt to Browne, 31 August 2006, [untitled].

⁸⁹ Minute Dannatt to CDS, 2 October 2006, ‘CGS’ Visit to Iraq: 26-28 Sep 06’.

⁹⁰ A reference to the decision to establish a Military Managed Ward at Selly Oak hospital.

⁹¹ Minute DAG [MOD] to CGS, 30 November 2006, ‘Welfare and Aftercare’.

132. Mr Ingram visited Iraq from 30 September to 1 October.⁹² His Private Secretary reported that three concerns had been raised with Mr Ingram with regard to “psychiatric treatment”:

- There was an “apparent upward trend (if not surge)” in the number of people requiring support in the second half of six-month tours.
- The US provided “significantly more in-theatre welfare/counselling support” than the UK (although the US deployed personnel for longer than the UK).
- Personnel evacuated back to the UK to receive treatment at The Priory had, from their unit’s perspective, been “‘lost’ for weeks at a time”.

133. Maj Gen Mans replied to Gen Dannatt on 30 November, advising that:

- The high level of psychiatric casualties being referred to the Field Mental Health Team (FMHT) was a positive feature rather than a cause for concern, as it reflected a willingness by personnel to consult the FMHT. The number of personnel evacuated from theatre was lower than might be expected from the number of referrals to the FMHT.
- The current system for providing care for personnel evacuated from theatre with mental health problems (treatment at The Priory and/or the MOD’s Departments of Community Mental Health) conformed to psychiatric best practice. The recently activated RMHP would also help.
- Regarding commanders’ understanding of and ability to deal with psychiatric issues, the OROSM had recommended that personnel receive stress management training at points throughout their career. This recommendation had been partially implemented; full implementation required resources and training time.⁹³

134. In November, Mr Derek Twigg, Parliamentary Under Secretary of State for Defence, expressed his concern that the MOD was not providing a “comprehensive rehabilitation package” for personnel returning from operations.⁹⁴

135. AM Pocock responded in December.⁹⁵ He advised that a forecast that the current downward trend in Road Traffic Accidents would stall, and a recent King’s Centre paper indicating an increased tendency towards risk-taking behaviour after deployment, both supported Mr Twigg’s “nagging concern” that the MOD might not be providing the support that personnel (including Regulars, Reservists, formed units, individuals, and individuals who had been medically evacuated) required.

⁹² Minute PS/Min(AF) [MOD] to MA/CJO, 4 October 2006, ‘Iraq: Minister (AF)’s Visit 30 Sept – 1 Oct ‘06’.

⁹³ Minute DAG to CGS, 30 November 2006, ‘Welfare and Aftercare’.

⁹⁴ Minute DCDS(Pers) to MA/USoS [MOD], December 2006, ‘Management of Personnel Returning from High Intensity Operations’.

⁹⁵ Minute DCDS(Pers) to MA/USoS [MOD], December 2006, ‘Management of Personnel Returning from High Intensity Operations’.

136. AM Pocock set out the six-step process defined by the MOD's Operational Stress Management Policy and highlighted the role of decompression as one element of step 5 (post-operational recovery). Work to evaluate the effectiveness of decompression was under way.

137. In July 2007, AM Pocock advised Gen Granville-Chapman that, following the 2005 OROSM review, the MOD's policy on operational stress management was "both comprehensive and robust".⁹⁶ The MOD had now undertaken an analysis within the three Services and the Civil Service of how much training for operational stress was available and how effective it was. This "gap analysis" indicated that the three Services "already do much to address [operational stress management] training needs". A bid for resources to plug the gaps, including the wider implementation of the Royal Marines' Trauma Risk Management programme proposed by the Army, would be submitted.

Trauma Risk Management

138. In 2008, the Armed Forces rolled out Trauma Risk Management (TRiM) in all three Services.⁹⁷

139. Lt Gen Lillywhite described TRiM as a form of debriefing after a traumatic event,⁹⁸ but undertaken in peer groups rather than by an external counsellor. The person who was leading the debriefing was taught to identify whether their colleagues were under stress and might need referral elsewhere.⁹⁹

Further findings from the King's Centre study

140. Further reports from the King's Centre study in 2009 and 2010 reported that:

- There was no increase in mental health problems in Regular Personnel serving in Iraq or Afghanistan, compared with Regular Personnel not deployed to Iraq or Afghanistan.
- The rate of symptoms of PTSD remained "relatively low" among Regular Personnel deployed to Iraq or Afghanistan; estimates ranged between 1.3 and 4.8 percent following deployment. The rate of symptoms of PTSD in the general UK population was approximately 3 percent.
- Between 16 and 20 percent of Regular Personnel reported common mental disorders, such as depression and anxiety. This was similar to the rate in the general UK population.

⁹⁶ Minute DCDS(Pers) to VCDS, July 2007, 'Decompression'.

⁹⁷ Seventh Report from the House of Commons Defence Committee, Session 2010-2012, *The Armed Forces Covenant in Action?*, HC 762.

⁹⁸ Traumatic events might include sudden death, serious injury, near misses and overwhelming distress when dealing with disaster relief and body handling.

⁹⁹ Public hearing, 20 July 2010, pages 56-57.

- Alcohol misuse was a common problem among Regular Personnel deployed to Iraq and Afghanistan. In the first phase of the King's Centre study (2003 to 2006), only "combat troops" were found to have a higher prevalence of alcohol misuse following deployment to Iraq. Later analyses showed a higher prevalence of alcohol misuse among all Regular Personnel who were deployed to Iraq or Afghanistan, regardless of their role on deployment.
- "Combat troops" deployed to Iraq and Afghanistan showed a small but significant increase in the risk of symptoms of PTSD compared with non-combat troops. Approximately 7 percent of combat troops had symptoms of PTSD following deployment.
- Reservists deployed to Iraq or Afghanistan were at a higher risk of reporting symptoms of PTSD, when compared with Reservists not deployed to Iraq or Afghanistan. The King's Centre commented that many factors could contribute to the excess of mental ill-health observed in deployed Reservists, including their relative inexperience of combat operations, lower unit cohesion, and problems in the home and work environment during or after deployment. The King's Centre also commented that despite the introduction of measures focused on helping Reservists (including the RMHP and better support for Reservists' families), the excess of mental health problems (specifically PTSD) observed among Reservists deployed to Iraq and Afghanistan was "disappointingly persistent".
- Multiple deployments were not consistently associated with an increased risk of mental health problems. However, the cumulative duration of deployments did affect mental health; if troops deployed for more than 13 months over a three-year period they were at increased risk of mental health problems, particularly an increased risk of PTSD symptoms. The King's Centre commented that the finding supported the MOD's Harmony Guidelines for Army Personnel. Ensuring that the Guidelines were not exceeded could help to reduce the risk of mental health problems in the UK's Regular forces.
- Regular Personnel were at increased risk of alcohol misuse and PTSD symptoms where the tour length was extended during the deployment itself.¹⁰⁰

141. The King's Centre concluded:

"Despite extended campaigns in Iraq and Afghanistan, the prevalence of mental disorders in the UK's Armed Forces remains low. PTSD is in fact an issue for a relatively small proportion of military personnel. Of particular concern, however, are the high levels of alcohol misuse in Regulars, the mental health of combat troops and also the mental health of Reservists. These three issues require attention over the coming years."

¹⁰⁰ Forbes et al. The Mental Health of UK Armed Forces Personnel: The Impact of Iraq and Afghanistan. *RUSI Journal*, **156**: 14-20 (2011).

The Harmony Guidelines and mental health

Professor Christopher Dandeker, Professor of Military Sociology at King's College London and Co-Director of the King's Centre for Military Health Research, told the House of Commons Defence Committee in March 2008 that:

“... so far as our own research is concerned ... I think that the Harmony Guidelines have been well constructed because the evidence suggests that if you stay within them they [Service Personnel] do not suffer; if you go beyond them there is a 20 to 50 percent likelihood that they will suffer in terms of PTSD [Post Traumatic Stress Disorder]”.¹⁰¹

In his evidence to the Inquiry, Air Marshal David Pocock, Deputy Chief of Defence Staff (Personnel) from 2005 to 2007, questioned whether Professor Dandeker was right to suggest that the Harmony Guidelines were an appropriate basis for assessing the effect of operational deployment on individuals.¹⁰² The Guidelines had been derived in a straightforward way from the planning assumptions used in SDR 98 (‘what operations have we got? How many people have we got? ... that means that they can spend this long away’). AM Pocock said that his focus had been on the broader relationship between time deployed on operations and the risk of mental health issues.

142. The Inquiry asked Lt Gen Lillywhite how the MOD’s approach to mental health had changed over the course of Op TELIC.¹⁰³

143. Lt Gen Lillywhite told the Inquiry that the “perennial challenge” was to overcome the stigma associated with mental health issues:

“A lot of effort has gone into educating both commanders and individuals that psychological adverse effects is not something that needs to be hidden. We have not fully succeeded, nor has any other nation, and neither has the civilian population. Mental health continues to have a stigma amongst many that actually inhibits its presenting for care early.”

144. Lt Gen Lillywhite highlighted the introduction of a decompression period after an operational deployment and TRiM, as two significant developments in the MOD’s approach to supporting mental health.

Compensation

145. The MOD provided compensation to Service Personnel who suffered from illness or injury, including mental health problems.

¹⁰¹ Fourteenth Report from the Defence Committee, Session 2007-2008, *Recruiting and retaining Armed Forces Personnel, Oral and Written Evidence (25 March 2008)*, HC424.

¹⁰² Public hearing, 19 July 2010, pages 68-70.

¹⁰³ Public hearing, 20 July 2010, pages 55-57.

146. For illnesses and injuries caused before 6 April 2005, compensation was provided under two separate compensation arrangements, the War Pensions Scheme (WPS) and the Armed Forces Pension Scheme 1975 (AFPS 75).

147. In September 2003, after a consultative process which began in 2001, the Government announced that it would introduce a new Armed Forces Pension Scheme (AFPS 05) (see Section 16.1) and a new compensation scheme.¹⁰⁴ The new compensation scheme would be introduced in April 2005 and would replace provisions under the War Pensions Scheme and attributable benefits under AFPS 75.

148. Mr Ivor Caplin, the Parliamentary Under Secretary of State for Defence, told Parliament that the new compensation scheme would have “more focus on the more severely disabled” and would provide a lump-sum payment for “pain and suffering” – a benefit that was not available under the current arrangements.

149. The new compensation scheme – the Armed Forces Compensation Scheme (AFCS) – was introduced on 6 April 2005.¹⁰⁵ The AFCS:

- Provided compensation for any injury, illness or death which was caused by service on or after 6 April 2005. That included injury or illness which occurred while participating in a “service related activity”, such as organised sport.
- Covered all current and former members of the Armed Forces, including Reservists. For the first time, serving members of the Armed Forces could make claims.
- In the event of service-related death, paid benefits to eligible partners and children. An eligible partner was described as “someone with whom you are cohabiting in an exclusive and substantial relationship, with financial and wider dependence”.
- Provided lump sum payments and, for the most severe injuries and illnesses, Guaranteed Income Payments (GIPs) to provide a regular income stream. Those payments were made according to a comprehensive tariff reflecting, for lump-sum payments, the severity of the injury or illness and, for GIPs, estimated loss of future earnings. The most severe injuries and illnesses qualified for a lump-sum payment of £285,000.
- Used the balance of probabilities standard of proof, in line with similar schemes for civil claims.¹⁰⁶

150. Public concern over the level of compensation paid to injured Service Personnel grew in autumn 2007, following press coverage of the compensation awarded to Lance Bombardier Ben Parkinson.¹⁰⁷ Lance Bombardier Parkinson was severely injured in

¹⁰⁴ House of Commons, *Official Report*, 15 September 2003, column 40WS.

¹⁰⁵ Armed Forces (Pension and Compensation) Act 2004.

¹⁰⁶ Ministry of Defence, *Guidance: Armed Forces Compensation: What You Need to Know*, [undated].

¹⁰⁷ Ministry of Defence, *Military Covenant: the Support Available to Current and Former Servicemen*, 2008.

Afghanistan, losing both his legs and suffering a brain injury and multiple other serious injuries.¹⁰⁸ The *BBC* reported that he had been awarded £152,150 in compensation.

151. In February 2008, the MOD amended the AFCS to take account of individuals who had suffered more than one injury in a single incident and to increase the lump-sum payments to those with the most serious multiple injuries (within the £285,000 maximum).¹⁰⁹ The MOD stated that, when the AFCS was developed, the MOD had not envisaged the “severe, multiple injury cases of the type that are now unfortunately occurring”. The changes enabled the AFCS to respond to that challenge.

152. In July 2008, within the Service Personnel Command Paper, the Government doubled the lump-sum payment for the most serious injuries, from £285,000 to £570,000.¹¹⁰ All payments were increased by at least 10 percent. The Government committed to apply those increases retrospectively to all those who had already made claims under the AFCS. GIPs remained unchanged.

153. Mr Ainsworth told the Inquiry that when he pressed for that increase, he had experienced “some resistance” from some officials in the MOD:

“... I can remember a particular official amusing me no end when he told me, ‘You cannot, Minister, double the upfront compensation payment’ ... I think he had worked on the scheme for quite some time and was pretty dedicated to it, and he knew some of the other consequences of doubling the upfront payment, [that] potentially it would cause disparities with other people, but my attitude was ‘So what? I can’t defend the level of upfront payment as it exists today and you do not have to, and you are not injured and we are going to double it’, and we did.”¹¹¹

154. Further increases in lump-sum payments (though not to the maximum amount) and to GIPs, and changes to the operation of the AFCS, were made in 2010 following a review of the AFCS.¹¹²

Support for veterans

155. In March 2001, the Government launched the Veterans Initiative to identify and address the needs of veterans, in close partnership with ex-Service organisations.¹¹³ It also announced the appointment of Dr Moonie as the first Minister for Veterans’ Affairs. The Initiative’s priorities included:

- co-ordinating the Government’s response to issues affecting veterans;

¹⁰⁸ *BBC*, 28 August 2007, *Maimed soldier ‘let down’ by Army*.

¹⁰⁹ Ministry of Defence, *Military Covenant: the Support Available to Current and Former Servicemen*, 2008.

¹¹⁰ *The Nation’s Commitment: Cross-Government Support to our Armed Forces, their Families and Veterans*, July 2008, Cm 7424.

¹¹¹ Public hearing, 6 July 2010, pages 25-26.

¹¹² Ministry of Defence, *The Review of the Armed Forces Compensation Scheme*, February 2010.

¹¹³ Standard Note SN/IA/3070, 28 June 2005, ‘Veterans Policy’.

- improving communications between veterans and the Government; and
- promoting partnership between the Government and ex-Service organisations.

156. In June 2001, the War Pensions Agency was transferred to the MOD and in April 2002 it was re-launched as the Veterans Agency, with a remit to provide financial and welfare support to all former members of the Armed Forces, their widows/widowers and dependants.

157. The Veterans Agency published the *Strategy for Veterans* in March 2003, to “help ensure” a coherent Government policy and a structured plan of action.¹¹⁴ The Strategy stated that services for veterans were increasingly delivered on a cross-Government basis, or through a partnership between Government and the private or voluntary sectors. Partnerships between Government and the voluntary sector should not detract from the Government’s responsibilities or impinge on charities’ independence.

158. The Veterans Agency published the *Communications Strategy for Veterans* in September 2003, in response to research commissioned by the MOD that indicated that many veterans, members of the general public, and “statutory and charitable service providers” were unaware of the services, advice and support available to veterans.¹¹⁵

Mental healthcare for veterans

159. The Medical Assessment Programme (MAP) was established in 1993 to examine veterans of the 1990/1991 Gulf Conflict who were concerned that their health had been adversely affected by their service.¹¹⁶ The majority of cases seen by the MAP were mental health related and the service evolved into a mental health assessment programme. The MAP was extended in 2003 to include Op TELIC veterans.

160. The MAP provided a thorough assessment by a physician with knowledge of veterans’ physical and mental health issues. The physician would provide a report for the referring doctor including any diagnosis made and recommendations for treatment.

161. In July 2003, King’s College London published its final report on the delivery of cross-departmental support and service to veterans.¹¹⁷ The study (which ran from July 2002 to March 2003) had been commissioned by the MOD to examine key areas of need not already addressed under the Veterans Initiative and the *Strategy for Veterans*.¹¹⁸

¹¹⁴ Veterans Agency, *Strategy for Veterans*, March 2003.

¹¹⁵ Veterans Agency, *Communications Strategy for Veterans*, September 2003.

¹¹⁶ [Paper MOD, 29 June 2010, ‘Veterans Mental Health’](#).

¹¹⁷ King’s College London, July 2003, *Improving the delivery of cross-departmental support and services for veterans*.

¹¹⁸ Standard Note SN/IA/3070, 28 June 2005, ‘Veterans Policy’.

162. Key findings from the study included:

- There was very little published information on the experience of UK veterans.
- For “many (indeed most)” personnel, military life was a positive experience.
- Most veterans did not develop mental health problems as a result of serving in the Armed Forces. The minority of veterans who did, fared badly.
- There had been a decline in “civilian-military understanding”, which adversely affected veterans’ dealings with Local Authorities and Social Services.
- Only half of veterans with mental health problems were currently seeking help. Of those who had sought help, many were receiving anti-depressant therapies but few were receiving specialist advice or treatment.¹¹⁹

Community mental health pilots

163. In 2005, following recommendations on mental health services for veterans presented by the independent Health and Social Care Advisory Service (HASCAS), the MOD, in collaboration with the DoH and the Devolved Administrations, launched six community NHS mental health pilots.¹²⁰ The purpose of the pilots was to provide expert, evidence-based assessment and treatment, led by a mental health therapist with an understanding of the issues faced by veterans, and to improve local health professionals’ awareness and understanding of veterans and military life.

164. The first pilot, in Stafford, started in November 2007; the sixth pilot, in Edinburgh, started in April 2009.

Priority treatment within the NHS

165. From 1953, it was Government policy that war pensioners (not all ex-Service Personnel) should receive priority examination and treatment within the NHS for the condition for which they received a pension or gratuity.¹²¹

166. In spring 2007, in response to a series of Parliamentary questions on the efficacy of the arrangements underpinning that policy, the MOD tasked the Service Personnel and Veterans Agency (SPVA) to record all complaints relating to priority access.

167. In June 2007, a junior MOD official advised Gen Dannatt that the arrangements for ensuring priority access had several “inherent weaknesses”:

- The MOD owned the policy but was reliant on the DoH for delivery. The DoH did not regularly remind NHS clinicians and GPs of the policy. Even when clinicians

¹¹⁹ King’s College London, July 2003, *Improving the delivery of cross-departmental support and services for veterans*.

¹²⁰ [Paper MOD, 29 June 2010, ‘Veterans Mental Health’](#).

¹²¹ Minute MOD [junior officer] to MA1/CGS, 19 June 2007, ‘War Pensioners – Priority in the NHS’.

and GPs were aware of the policy, the allocation of priority treatment was determined by a number of factors.

- The arrangement between the MOD and the DoH had never been formalised, but was rather a “gentleman’s agreement”. “Priority access” had never been defined.
- The MOD did not regularly remind war pensioners of their right to priority access.

168. The official stated that the only alternative to the current arrangement, the provision of treatment in the private sector, was unlikely to be affordable. To mitigate the weaknesses of the current arrangement, the MOD’s current level of engagement with the DoH, including at Ministerial level, should be sustained. The information that was now being collected by the SPVA would, in the future, allow better analysis and “evidence-based” action.

169. On 23 November, Mr Alan Johnson, the Health Secretary, and Mr Derek Twigg, Parliamentary Under Secretary of State for Defence and the Minister for Veterans, announced that the NHS would provide priority treatment for all veterans (not just those in receipt of war pensions), whose ill-health or injuries were attributed to their military service.¹²²

170. Lt Gen Lillywhite told the Inquiry that the arrangement on priority access was of limited – but some – utility to veterans.¹²³

171. In July 2008, the Government published a command paper entitled *The Nation’s Commitment: Cross-Government Support to our Armed Forces, their Families and Veterans* (known as the *Service Personnel Command Paper*).¹²⁴ The paper contained a number of measures to address the disadvantages experienced by veterans, including:

- a commitment that the standard of prosthetic limbs provided to veterans by the NHS, would match or exceed the standard of limbs provided to injured personnel by the DMS;
- a commitment to raise awareness amongst healthcare professionals of the healthcare needs of veterans;
- funding for supported housing for Service leavers;
- a commitment to fund tuition fees in further and higher education for Service leavers; and
- measures to improve veterans’ access to transport and employment opportunities.

172. The Inquiry’s conclusions and lessons on the care provided to Service Personnel are set out in Section 16.4.

¹²² Ministry of Defence, *Government boost to veterans healthcare*, 23 November 2007.

¹²³ Public hearing, 20 July 2010, page 80.

¹²⁴ *The Nation’s Commitment: Cross-Government Support to our Armed Forces, their Families and Veterans*, July 2008, Cm 7424.