CAF/2242/2016

DECISION OF THE UPPER TRIBUNAL
(ADMINISTRATIVE APPEALS CHAMBER)

Decision and Hearing

1. **This appeal by the claimant succeeds**. Permission to appeal having been given by a judge of the First-tier Tribunal on 10th June 2016, and in accordance with the provisions of section 12(2)(b)(ii) of the Tribunals, Courts and Enforcement Act 2007 I set aside the decision of the First-tier Tribunal (WPAFC Chamber) sitting at Birmingham on 24th February 2016 made under reference AFCS/00419/2015. I substitute my own decision. This is to the effect that the claimed condition (type B meningitis meningococcal) was caused by service. I refer the matter to the Secretary of State to proceed with the consideration of the claim on this basis.

2. I held an oral hearing of this appeal at Field House (London) on 6th July 2017. The claimant attended in person and was represented by Glyn Tucker of the Royal British Legion. The Secretary of State was represented by Robert Dickason of counsel. I am grateful to them for their assistance in both written and oral argument.

The Legal Framework

3. The legal position is governed by The Armed Forces and Reserve Forces (Compensation) Scheme 2011 ("the 2011 scheme"). The relevant provisions are set out here (references are to articles of the 2011 scheme). Article 2(1) provides that "forces" means the armed forces and the reserve forces, "member" means a member of the forces and "injury" includes illness (which is also defined) subject to an exception which does not apply in the present case. Article 8 provides:

> **8(1)** Subject to articles 11 and 12, benefit is payable to or in respect of a member or former member by reason of an injury which is caused (wholly or partly) by service where the cause of the injury occurred on or after 6th April 2005.
>
> **8(2)** Where injury is partly caused by service, benefit is only payable if service is the predominant cause of the injury. [Article 2(1) provides that "predominant" means more than 50%].

Article 11 deals with exclusions relating to travel, sport and slipping and tripping. Article 12 deals with exclusions relating to tobacco, alcohol, drugs, consensual sexual activity, pre-service activities, self-inflicted injury, and the following:

> **12** Benefit is not payable to or in respect of a of a person by reason of an injury sustained by a member, the worsening of an injury, or death which is caused (wholly or partly) by –
>
> (f) an illness which is –

> (i) caused by a single gene defect or is predominantly hereditary in origin;
>
> (ii) a personality disorder;
>
> (iii) an endogenous infection; or
>
> (iv) an exogenous infection except where the infection is acquired in a non-temperate region, and the person has been exposed to the infection in the course of service or where, in a temperate region, there has been an outbreak of the infection in service accommodation or a workplace.

4. In the present case it is agreed that the claimant suffered an exogenous infection in a temperate region (the United Kingdom) and I have underlined the words which particularly need to be considered and which constitute an exception to an exception to entitlement to benefit.

5. Articles 60 and 61 provide that, subject to exceptions that are not relevant in this case, the burden of proving any issue is on the claimant on the balance of probabilities.

Background and Procedure

6. The basic facts in this appeal are not in dispute – what is disputed is the meaning and application of the exception to the exception in article 12(f)(iv). The claimant was born on 15th February 1989. He served as a private in the army from 13th November 2011 to 19th April 2013. He was based in barracks and undergoing Parachute Regiment training at Catterick Garrison when, on 10th December 2011, while on a training exercise stretcher race "I began to experience intense pain across my shoulders and upper back". He continued with training, including a night exercise, over the next few days but his conditioned worsened and he sought medical help, but was prescribed painkillers and his condition was not regarded as an emergency. He felt increasingly unwell and went home on leave on 15th December 2011. On the evening of 17th December "I experienced severe vomiting, diarrhoea, back and leg pains, dizziness and disorientation". On the following day his brother suspected meningitis and called an ambulance. The claimant was admitted to a critical care ward with multiple organ failure, including acute kidney failure and a collapsed lung, and was diagnosed as suffering from type B meningitis. A coma was induced until 30th December 2011 and he remained in hospital until 10th April 2012. A series of operations took place including a series of amputations or partial amputations of his toes. He was left with damage to his knees, severe permanent scarring, pain and mobility difficulties. Meanwhile, shortly after his diagnosis, steps were taken to protect other relevant occupants of the garrison. There is and was no evidence that in the relevant period any other person in the garrison had a similar diagnosis.

7. On 4th April 2013 the claimant made a claim under the 2011 scheme. On 11th or 16th November 2013 the Secretary of State refused the claim on the basis that as this was an isolated case at the barracks the illness was not predominantly caused by

service. On 12th March 2014 the claimant requested a review of this decision but on 11th July 2014 it was confirmed. On 13th October 2014 the claimant appealed to the First-tier Tribunal against the decision of the Secretary of State. The First-tier Tribunal initially considered the matter on 17th November 2015 but adjourned for the Secretary of State to be represented and new grounds considered. The tribunal finally heard the matter on 24th February 2016 and confirmed the decision made by the Secretary of State. The full statement of reasons was signed on 29th April 2016 and issued on 16th May 2016. On 10th June 2016 Upper Tribunal Judge Wikeley, sitting as Chamber President (Temporary) in the First-tier Tribunal, gave the claimant permission to appeal to the Upper Tribunal against the decision of the Upper Tribunal, stating as follows:

> "The Chamber would doubtless benefit from the Upper Tribunal's guidance on the proper approach to Art 12(1)(f)(iv). Is "outbreak" – a word which is not defined in Art. 2 of the Order – an irreducible ordinary word of the English language that cannot be defined further? Did Veterans UK and the Tribunal adopt too demanding a threshold for what amounted to an "outbreak"? Can a sole case of meningitis in a garrison be an "outbreak"? Even if in principle it can, is it an "outbreak" when the individual may be the carrier (the infection must of course be exogenous under this limb of the exclusion)?"

8. I directed that there be an oral hearing of the appeal to the Upper Tribunal. This was originally fixed for 11th May 2017 but was postponed at the request of the claimant and finally took place on 6th July 2017. The Secretary of State opposed the appeal and supported the decision of the First-tier Tribunal.

The IMEG Report

9. Reference was made during the course of the proceedings to the 17th May 2013 report of the Independent Medical Expert Group, chaired by Professor Sir Anthony Newman Taylor. This was a report to the Secretary of State and I am not sure of its status in these proceedings – perhaps as expert evidence. In relation to meningitis as a recognised disease in the 2011 scheme this report does not really add to clarification of the issues that I have to decide. It states that meningitis can be accepted as due to service where it is appropriately diagnosed, the infective agent identified, the incubation period determined and "the illness is part of an outbreak". It does not comment on what is meant by "outbreak" (notwithstanding the Secretary of State's simple assertion that it does do so). In this particular matter the report seems to be describing the practice of the Secretary of State rather than doing anything else.

Dr Gowda

10. Dr Ravi Gowda was the consultant in infectious diseases responsible for the claimant. His report of 13th March 2013 confirmed the detailed account given by the claimant as set out above and confirmed the diagnosis of meningococcal septicaemia with meningitis. It included the following sentence:

> "… we know that his infection was acquired in army barracks and communal areas such as this are known risk factors for meningococcal meningitis".

11. Dr Gowda reported further on 30th June 2015 as follows:

> "We do know that outbreaks of meningitis occur amongst groups of people living closely together. During World War 1 outbreaks of meningitis in army barracks in Europe were common. Further work during World War 2 demonstrated that by appropriate chemoprophylaxis and isolation of the index case, outbreaks could be prevented.
>
> It is also Public Health guidance to ensure chemoprophylaxis is undertaken within institutions such as army barracks.
>
> The studies in a wider setting have demonstrated both short and long term reduction in transmission within such groups.
>
> It is therefore quite possible that [the claimant] acquired the infection as a result of living in close quarters amongst other young people and other cases may have been prevented as a result of the prompt chemoprophylaxis undertaken within the army barracks. We know that other young people living in close quarters such as university students are also at high risk and therefore Public Health England have recommended a vaccination of students against all the major strains of meningococcal meningitis."

Dr Braidwood

12. Dr Anne Braidwood, a Fellow of the Faculty of Occupational Medicine (FFOM) is (or was) a medical adviser to the Secretary of State (and, for these purpose, speaking on behalf of the Secretary of State). In a combined report and submission of 29th January 2016 Dr Braidwood stated (references are to her paragraph numbers):

> 5. … [The claimant] proposes that his peers at Catterick were the source of his illness as they were infected with the organism. They were not symptomatic or ill and [the claimant] uses the term "subclinical infection". He goes on to suggest that prompt action re prophylaxis prevented these colleague recruits from developing clinical illness. [Then refers to the report of 30th June 2015 from Dr Gowda].
>
> 6. From overall generally accepted understanding of meningococcal disease and its spread [the claimant's] suggested sequence of events is plausible. Unfortunately however there are no hard supporting data re numbers affected etc or even whether [the claimant] himself was a carrier; equally Dr Gowda's letter refers it being "quite possible" that [the claimant]'s illness was acquired in barracks. Neither being plausible nor possible meets the balance of probabilities standard of proof as required for AFCS award. "Quite possible" is some way from "more likely than not".

13. Dr Braidwood then referred to evidence produced by the claimant from Public Health England, with which she apparently agreed, to the effect that meningococci colonise the nasal pharynx of humans and are frequently harmless commensals.

Between 5 and 11% of adults and up to 25% of adolescents carry the bacteria without sign or symptoms of the disease. It was not fully understood why the disease develops in some individuals and not in others. Age, season, smoking, preceding influenza A and living in closed or semi-closed communities such as university halls of residence or military barracks had been identified as risk factors.

14. Dr Braidwood then considered the use of the word "outbreak" in article 12. In paragraph 8 she said "We take the word "outbreak" to mean "the sudden increase in the incidence of a disease or condition in a specific area or location".

The First-tier Tribunal

15. The claimant presented a deal of other medical evidence and argument to the First-tier Tribunal, including material as to possible aetiology. The tribunal correctly observed (paragraphs 33 and 34) that the standard of proof in 2011 scheme cases was on the balance of probabilities and that speculative evidence is insufficient. However, it then went too far in stating (paragraph 34) that:

> "In our view we find that the appellant can only succeed if his case is founded on established evidence-based research that provides reliable conclusions that can be reasonably followed".

16. It is usually inadvisable to try to reformulate statements about the standard of proof and the extract that I have quoted goes well beyond the balance of probabilities. That amounts to an error of law which itself justifies setting aside this decision.

17. In paragraph 35 the tribunal stated that having considered the evidence in the round it found that the appellant had not discharged the burden of proof. It agreed with paragraphs 6 and 8 of Dr Braidwood's document and with her conclusion that the evidence was insufficient to establish that the claimant contracted the disease as a result of an outbreak in service. However, in doing so it seems to me that the First-tier Tribunal failed to distinguish between the conceptually separate issues of whether there had been an "outbreak", and the aetiology of the claimant's condition. This led it to its confusing (to me) conclusions (my underlining):

> 37. … Whilst the appellant raises the possibility that he contracted meningitis as a result of being exposed to a sub-clinical infection whilst in service, it is equally possible that he was the carrier of the infection. Therefore, in the absence of anyone else infected by this condition, and where the appellant satisfies only two of the factors [age, season, smoking, preceding influenza A and living in closed or semi-closed communities] … we find it more probable then not that he did not contract the illness as a result of an outbreak in service.
>
> 38, Based upon the evidence, we find that merely because the Appellant fell ill with this condition whilst serving in 2011 it is not sufficient to overcome the exclusion set out in Article 12 because we find that he did not contract the illness as a result of an outbreak in service. We therefore find the Appellant has failed to prove that it is more likely than not he contracted this illness as a

result of an outbreak in service and, on that basis, the burden of proof has not been discharged.

18. I do not see how it can simultaneously be the case both that two causes are equally possible and that one of them is more probable (paragraph 38) or how a conclusion on the question of law (the meaning of "outbreak") can be based upon the evidence (paragraph 39).

19. I mean no disrespect to Mr Tucker that I have not gone through his grounds of appeal in the way or order that he presented them but I have tried to cover the issues in what I have said above and in what I say below.

20. In addition to simply disagreeing with the grounds of appeal, the main focus of the submissions on behalf of the Secretary of State was on the meaning of the word "outbreak".

Outbreak

21. The exception to the exception in article 12(1)(f)(iv) applies (in this case) where there has been an "outbreak of the infection" in service accommodation. In relation to the meaning of "outbreak" the Secretary of State has mainly relied on the August 2014 operational guidance from Public Health England on Communicable Disease Outbreak Management. The original version of this document was published in November 2011 and I assume that for present purposes there has been no significant change between the two versions. It must be remembered that this document is about disease management and not about compensation, and that it has no binding effect on the courts or tribunals.

22. Paragraph 4.1 of the guidance states:

> 4.1 An outbreak or incident may be defined as:
>
> - an incident in which two or more people experiencing a similar illness are linked in time or place
> - a greater than expected rate of infection compared with the usual background rate for the place and time where the outbreak has occurred
> - a single case for certain rare diseases such as diphtheria, botulism, rabies, viral haemorrhagic fever or polio
> - a suspected, anticipated or actual event involving microbial or chemical contamination of food or water.

23. Other (undisputed) evidence shows that in England in 2015/16 there were 805 cases of meningitis (including 444 of meningitis B), mostly in toddlers and infants but 68 of the 444 in the 15 to 24 age group (see the written submissions of 29th November 2016 from the Secretary of State). From this, the Secretary of State argues that meningitis B cannot be considered a rare disease in the same way as rabies, botulism or diphtheria, and that a single case of meningitis cannot be accepted as an outbreak.

24. At the hearing before me Mr Dickason adopted this argument. I asked whether he was suggesting that a single case can never be an "outbreak" but he explained that the position of the Secretary of State was that a single case of the rare diseases referred to above would be regarded as an outbreak.

25. I do not accept the Secretary of State's approach to the meaning of "outbreak" for compensation purposes. Clearly, for public health and disease management purposes different considerations apply, but there is no jurisprudential basis for reading the meaning for those purposes across to the meaning for compensation purposes. In the context of the 2011 scheme it seems to me that "outbreak" is an ordinary word with a plain meaning and does not have a technical or scientific meaning, and does not connote any particular quantity of cases. It does not take much imagination to envisage a conversation in which one lay person says to another "Did you hear that there has been an outbreak of meningitis at the barracks?", and for both of them to understand that the reference is to at least one case.

26. Adoption of the Secretary of State's approach would have (at least) two particular undesirable consequences. One is that "outbreak" would have a variable and unpredictable meaning depending on the particular disease. The other is (for example) that the first soldier to be diagnosed with meningitis would be excluded from compensation and the second soldier to be so diagnosed (even if only shortly afterwards) would be entitled to compensation. Neither result would be consistent with the purposes of a compensation scheme.

Conclusions

27. The decision of the First-tier Tribunal was made in error of law and must be set aside. This is because of its errors in relation to the burden of proof and its misunderstanding of the meaning of "outbreak". As there is no dispute as to the basic facts I see no advantage in referring the matter back to the First-tier Tribunal. And in accordance with the provisions of the 2007 Act I remake the decision my self.

28. To come within the scheme the claimant has to prove a number of matters on the balance of probabilities. First, that he is or was a member of the forces who suffered injury caused on or after 6th April 2005. This is all agreed. Second, that the injury was caused wholly or partly by service. The claimant argued that his peers at Catterick were the source of his illness as they were (or must have been) infected with the organism, although they were not symptomatic or ill. Dr Braidwood gave evidence that this was plausible (and the Secretary of State does not appear to dispute this). Dr Gowda's report of 13th March 2013 stated that "… we know that his infection was acquired in army barracks and communal areas such as this are known risk factors for meningococcal meningitis", although his report of 30th June 2015 was less dogmatic: "It is therefore quite possible that [the claimant] acquired the infection as a result of living in close quarters amongst other young people". It is agreed that the claimant met at least two of the special risk factors – the fact that he does not meet other risk factors is to be taken into account but cannot be determinative. The question is whether these matters are adequate to satisfy the balance of probabilities (which, contrary to the view of the First-tier Tribunal, is not a question of scientific proof) and in my view they are.

29. On the face of it article 12 nevertheless excludes the payability of benefit because the injury was an illness caused by an exogenous infection. To overcome this the claimant must prove (third) that he has acquired an infection (which is agreed) and, being in a temperate region, (fourth) there has been an outbreak of the infection in service accommodation. The emphasis here is not actually on the notion of "outbreak" but on "outbreak in service accommodation". If I am correct (above) as to the meaning of outbreak, then it is clear that the outbreak was in service accommodation.

30. For the above reasons this appeal by the claimant succeeds and I make the order indicated in paragraph 1 above.

H. Levenson
Judge of the Upper Tribunal

24th July 2017