IN THE ARMED FORCES TRIBUNAL, PRINCIPAL BENCH AT NEW DELHI
(Court No.1)

O.A. No. 89 of 2010 & M.A. No.61/12

In the matter of:

Satyananad Singh .....**Petitioner**

Versus

Union of India & Ors. .....**Respondents**

For petitioner: Mr. Tariq Adeeb, Advocate.
For respondents: Mr. Mohan Kumar, Advocate

CORAM:
HON'BLE MR. JUSTICE A.K. MATHUR, CHAIRPERSON.
HON'BLE LT. GEN. M.L. NAIDU, MEMBER.

JUDGMENT

M.L. Naidu, Member

Date: 05.09.2012

1. This case was filed on 05.02.2010.

2. The applicant vide this petition has prayed for quashing of the order dated 20.10.2009 passed by respondent No.3 (Annexure P-1) in which his appeal was rejected alongwith discharge order dated 08.12.2001 (Annexure P-2) passed by respondent No.4. The applicant has also sought reinstatement in service with all consequential benefits.

3. Brief facts of the case are that the applicant was enrolled in the Indian Army in 1993. In March 1999, the applicant was detected with HIV (+) virus. On 16.04.1999 it was confirmed that the applicant is infected with HIV (+) virus. On 08.05.1999, he was placed in Low Medical Category. On 20.08.2001, applicant was admitted into MH Jabalpur complaining of fever, headache and vomiting. On 25.08.2001, the applicant developed swollen eyes and some eye drops were prescribed. On administering these eye

drops, the applicant developed a condition called (diploplia) or double vision. However, the applicant regained his normal vision by 15.11.2001.

4. It has been alleged that the medical authorities mistook the double vision for blindness and presumed that the 'blindness' was a symptom of neurotuberculosis. On 14.09.2001, Lt Col R. Varadarjulu signed an opinion that the applicant had neurotuberculosis and further that it was caused by AIDS. Based on this report and on account of his HIV (+) status, the applicant was brought before an Invaliding Medical Board (IMB), which placed the applicant in P-5 medical category and found him unfit for military service, due to "*gross limitations in physical capacity and stamina*". Consequently, the applicant was discharged on 26.12.2001 under Army Rule 13(3) of Army Rules 1954 having put in 08 years of service.

5. On 04.12.2001, the applicant filed a writ petition No.6555/2001 before the Hon'ble High Court of Jabalpur which was disposed off on 20.04.2006 quashing the discharge order dated 26.12.2001 and directing the respondents to reinstate the petitioner with all consequential benefits.

6. Aggrieved with the said order, the respondents filed a writ appeal No.178/2006 with the Division Bench of the High Court of Jabalpur seeking to set aside the order dated 20.04.2006. On 28.03.2007, the Division Bench of the High Court of Jabalpur, passed an order in favour of the respondents and they held that the diagnosis of the applicant was based on the report of the medical specialist dated 14.09.2001.

7. In response to this decision, the applicant filed a review application with the Division Bench on 28.03.2007. The Division Bench dismissed the review application vide order dated 27.08.2007. Against this order, the applicant filed

an SLP No.10559 of 2007 before the Hon'ble Supreme Court. The Hon'ble Supreme Court disposed off the said SLP on 01.04.2009 as under:-

> "*Challenge in these appeals is to the order dated 28.03.2007 in Writ Appeal No.178/2008 passed by a Division Bench of the Madhya Pradesh High Court, Jabalpur and the order passed in the Review Application dated 27.08.2007. In appeal before the High Court challenge was to the order dated 20th April, 2006 passed in Writ Petition No.6555/2001 by a learned Single Judge. After some hearing, learned counsel for appellant stated that there is a remedy available to assail the opinion of the Medical Board on the basis of which the appellant was discharged.*
>
> *Learned counsel for the appellant stated that there is obviously some delay because instead of availing the statutory remedy the appellant had availed a writ petition and the judgment in his favour was upset by the Division Bench in the order passed in the writ appeal. While permitting withdrawal of the appeal and consequentially the writ petition, we direct that in case the statutory remedy, if any, is availed within a period of two months from today the same shall be considered on merits without raising the question of limitation, if any.*
>
> *Since we have permitted withdrawal of the appeals and the writ petition, needless to say we have not expressed any opinion on the correctness or otherwise of the judgment of either the single Judge or the Division Bench.*
>
> *The appeals are disposed of accordingly.*"

8. The applicant thereafter filed an appeal on 13.04.2009 with the Army Headquarters and the Director General, Armed Forces Medical Service (DGAFMS) seeking for review of the Medical Board to be held in his case. On 20.01.2009 this appeal was dismissed.

9. Learned counsel for the applicant argued that traditionally the Armed Forces have been assessing the HIV (+) cases based on the WHO norms and since WHO norms are themselves being updated, so are the Armed

Forces upgrading the medical policies. In this regard, he argued that the applicant even to this date is alive. In HIV (+) cases, normally a person would not have survived so long. This proves that he was not infected by AIDS virus while he was certainly HIV (+). He argued that the eye infection which caused double vision was misconstrued by the specialist Lt. Col R. Varadarajulu who was a Reader and Neurologist in the Department of Medicine. He had not treated the eye infection of the applicant and the eye infection has subsided on treatment. Now the applicant is free from that infection. This in itself shows that it was double vision and not blindness.

10. Learned counsel for the applicant further argued that as late as 16.02.2012 his VDRL test has been "non-reactive". The CD-4 count of the applicant has been 379 as on 05.08.2012. Both these tests were carried out at AIIMS and therefore, he argued that the applicant was not within the parameters to be called AIDS. The normal yardstick for CD-4 Count is 304 when it is considered by the WHO that the patient will be susceptible to AIDS virus.

11. Learned counsel for the applicant also argued that the applicant was declared as having AIDS due to the use of wrong methodology and that is why the Hon'ble Apex Court in its order dated 01.04.2009 had recommended that the applicant should take recourse to the statutory remedy. In the statutory remedy, he had prayed during the first appeal and the second appeal for being screened by a Re-survey Medical Board afresh. He, therefore, suggested that applicant may be permitted to be re-examined by a fresh Medical Board preferably at New Delhi so that his status of HIV (+) can be verified. In support of his contentions, he cited the case of **Ex Sailor Roopesh Kumar Vs Union of India and others in OA No.179 of 2009**

passed by the AFT wherein it has been opined that fresh medical board should be held in order to assess the medical fitness of the candidate since the AIIMS had opined that the applicant was not suffering from colour blindness.

12. Learned counsel for the applicant also argued that the IMB which was held on 16.11.2001 has not been constituted properly as it did not have a specialist medical officer as part of the Medical Board. The IMB should also have a relevant specialist in that field. In this case it should have been a Neurologist as a Member of the Medical Board.

13. Learned counsel for the respondents stated that the applicant was suffering from HIV infection and his HIV (+) status was confirmed on 16.04.1999. Thereafter, he was placed in low medical category. He was undergoing treatment for HIV (+) status. On 20.08.2001, when he reported to the MH for treatment for fever and connected complications, it was detected that his eye was causing problems. Suitable treatment was given to him and his condition of double vision was thus treated. Thereafter, he was sent to the Command Hospital at Pune for further diagnosis and treatment. He drew our attention to Annexure P-10 in which the medical specialist and neurologist had opined that :

> *"CSF [central spinal fluid] had shown to WBC/mm3 (lymphocytes) [normal: range 3.8-10.8], 10 RBC.mm3, protein-30 mg% sugar - 44 mg% and chloride -122 mmol/i. India ink for cryptococci [bacteria that affects the nerve endings] was negative. MRI of Brain-Normal [would not be so for neuro-tuberculosis].*
>
> *In view of lymphocyte predominant CSF with focal neurological deficit, fever, headache in setting of HIV infection, he was diagnosed to have*

CNS [central nervous system] Tuberculosis and started on EHRZ w.e.f 02.09.01 with oral steroids.

Patient has shown improvement in that he is aferbrile for 10 days.

(1) CNS Tuberculosis

(2) Immune Surveillance for HIV

PART-III

This 27 year old soldier is a case of HIV+ive since 99.

Since Aug 2001 he was developed AIDS defining illness in the form of NEUROTUBERCULOSIS.

Hence, invalided out in P5.

DIAGNOSIS: ACQUIRED IMMUNE DEFICIENCY SYNDROME ADV".

14. He further argued that sudden blindness due to Neuro Tuberculosis as diagnosed by the Neuro Physician is a complication of AIDS. He submitted that the blindness due to Neuro Tuberculosis produces permanent disability which is not curable, hence the applicant was invalided out in accordance with law.

15. Learned counsel for the respondents also drew our attention to Annexure P-25 dated 09.01.2000 wherein the Dte. Geneal of Medical Services (Army) has laid down the policy to say that :

"a) Longevity: By the time HIV+ve case is brought before Release Medical Board, it is likely that he had acquired the infection about 1-2 years earlier. Therefore it is likely that he would develop AIDS within next 6-8 years. After development of AIDS the average life span is 1-2 years. Therefore loading of age by 2 years at the time of Release Medical Board is considered appropriate.

b) Percentage of disability: In fact viral multiplication during this period is average and the immune system being systematically destroyed. Apart from infection, HIV +ve cases will suffer emotionally, psychologically and socially. Taking all these factor in consideration, 40% disability for asymptomatic cases and upto 100% for symptomatic cases will be awarded."

16. On the request of the Bench, the respondents produced Col. K. Shanmuganandan, Sr. Advisor (Medicine and Rheumatology) R&R Hospital, Delhi Cantt. as an expert. He gave us his analysis and explained the AIDS Defining Conditions in Appendix A to the WHO guidelines wherein it has been stated that:

"Mycobacterium tuberculosis of any site, pulmonary, disseminated, or extra-pulmonary

Mycobacterium, other species or unidentified species, disseminated or extrapulmonary."

In the note it states that "*Condition that might be diagnosed presumptively.*"

17. He also drew our attention to the WHO guidelines in which it was stated what is a normal CD4 Cell count. The normal CD4 count for most laboratories falls in a range of 800 to 1050 cells/mm3; furthermore, when considering laboratory variations of two standard deviations, the normal CD4 cell count range falls within 500 to 1400 cells/mm3. This broad range in normal values reflects the fact that the CD4 cell count is the product of three variables: the white blood cell count, the percentage of lymphocytes and the percentage of lymphocytes that bears the CD4 receptor. Laboratory testing also reports CD4:CD8 ratios, which are greater than 1 in a normal host.

18. He further explained that WHO norms which recommend treatment of a patient which says "*Specific antituberculous chemotherapy should be initiated on the basis of strong clinical suspicion and should not be delayed until proof of infection has been obtained. The clinical outcome depends greatly on the stage at which therapy is initiated; much more harm results from delay, even for only a few days, than from inappropriate therapy as long as efforts are continued to confirm the diagnosis*". He further explained that in this case the Medical Specialist has clearly diagnosed that he was suffering from Central Nervous System Tuberculosis. In his analysis, the Medical Specialist has opined that the applicant was suffering from fever with headache & vomiting of 4 days duration on 20.08.2001. On 26.08.2001 he developed sudden onset B/L Lateral Rectus Palsy (muscle in the eye affected). CECT brain (CT Scan) WNL (within normal limits). X-ray Chest PA and widals was within normal limits and was started EHRZ w.e.f. 02.09.2001 with oral steroids. Thus, the condition of the patient was brought to near normal. But the diagnosis remains as CNS Tuberculosis.

19. Learned counsel for the respondents stated that the applicant was not discharged on the basis of being HIV(+) but was discharged as per the prevailing policy as he was suffering from AIDS defining illness in the form of Neuro Tuberculosis at the time of his discharge in 2001. He further argued that the averments by the applicant is misleading because as per the records of the applicant, he was admitted in Hospital for a period of 175 days since the time he was diagnosed with HIV infection i.e. on 07.03.1999. The applicant was again admitted on 20.08.2001 and was on anti-tuberculosis treatment w.e.f. 02.09.2001 onwards for a period of one year. He asserted that in 2001, the applicant was admitted in Hospital for 58 days. Considering

these facts, the medical authority held that he was not fit for further military duties.

20. Learned counsel for the respondents argued that the average life span after development of AIDS was 1-2 years as per the understanding of the disease way back in 1992 and therefore reflected in the policy at that time. In subsequent revisions of the policy the same does not find a mention as medical sciences are in a state of constant evolution and changes that take place are reflected in the medical policies issued from time to time. As such, at present there is no such time limit for survival of a AIDS patient has been laid down because the medical science have been able to treat the AIDS patient in a more effective manner so that his longevity is ensured. But it does not mean that he is fit for military service.

21. Learned counsel for the respondents also drew our attention to the special analysis of the case on 14.09.2001 in which the Specialist has opined that the diagnosis of neurotuberculosis was established not based on a single test or finding, but on a combination of clinical features (high grade fever, headache, vomiting and neck stiffness) with focal neurological deficit (VI cranial nerve palsy), CSF findings suggestive of tuberculous etiology (lymphocyte predominant leucocytosis, and raised Adenine Deaminase (ADA) levels), alongwith normal neuro-imaging studies including CECT and MRI of brain. There was a positive response to anti-tuberculous treatment. Other differential diagnosis like cryptococcal meningitis were considered and excluded.

22. Learned counsel for the respondents also stated that the case has been examined several times and no useful purpose would be served by subjecting the applicant to another medical test because despite the fact that

he is still alive, he remains HIV (+) and his CD count as on 17.02.2012 is 379, against a healthy person's CD4 count of 400/500.

23. We have heard both the parties at length and have examined the documents brought before us. We have also examined the opinion of the specialist, Col. K. Shanmuganandan, Sr. Advisor (Medicine and Rheumatology) R&R Hospital, Delhi Cantt.

24. We are of this opinion that the applicant was declared having HIV (+) status based on the parameters as laid down by the guidelines issued by DGAFMS which are in consonance with the WHO guidelines. The WHO guidelines also suggest that in such a case one cannot delay the treatment of Tuberculosis symptoms. We feel that a delay of even a couple of days for awaiting the detailed test reports/analysis would have caused irreparable damage to the applicant. The Medical Officers who are treating the applicant, therefore, took presumptive action as recommended by the WHO guidelines, thus, the vision of the applicant recovered.

25. The Medical Specialist/Neurologist in his report dated 14.09.2001 has analysed the symptoms in great detail and has opined in an unambiguous manner by stating that the applicant was suffering from (1) CNS Tuberculosis and (2) Immune Surveillance for HIV. Considering all the medical symptoms, he has recommended that the applicant be invalided out in P-5.

26. We have also examined the IMB proceedings which was carried out on 14.09.2011. The IMB had taken the opinion of the Neurologist into consideration. The composition of the Medical Board was examined and we note the presence of a Medical Specialist as a Member of the Board. We are of this opinion that the Medical Specialist Lt Col. Y.S. Sama (Medicine and Oncologist) can be termed as a specialist for the purpose of forming the

coram for IMB. Neurologist is a super-specialisation within the "Department of Medicine". Similarly, an Oncologist is also a super-specialisation within the "Department of Medicine". Lt. Col R. Varadarajulu who gave his opinion on 14.09.2001 was from the Department of Medicine and also a Neurologist. So was also the case with Lt Col Y.S. Sama who was from Department of Medicine and also an Oncologist. Thus, the IMB held on 16.11.2001 was correctly constituted.

27. In view of the above, we feel that no purpose will be served by sending the applicant to a fresh Medical Board since his CD count, even as late as on 16.02.2012 is marginal and therefore, he does not qualify to be called AIDS free.

28. In view of the foregoing, we dismiss the petition. No order as to costs.

A.K. MATHUR
(Chairperson)

M.L. NAIDU
(Member)

Dated 05th September , 2012

ns