COURT No.1
ARMED FORCES TRIBUNAL
PRINCIPAL BENCH: NEW DELHI

OA No.1236/2022

Ex Sub Jitender Kumar Sharma ... Applicant
Versus
Union of India and Ors. ... Respondents

For Applicant : Mr. US Maurya, Advocate
For Respondents : Ms. Sheetal Raghuvanshi, Advocate

CORAM
HON'BLE MR. JUSTICE RAJENDRA MENON, CHAIRPERSON
HON'BLE LT GEN C.P. MOHANTY, MEMBER (A)

ORDER

Invoking the jurisdiction of this Tribunal under Section 14 of the Armed Forces Tribunal Act, 2007, the applicant filed this OA praying to direct the respondents to accept the disability of the applicant as attributable to/aggravated by military service and grant disability element of pension @40% rounded of to 50% with effect from the date of discharge of the applicant; along with all consequential benefits.

2. The applicant was enrolled in the Indian Army 09.01.1989 and retired on 31.01.2019. The Release Medical Board dated 11.12.2018 held that the applicant was fit to be released from service in composite low medical category S1H1A1P2(P)E1 for the disability -

Chronic Kidney Disease @40% for life while the qualifying element for disability pension was recorded as NIL for life on account of disabilities being treated as neither attributable to nor aggravated by military service (NANA).

3. The claim of the applicant for grant of disability pension was rejected and subsequently, his first appeal and second appeal were rejected as well stating that the aforesaid disabilities were considered as neither attributable to nor aggravated by military service. Aggrieved by the aforesaid rejection, the applicant has approached this Tribunal.

4. Placing reliance on the judgement of the Hon'ble Supreme Court in ***Dharamvir Singh*** Vs. ***UOI & Ors*** [2013 (7) SCC 36], Learned Counsel for applicant argues that no note of any disability was recorded in the service documents of the applicant at the time of the entry into the service, and that he served in the Air Force at various places in different environmental and service conditions in his prolonged service, thereby, any disability at the time of his service is deemed to be attributable to or aggravated by military service.

5. Per contra, while the learned counsel for the respondents has not disputed the facts of the case regarding the disability, he highlighted the Opinion of the Release

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Medical Board to the effect that the aforesaid disability of the applicant was assessed as "neither attributable to nor aggravated".

6. We have heard the learned counsel for the parties and have perused the record produced before us. However, we find it pertinent to refer to the Regulation 53(a) of the Pension Regulations for the Army, 2008 (hereinafter referred to as 'the Regulations'), which deals with the grant of disability pension, being relevant in the present case, is reproduced as follows:

> *DISABILITY ELEMENT FOR DISABILITY AT THE TIME OF DISCHARGE /RETIREMENT*
>
> *53. (a) An individual released/retired/discharged on completion of term of engagement or on completion of service limits or on attaining the prescribed age (irrespective of his period of engagement), if found suffering from a disability attributable to or aggravated by military service and so recorded by Release Medical Board, may be granted disability element in addition to service pension or service gratuity from the date of retirement/discharge, if the accepted degree of disability is assessed at 20 percent or more. "*

7. A perusal of the aforesaid Regulation 53(a), therefore, reveals that the disability pension is payable to an individual who is discharged from service on account of a disability which is attributable to or aggravated by military service and assessed at 20% or more. The question whether the disability is attributable to or aggravated by military service is to be

determined under the rules contained in Appendix II. The said Appendix II contains the Entitlement Rules for Casualty Pensionary Awards, 1982 as amended from time to time. Prior thereto, there had been other Entitlement Rules for Casualty Pensionary Awards. Rule 4 of the Entitlement Rules for Casualty Pensionary Awards, 1982, being relevant on the point, is re-produced as follows:

> *"4. Invalidment from Service:*
>
> *(a) Invalidation from service with disablement caused by service factors is a condition precedent for grant of disability pension. However, disability element will also be admissible to personnel who retire or are discharged on completion of terms of engagement in low medical category on account of disability attributable to or aggravated by military service, provided the disability is accepted as not less than 20%.*
>
> *(b) An individual who is boarded out of service on medical grounds before completion of terms of engagement shall be treated as invalided from service."*

8. At this point, with respect to attributability and aggravation, we find it relevant to refer to Para 69 to 74 of the Chapter VI of the Guide to Medical Officers, 2002 (as amended in 2008), reproduced as under:

> *69. Acute Renal Failure.*
>
> *It is a rapid deterioration in renal function sufficient to result in accumulation of nitrogenous wastes in the body. The common causes are:*
>
> *(a) Acute Glomerulonephritis :*
> *-Due to post streptococcal infection.*
> *-Occult visceral sepsis*

-Infective endocarditis
-SLE, vasculitis

(b) Acute Tubulo-interstitial Nephritis :
-Acute pyelonephritis, chronic pyelonephritis
-Chronic UTI
-Acute tubular necrosis
-Arteriolar nephrosclerosis
-Analgesic nephropathies
-Nephrotoxins e.g. antibiotics and radiography contrast media
-Transplant rejection
-Multiple myeloma, leukaemia

(c) Acute Tubular Necrosis:
-Hypovolemia due to burns, hemorrhage
-Vascular pooling in anaphylaxis, Sepsis and drugs - Decreased cardiac output in CVS failure.
-Haemolysis in malaria
-Rhabdo-myolysis in trauma and heat stroke
-Infection e.g. Diarrhoea, Septic abortion, peritonitis, pancreatitis
-Drugs - contrast media, anaesthetic agent

(d) Calculus:
Sixty to eighty percent of adults suffering from acute glomerulonephritis recover over a period of 2 to 4 years. Twenty to forty percent of the cases have residual hypertension and asymptomatic urinary abnormalities.
Majority of Acute renal failure cases recover. Only ten percent of cases progress to chronic renal failure.
If Acute renal failure follows trauma on duty, infection hypovolemia, drug therapy, attributability can be conceded. When associated with multi-system disease, aggravation due to service can be examined based on his service profile.

70. Chronic Renal Failure.
Chronic renal failure is a syndrome resulting from progressive and irreversible destruction of nephrons. This syndrome is considered when azotaemia lasts for more than 3 months. The causes are:

(a) Chronic glomerulonephritis i.e. end stage of glomerular diseases with infection central to pathogenesis e.g. post streptococcal GN, MPGN, Focal sclerosing glomerulonephritis.
(b) Chronic pyelonephritis

(c) Calculus
(d) Hypertension
(e) Diabetes mellitus.

Recovery is poor as the disease is progressive irrespective of the cause and the course is unpredictable.
Attributability/Aggravation can be awarded taking into account the cause and also service profile which would have adversely affected the course of disease.

71. Rapidly Progressive Renal Failure.

A separate entity which invariably progresses to chronic renal failure within a period of one to two years if course is not halted by therapy. The causes are :

(a) Acute and sub acute infections e.g. post streptococcal glomerulonephritis.
(b) Multi system disease eg SLE, Vasculitis, PAN, HS Purpura, malignant hypertension.
(c) Idiopathic primary glomerular disease e.g Idiopathic crescentic GN, Membranoproliferative GN, Berger's Disease.
(d) Acute tubulo-interstitial disease due to infection and multi system disease.
Diseases due to infection acquired during service are acceptable as attributable. Aggravation due to service can be examined, in case due to multi system disease and vasculitis taking into account the service factor modifying the course of disease.

72. Asymptomatic Urinary Abnormalities.
It is characterized by mild degree of hematuria, pyurea casts and protenuria below nephrotic range. The causes are due to glomerulonephritis and tubulo interstitial disease.

The combination of nephronal hematuria and protenuria suggests worse prognosis than one alone.

Course is usually unpredictable and may lead to chronic renal failure. This category of cases are usually detected during routine medical check up.

73. Nephrotic Syndrome.

The syndrome is generally held to be present when a patient demonstrates massive proteinuria, reduced serum albumin, edema and hyperlipidemia. The causes of nephrotic syndrome are:

(a) Primary glomerular diseases.
Minimal change glomerular disease.
Membranous glomerulopathy.
Focal Segmental glomerular sclerosis.
Mesangio proliferative glomerular nephritis.
Membrano proliferative glomerular nephritis.
(b) Infection - post streptococcal GN, leprosy, hepatitis B, malaria.
(c) Multi system Disease - SLE.
- Vasculitis.
-Diabetic glomerular sclerosis

If the syndrome is due to infection during service, attributability can be conceded. Primary glomerulonephritis which may arise out of immune complex disease in the absence of infection and septic foci as a precursor to immune phenomenon, aggravation due to service can be examined. Similarly aggravation can be thought of in kidney disorder due to multi system disease taking into account his service profile.

(a) Minimal lesion GN recover completely.
(b) In membranous glomerulo nephritis, 50% develop chronic renal failure in 25 years.
(c) 50% of Focal segmental glomerulo nephritis develop chronic renal failure.
(d) 50% of membrano proliferative glomerulo nephritis develop chronic renal failure in few years.
(e) Course is variable in mesangio proliferative glomerulo nephritis.

74. Congenital Diseases of Kidney.

Certain congenital diseases such as polycystic disease of kidney, horse-shoe kidney, pelvic-ureteric junction obstruction (hydronephrosis), ectopic kidney, vescico-ureteric reflux, megaureter, ureterocele, retrocaval

ureteric reflux, megaureter, ureterocele, retrocaval ureter, ureteral duplication, and duplication of collecting system escape detection at the time of enrolment and many manifest later in service as asymptomatic urinary abnormality, hypertension and frequent urinary tract infection. Such kidneys may be easily injured if hydronephrotic or ectopically located. Aggravation will be considered if there is trauma related to service.

9. On an analysis of the aforesaid Paras of GMO, 2002, it can be taken into consideration that for disabilities pertaining to Kidney, infection is a precursor for attributability to be established with the military service, or a kidney disease arising due to multisystem diseases can be considered for attributability. Similarly, aggravation can only be considered wherein service factors like posting in HAA or the presence of multi-system diseases/vasculitis could be considered to be aggravating factors.

10. That apart, we find that the applicant enrolled in the Indian Army on 09.01.1989, and the onset of the disability is in Nov 2018, one month before his discharge, in a peace station, within less than one year left of his service, and the applicant last served in the field posting at Rajouri, almost 7 years prior to the onset of disability, and during his total service of 30 years, nowhere has any evidence of any infection has surfaced, which is concurred by the detailed

reasoning given by the Release Medical Board vide Part V, which reads to the effect:

> *"Disability detected during service in peace (Lucknow). There is no evidence of infection, trauma, autoimmune factor or anu other factor related to service. Hence, disability is neither attributable nor aggravated to mil service. Para 71 of Ch-VI of GMO, 2008 refers."*

11. Furthermore, not to lose sight of the Part III of the Summary& Opinion of the Col Indranil Ghosh, Sr Adv (Med) and Nephrologist, CH (CC) dated 30.11.2018 which records that the renal dysfunction has been caused due to renal stone disease, with evidence of angiomyolipoma. In these circumstances, the possibility of any link to military service of the disabilities can be ruled out, and the aggravation cannot be conceded in the absence of any substantiated aggravation factor.

12. We find resonance in the observations made by Hon'ble Supreme Court in ***Secretary, Ministry of Defence and others*** Vs ***A.V.Damodaran (dead) through LRs and others*** [(2009) 9 SCC 140], which clearly brings out the following principles with regard to primacy of medical opinion have been laid down:-

> *8. "When an individual is found suffering from any disease or has sustained injury, he is examined by the medical experts who would not only examine him but also ascertain the nature of disease/injury and also*

record a decision as to whether the said personnel is to be placed in a medial category which is lower than 'AYE' (fit category) and whether temporarily or permanently. They also give a medical assessment and advice as to whether the individual is to be brought before the release/invalidating medical board. The said release/invalidating medical board generally consists of three doctors and they, keeping in view the clinical profile, the date and place of onset of invaliding disease/disability and service conditions, draws a conclusion as to whether the disease/injury has a causal connection with military service or not. On the basis of the same, they recommend (a) attributability, or (b) aggravation, or (c) whether connection with service. The second aspect which is also examined is the extent to which the functional capacity of the individual is impaired. The same is adjudged and an assessment is made of the percentage of the disability suffered by the said personnel which is recorded so that the case of the personnel could be considered for grant of disability element of pension. Another aspect which is taken notice of at this stage is the duration for which the disability is likely to continue. The same is assessed/recommended in the form of AFMSF-16. The Invalidating Medical Board forms its opinion/recommendations on the basis of the medical report, injury report, court of enquiry proceedings, if any, charter of duties relating to peace or field area and, of course, the physical examination of the individual.

9. The aforesaid provisions came to be interpreted by the various decisions rendered by this Court in which it has been consistently held that the opinion given by the doctors or the medical board shall be given weightage and primacy in the manner for ascertainment as to whether or not the injuries/illness sustained was due to or was aggravated by the military service which contributed to invalidation from the military service."

13. With the issue of primacy of medical opinion no longer res integra as held by Hon'ble Supreme Court in ***Ex CFN***

Narsingh Yadav Vs *UoI* (Civil Appeal No. 7672 of 2019), we must reiterate that we are not medical specialists to scrutinize the opinion of medical boards, and it would not only be beyond our jurisdiction but also hazardous if this Court were to examine the accuracy of such expert opinion, based on competing medical opinions. The scope of judicial review does not entail the Court embarking upon such misadventures. As far as judicial review of decisions based on medical expert opinion is concerned, there is no doubt that wide latitude is provided to the executive in such matters and the Court does not have the expertise to appreciate and decide on merits of medical issues on the basis of divergent medical opinion.

14. It can be concluded from the aforesaid analysis that the disability of the applicant cannot be held to be attributable, in absence of any evidence of infection as well as the posting profile of the applicant does not show any aggravation factors, and and thus, the disability of Chronic Kidney Disease @40% for life has to be considered neither attributable to nor aggravated by the military service as in the case of the applicant, there is nothing to show that the conditions of military service determined or contributed to the onset of the

disease and that the conditions were due to the circumstances of duty in military service.

15. In view of the aforesaid analysis, we are of the view that the present OA is devoid of merit and therefore is liable to be dismissed.

16. Hence, the OA 1236/2022 is dismissed.

17. No order as to costs.

18. Pending miscellaneous applications, if any, stand disposed of.

Pronounced in the open Court on 29 day of May, 2025.

(JUSTICE RAJENDRA MENON)
CHAIRPERSON

(LT GEN C.P. MOHANTY)
MEMBER (A)

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