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* **IN THE HIGH COURT OF DELHI AT NEW DELHI**

\+ W.P.(C) 3769/2025 & CM APPL. 17525/2025, CM APPL. 17526/2025

UNION OF INDIA & ORS. .....Petitioners

Through: Mr. Kameshwar Nath Mishra, Sr. Panel Counsel with Mr. Shubhashish Roy, Mr. Vidya Mishra, Advocates with Sgt. Manish Kumar Singh, Sgt. Mritunjay and Sgt. Pankaj Sharma

Versus

EX JWO DHARMENDRA PRASAD .....Respondent

Through:

CORAM:
HON'BLE MR. JUSTICE C. HARI SHANKAR
HON'BLE MR. JUSTICE AJAY DIGPAUL

JUDGMENT (ORAL)

% 04.04.2025

C. HARI SHANKAR, J.

1. The Union of India challenges, by means of the present writ petition, order dated 18 March 2024, passed by the Armed Forces Tribunal, New Delhi[1] in OA 608/2019. By the impugned order, the Tribunal has allowed the respondent's claim of disability pension.

2. The respondent was enrolled in the Indian Air Force[2] on 15 July

[1] "AFT" hereinafter
[2] "IAF" hereinafter

1996. He served the Air Force for over twenty years, and was discharged from the Air Force in low medical category as suffering from CAD (TVD)[3], consequent to the recommendation of a Release Medical Board[4], which convened on 10 June 2016.

3. The respondent applied for release of disability pension to him. His application was rejected by the IAF on 26 May 2017. An appeal preferred against the said decision by the respondent was also rejected by the Appellate Board on 4 January 2019.

4. The rejection, in both cases, was on the ground that the CAD (TVD) from which the respondent suffered was neither attributable to, nor aggravated by, military service.

5. The respondent approached the AFT by way of OA 608/2019[5], seeking disability pension from the date of his discharge, rounded off to 50% along with interest.

6. By order dated 18 March 2024, the AFT has allowed the respondent's claim, relying on the judgment of the Supreme Court in ***Dharamvir Singh v UOI***[6].

7. Aggrieved thereby, the UOI has approached this Court by means of the present writ petition.

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[3] Coronary Artery Disease (Triple Vessel Disease)
[4] "RMB", hereinafter
[5] **Ex. JWO Dharmendra Prasad v UOI**
[6] **(2013) 7 SCC 316**

8. We have heard Mr. Kameshwar Nath Mishra, learned SPC for the petitioners at length.

9. We note the following features from the RMB proceedings:

(i) The respondent had served the IAF for 19 years and 11 months before he was released in the low medical category as suffering from CAD (TVD).

(ii) The CAD was first detected in April 2015, when the respondent was at New Delhi.

(iii) In his personal statement, the respondent specifically stated that he was not suffering from any disability before joining the IAF. This statement has not been doubted by the RMB or in the pleadings of the petitioners either before the AFT or before this Court. Nor was it so sought to be contended by learned Counsel for the petitioners before us either.

(iv) In the opinion of the RMB constituting Part-V of the RMB record, it is specifically stated thus:

> "2. Did the disability exist before entering service ? (Y/N) "No"
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> *****
>
> 5(a) Was the disability attributable to the individual's own negligence or misconduct? If Yes in what way. "No"
>
> (b) If not attributable, was it aggravated by negligence of misconduct? If so in what way and for what percentage of

the total disablement ? "No"

(v) The respondent was certified as suffering from 30% disability for life.

10. Para 47 of Chapter VI of 2008 Guidelines

10.1 Against the entry "reason/cause/specific condition and periodic service" under the head "casual relationship of the disability with service conditions or otherwise", it is entered:

"As per para 47 of Chap VI of GMO 2008."

10.2 We have seen para 47 of the 2008 Guidelines, which read as under :-

> 47. Ischaemic Heart Disease (IHD). IHD is a spectrum of clinical disorders which includes asymptomatic IHD, chronic stable angina, unstable angina, acute myocardial infarction and sudden cardiac death (SCD) occurring as a result of the process of atherosclerosis. Plaque fissuring and rupture is followed by deposition of thrombus on the atheromatous plaque and a variable degree of occlusion of the coronary artery. A total occlusion results in myocardial infarction in the territory of the artery occluded. Prolonged stress and strain hastens atherosclerosis by triggering of neurohormonal mechanism and autonomic storms. It is now well established that autonomic nervous system disturbances precipitated by emotions, stress and strain, through the agency of catecholamines affect the lipid response, blood pressure, increased platelet aggregation, heart rate and produce ECG abnormality and arrhythmias.
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> The service in field and high altitude areas apart from physical hardship imposes considerable mental stress of solitude and separation from family leaving the individual tense and anxious as quite often separation entails running of separate establishment, financial crisis, disturbance of child education and lack of security

for family. Apart from this, compulsory group living restricts his freedom of activity. These factors jointly and severally can become a chronic source of mental stress and strain precipitating an attack of IHD. IHD arising in while serving in Field area/HAA/CI Ops area or during OPS in an indl who was previously in SHAPE-I will be considered as attributable to mil service.

Entitlement in Ischemic heart disease will be decided as follows:-

> (a) Attributability will be conceded where: A myocardial infarction arises during service in close time relationship to a service compulsion involving severe trauma or exceptional mental, emotional or physical strain, provided that the interval between the incident and the development of symptoms is approximately 24 to 48 hours. IHD arising in while serving in Field area/HAA/CI Ops area or during OPS in an indl who was previously in SHAPE-I will be considered as attributable to mil service.
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> Attributability will also be conceded when the underlying disease is either embolus or thrombus arising out of trauma in case of boxers and surgery, infectious diseases. E.g. Infective endocarditis, exposure to HAA, extreme heat.
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> (b) Aggravation will be conceded in cases in which there is evidence of:-
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> IHD occurring in a setting of hypertension, diabetes and vasculitis, entitlement can be judged on its own merits and only aggravation will be conceded in these cases. Also aggravation may be conceded in persons having been diagnosed as IHD are required to perform duties in high altitude areas, field areas, counter insurgency areas, ships and submarines due to service compulsions.
>
> There would be cases where neither immediate nor prolonged exceptional stress and strain of service is evident. In such cases the disease may be assumed to be the result of biological factors, heredity and way of life such as indulging in risk factors e.g. smoking. Neither attributability nor aggravation can be conceded in such cases."

10.3 Thus, Para 47 states that "IHD" represents a spectrum of

clinical cardiac disorders. It goes on to explain the physiological mechanism by which the arteries get occluded. Significantly, it identifies prolonged stress and strain as a precipitating factor for CAD. Service in field and high altitude areas, separation from family, and compulsory group living are all identified as aiding factors. It then proceeds to identify circumstances in which attributability of the IHD/CAD to military service would be conceded. There is no mention, in the RMB Report in the present case, as to whether any of these circumstances existed, or whether this was even assessed. It thereafter goes on to state that where there is neither immediate nor prolonged exceptional stress and strain of service, "the disease *may be assumed to be the result of biological factors, heredity and way of life such as indulging in risk factors, e.g. smoking"*. In *such cases*, the instruction states that neither attributability nor aggravation *can be conceded*.

10.4 There appears to be a serious misconception, in the petitioners' understanding, of the actual meaning and effect of this, and similar, instructions contained in the 2008 Guidelines. The petitioners seem to be reading Para 47 as implying that, if the precipitating or debilitating factors mentioned in the said Para are *not* present in a present case, then, *ipso facto*, the IHD/CAD *is not attributable to* or *aggravated by* military service. Para 47 does not say anything of the kind. It identifies certain circumstances in which attributability *would* be conceded, and certain others in which attributability *would not be conceded*. *It does not follow, per converse, that non-attributability would be implied.* At the highest, what the Para would mean is that,

where the precipitating or aggravating factors mentioned in the Para, such as physical stress or strain or isolated living, etc., are not present, there would be no *automatic implication* of the IHD/CAD being attributable to military service. *That does not exempt the RMB of its responsibility to examine, in such cases, the actual cause of the IHD/CAD, and whether it was, or was not, attributable to military service.*

10.5 *While doing so, para 7 of the 2008 Entitlement Rules, which admittedly apply, is often overlooked. It reads:*

> "Ordinarily the claimant will not be called upon to prove the condition of entitlement. However, where the claim is preferred after 15 years of discharge/retirement/invalidment/release by which time the service documents of the claimant are destroyed after the prescribed retention period, the onus to prove the entitlement would be on the claimant."

Thus, except where the claim is preferred belatedly, more than 15 years after the discharge/retirement/invalidment/release, *the onus of proof is on the establishment, to be discharged by the RMB.* Thus, even if one of the aggravating factors to which Para 47 of the 2008 Guidelines is present in a given case, the RMB, nonetheless, is bound to prove, positively, that the disease is *not attributable* to military service. This would necessarily entail, in its wake, the requirement of *identifying the precipitating factor*.

10.6 We hardly, if ever, however, find that the RMB undertakes this exercise. It certainly has not done so, in the present case.

11. The mere fact that the respondent may be obese does not of necessity mean that the CAD from which he suffers is necessarily attributable to obesity. No medical report, to that effect, has been shown to us by Mr Mishra.

12. In fact, the RMB Report does not even *suggest* that the CAD, from which the respondent was found to be suffering, was attributable to obesity. Neither does para 47 of the 2008 Guidelines state that in every case of obesity and CAD, the CAD would be attributable to obesity.

13. We have seen the medical examination report, which has also been placed on record. The said examination report also does not certify that the respondent's CAD was attributable to obesity.

14. It is settled from the time of ***Mohinder Singh Gill v Chief Election Commissioner***[7] that an executive decision has to fall or stand or fall on the basis of the reasons contained therein. It cannot be improved either by arguments at the bar or by affidavits in Court.

15. There are no reasons justifying the decision that the respondent's CAD was not attributable to military service.

16. Accordingly, following our judgment in ***UOI v Gawas Anil Madso***[8], this writ petition is dismissed in *limine*.

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[7] **(1978) 1 SCC 405**
[8] **2025 SCC OnLine Del 2018**

17. Compliance with the judgment of the AFT be ensured within four weeks from today.

C. HARI SHANKAR, J

AJAY DIGPAUL, J

APRIL 4, 2025/yg

Click here to check corrigendum, if any