RESERVED
Court No.1

ARMED FORCES TRIBUNAL, REGIONAL BENCH, LUCKNOW

O.A. No. 333 of 2013

Monday, the 28th day of August, 2017

Hon'ble Mr. Justice D.P. Singh, Member (J)
Hon'ble Air Marshal Anil Chopra, Member (A)

Jeewan Chandra (Ex Sapper(OEM) No. 1493083K of 51 Engineer Regiment, presently residing at village Khuni, Police Chowki Jajar Dewal, District Pithoragarh (Uttarakhand).

…. Applicant

By Legal Practioner **Shri G.D.Joshi**, Learned counsel for the applicant.

Versus

1. Union of India through Secretary, Ministry of Defence, Govt of India, South Block, New Delhi-110011

2. The Chairman, Second Appellate Committee on Pension, Integrated Headquarters of Min of Def (Army), Adjutant General Branch, Addl Dte Gen Pers Services-4 (Imp-II), Sena Bhawan, DHQ PO New Delhi-110011.

3. The Senior Records Officer, Bengal Engineer Group Çentre, PIN-908779, C/O 56 APO

4. The Commanding Officer, 51 Engineer Regiment, Care of Records BEG/Centre, Roorkee, Pin-908779, C/O 56 APO

5. The Principal Controller of Defence Accounts (Pensions) Craupadi Ghat, Allahabad, UP.

6. Col S Mansingh, Commanding Officer, 51 Engineer Regiment, C/O 56 APO

7. Lt Col SK Salujha, Classified Specialist (Psychiatrist), Military Hospital, Jallundhar Cantt.

…Respondents

By **Dr. Gyan Singh**, Learned Central Govt Counsel assisted by Capt Priyank Malviya,OIC Legal Cell.

ORDER

Per Justice Devi Prasad Singh, Member 'J'

1. The instant petition under Section 14 of the Armed forces Tribunal Act, 2007 has been preferred by the applicant on account of denial of disability pension to him.

2. We have heard Shri G.D.Joshi, learned counsel for the applicant and Dr. Gyan Singh, learned counsel for the respondents assisted by Capt Priyank Malviya, OIC Legal Cell and perused the record.

3. The applicant was enrolled in the Indian Army as Sepoy Sapper on 20.03.1996 and after due training, he was posted in 51 Engineer Regiment with effect from 11.02.1998. At the time of enrolment, the applicant was found in SHAPE-I category. However, he was invalided out on 19.10.2004 under Army Rule 13(3)(III)(iii) under medical category S-5 for diagnosis Alcohol Dependence Syndrome (F-10-2). He rendered 8 years and 7 months' service, out of which, as per respondents, 107 days were non-qualifying service, hence the total qualifying service rendered by the applicant was 8 years, 3 months and 13 days.

4. During tenure of his service, the applicant was posted at different places, out of which almost for about three years, he was posted at Akhnoor station under field/cold conditions. In para 3 of the counter affidavit, the respondents have placed on record the service profile of the applicant as under:

Ser No.	From	To	Place/Ship	Peace/Field
(a)	20.03.1996	10.02.1998	Roorkee	Peace
(b)	11.02.1998	10.03.2001	Akhnoor	Field
(c)	11.03.2001	19.12.2001	Jalandhar	Peace
(d)	20.12.2001	19.12.2002	Ferozepur	Peace
(e)	20.12.2002	19.10.2004	Jalandhar	Peace

5. While posted at Akhnoor near Pakistan Boarder, he was working as MT driver on dozers/machine to clear roads and also to remove snow under Operation Parakram. He became accustomed of consuming liquor, which is very common in the Army, particularly amongst those who are posted at difficult field conditions or at high altitude. The Medical Board invalided the applicant out vide its opinion dated August 2004 on the ground of Alcohol Dependence Syndrome, which is reproduced as under:

> *"Recommended to be invalided out of service in Medical Category S5 for Alcohol Dependence Syndrome (F-10-2).*
>
> *Date: Aug 2004*
>
> *Sd./-*
> *S.K.Salujha,*
> *Lt Col*
> *Classified Specialist*
> *(Psychiatry)"*

6. According to the Medical Board's opinion, the applicant was suffering from Alcohol Dependence Syndrome (F-10-2) with disability of less than 20% (11-14%) for life under $S_5h_1A_1P_1E_1$ category. The medical certificate issued by the Board with regard to applicant's fitness is reproduced as under:

"Certified that No. 1493983-H Rank SPR Name JEEWAN CHANDRA Unit 51 ENGR'S REGT. C/O 56 APO is a case of ALCOHOL DEPENDENCE SYNDROME (IMB) F-10.2)

He is FIT to received the balance of his AFPF fund amount and other financial benefits.

Military Hospital
Jalandhar Cantt
Dated: Aug 2004

Sd./-
S.K.Salujha,
Lt Col
Classified Specialist
(Psychiatry)"

From the aforesaid medical certificate, it does not appear that the applicant has been discharged in such a medical category that he was totally unfit to perform suitable duties if he was given shelter appointment.

7. A perusal of the Medical Board's opinion further shows that the applicant was alleged to have been found to be a day-time drinker, but on physical examination and other relevant investigations, he was found to be normal and there was no feature of psychosis or cognitive dyfunotionence. Para 2 of IMB proceedings further shows the aforesaid disability did not exist in the applicant before entering into service.

8. In view of above, there is no room of doubt that the applicant suffered Alcohol Dependence Syndrome (F-10-2) after joining the Indian Army.

9. Though the applicant, during the course of service, was awarded two punishments of short term imprisonment on account of overstayal of leave and absence without leave under Sections 39(a) and 39(b) of the Army Act, but his discharge is on account of Alcohol Dependence Syndrome (F-10-2) and not due to the punishments as indicated above. It is submitted that the PCDA(P), Allahabad on recommendations from its Medical Advisor communicated its decision rejecting the applicant's claim of disability pension in March, 2012 after six years of his first appeal dated 20.04.2006.

10. It may be noted that the applicant's second appeal dated 09.07.2012 preferred to the Defence Minister, Government of India with respect to disability pension was kept pending for long without any justified cause, as is evident also from the letters dated 06.03.2013 and 12.09.2013 annexed with the OA. The applicant had raised the following grounds in the said appeal:

> *"In view of the above, I humbly pray to kindly go through the varius facts and feelings for patronising the case of the Ex-serviceman sympathetically to enable the post-invalidated Army personnel be rehabilitated in the remaining part of Life. My case may kindly be looked into from the point of natural justice and reliefs be granted to me accordingly:-*
>
> *(a) In the light of my medical fitness/improvement as opined by the Invaliding Med Bd Proceedings to the extent reproduced in para 2 above, my case was wrongly brought under alcoholic dependence syndrome (F-10.2) and awarded disability 11-14% (less than 20) which is*

unjustified and erroneously assessed to this extent out of once whim and pressure with no back history as I continued for 8 yrs and 7 months service and only a very few period involved which could have been given weightage in such a consideration for pension grant etc.

(b) The attributability or aggravation towards the I.D has been advanced to be not related to Military Service and as self indulgence should have been investigated through the summary of evidence after the Disability Award by the Medical Board at 11-14% due to Alcoholic Dependence Syndrome. After-all the Administrative authy having old records of goods and bads should have screened his fitness to retain in service or grant pension because Govt can rebut the presumption of attributable to or aggravation as the claimant is not supposed to prove his entitlement as also supported by the Supreme Court verdict brought out under para 2 above.

(c) The Records, BEG Roorkee initiated claim to Med Advisor to PCDA (P) Alld who were pre-occupied with negative thought lost no time to reject the claim but to fulfil procedural requirement asked claimant to appeal within 6 months. But again Ist Appeal application which I sent on 20.04.2006 (by Regd Post) but decision thereon has not been received by me so far and my right to IInd appeal has been lapsed as elaborated in para 3 above and now Records, BEG Roorkee has informed that No appeal will be considered at this belated stage although further delaying tactics are being played by Records BEG Rpoorkee but even not replying the Ist Appeal under RTI Act as also explained in para 3. The matter be investigated and right to 2nd Appeal under rejection of claim be granted to me under the circumstances.

(d) As explained in para 5 above, 51 Engr Regmt or HQ-14 Corps should be directed to provide all records as sought for which are relevant in the present case for establishing the contributable responsibility of the Army Organisation apart from that of the claimant concerned. It is well known fact that there is specific quota of liquor or quality liquor which the Jawans/JCOs/Offrs in the unit used to take through Unit Liquor Issue Register vis-a-vis CSD Canteen which is allowed and authorised under the MoD Policy to the extent the same issued to the Ex-Servicemen too under that specific Policy. The Medical authorities opinion that the I.D.Alcoholic Dependence Syndrome is that of self indulgence on the face of in certain cases a Jawan becomes habitual of heavy drinking although it is self-indulgence but at the same time it is issued and regulated through the Unit Liquor Issue Register. Moreover consuming each Chapati decreases the utility/hunger but on consuming liquor it goes on increase. Such a factor is incidental when these non-drinkers'shar eis friendly used by those drinkers in Unit and become habitual in the time to come and the claimant could be such exception which was consequential to such Unit Issue of liquor cannot be ruled out and hence benefit of doubt goes to the claimant which has been allegedly waged against him which is injustice. Further in the context of Supreme Court of India's version to rebut the presumption of attributability or aggravation by the Govt not by the claimant/pensioner. Therefore, based on med docs, Summary of Evidence or Inquiry must have been conducted to assess the ins and outs before finally discharging the claimant through invalidation or otherwise which is absent in the procedure as mush as such detrimental to the interest of claimant concerned.

(e)As the claimant's family comprises of one wife and one Son as such facing acute financial hardships for the livelihood and education of child, but with no pension or job in these days of market rocketing prices or essential commodities it is difficult to make both ends meet without Job. I am healthy and active but based on my Med docs/black sheep any employer is reluctant to engage me. Certificate of fitness given by the Army Docs has no meaning for them as the private employer remarks that where are civilian employees in the Min of Def any could he not be adjusted by authy giving such a bogus certificate, which is meaningless to them. Alternatively I could have been protected by RSMB afresh, the option may be allowed to avail of it a spl case.

7. It is therefore once again requested with folded hands to consider for the reliefs sympathetically at the earliest and obliged please, otherwise it would cause irreparable loss or injury to the claimant concerned.

Yours faithfully,

Dated 09 Jul 2012 *Sd./-Jeewan Chandra"*

11. Submission of learned counsel for the applicant is that while rejecting the applicant's second appeal, the respondents travelled beyond the ground of discharge from service. As is evident from the above, the order of discharge was passed only on the ground of Alcohol Dependence Syndrome (F-10-2), but the second appeal has been rejected on the ground of two punishments awarded earlier to the applicant for overstayal of leave and absence from duty.

12. It has been vehemently argued by learned counsel for the respondents that the development of Alcohol Dependence Syndrome was because of the applicant's own conduct and it shall not be attributable to or aggravated by military service under Army Regulation 173. We find that though It is mentioned in the impugned order dated 11.10.2013 that the applicant was alcoholic from 16 years of age i.e. from before his enrolment in the Army, but according to medical opinion, which was made the basis of his discharge from service, the applicant was non-alcoholic at entry level. The same is mentioned very clearly in Part III Para 2 and Part V Para 2 of Invaliding Medical Board proceedings. The medical certificate also assigns the reason for discharge from army service on account of medical disability as alleged in the impugned order dated 11.10.2013 and not any misconduct. Since the petitioner became the alcohol addict on account of his posting at hard field assignment part of which involved high altitude, his disability was clearly attributable to and aggravated by military service.

13. With regard to use of alcohol by members of armed forces, while deciding **OA No. 168 of 2013**, *Abhilash Singh Kushwaha versus Union of India and others*, decided on 23.09.2015, we had noticed that on occasions of festivals or other occasions, alcohol is given free to army personnel upto appropriate quantity. While posted at high altitude, it is not unusual that a person may consume more alcohol to keep himself warm to be physically and mentally fit to meet out the challenges. In this view of the matter, it cannot be said that Alcohol Dependence

Syndrome (F-10-2) suffered by the applicant was not attributable to or aggravated by military service.

14. In this context, we would like to refer to a Review Article of Griffith Edwards, DM, Reader in drug dependence, in Addiction Research Unit, Institute of Psychiatry, London SE5 8AF and Milton M Gross, MD, Professor of psychiatry in Downstate Medical Centre, Brooklyn, New York 11203. The said article was published in British Medical Journal in 1976, wherein the learned authors defined the essential elements of the syndrome and the manner and mode in which a person becomes alcoholic. The relevant extract of the said Article is reproduced as under:

> ***"Essential elements of the syndrome***
>
> *Essential elements might provisionally include : a narrowing in the repertoire of drinking behaviour; salience of drink-seeking behaviour; increased tolerance to alcohol; repeated withdrawal symptoms; repeated relief or avoidance of withdrawal symptoms by further drinking; subjective awareness of a compulsion to drink; reinstatement of the syndrome after abstinence. All these elements exist in degree, thus giving the syndrome a range of severity. They represent the dimensions along which the clinician can order the information given to him; one clinical element may reflect underlying psychobiological happenings of several types, and different clinical elements may be partial descriptions of the same underlying psychobiological process. In discussing the clinical presentations of each element we shall give patterning in representation by personal and social factors.*
>
> ***Narrowing of the Drinking Repertoire***
>
> *The ordinary drinker's consumption and beverage will vary from day to day and from week to week: he may have beer at lunch on one day, nothing to drink on another,*

share a bottle of wine at dinner one night, and then go to a party on a Saturday and have a lot to drink. His drinking is patterned by varying internal cues and external circumstances.

At first, a person becoming caught up in heavy drinking may often widen his repertoire and also the range of cues that signal drinking. As dependence advances, the cues are increasingly related to relief or avoidance of alcohol withdrawal and the personal drinking repertoire becomes increasingly narrowed. The dependent person begins to drink the same whether it is work day, weekend, or holiday: the nature of the company or his own mood makes less and less difference. Questioning may distinguish earlier and later stages of dependence by the degree to which the repertoire is narrowed. With advanced dependence the drinking may become stereotyped-scheduled to a daily time table to maintain a high blood alcohol-and the patient will be able to recount where and when each drink of the daily ration was bought and consumed. More careful questioning will, however, show that even when dependence is well established some capacity for variation remains. Change in personal circumstances such as a new job or a different marriage may for a time constrain the drinking. Pricing and sales regulations may also influence the dependent drinker. The syndrome must be pictured as subtle and plastic rather than as something set hard, but as dependence advances the pattern tends to become increasingly stereotyped. Available data on the consumption of alcoholics generally refer to heterogeneous samples with not all patients dependent or severely dependent and may underestimate the mean consumption of heavily dependent subjects.

Salience of Drink-Seeking Behaviour

This stereotyping of the drinking pattern as dependence advances leads to the individual giving priority to maintaining his alcohol intake; indeed the failure of unpleasant consequences to deter may be a clinical indicator of the degree of dependence. The wife's distressed scolding-once effective-is later neutralized by the drinker as evidence of her lack of understanding. Income which had previously to serve many needs now satisfies only the drive for drink. Gratification of the need

for drink may become more important for the patient with liver damage than even considerations of survival- "a short life and a merry one."

In clinical assessment attention has to be paid to the patient's basic personality, for many people are not dependent but none the less drink without much regard for consequences because of their general irresponsibility. These people may, of course, in the end develop the dependence syndrome. Diagnostically the progressive change in the salience given to a alcohol is important rather than behaviour at any one time. Typically, the patient relates that he used to be proud of his house but now the paint is peeling off, used always to take the children to football matches but now spends no time with them, used to have rather rigid moral standards but will now beg, borrow, or steal to obtain money for alcohol. In the same way the drug-dependent monkey will work hard for its alcohol, and experiments with human volunteers have supported the appropriateness of such a model.

Increased Tolerance to Alcohol

Alcohol is a drug to which the central nervous system (CNS) develops tolerance. The precise mechanism is not yet known, but presumably there are changes at the synaptic junction- a sort of homoeostatic adjustment to continued alcohol exposure. Metabolic tolerance (increased liver clearance) makes a relatively trivial contribution. Clinically, tolerance is shown by the dependent person being able to sustain an alcohol intake and go about his business at blood alcohol levels that would incapacitate the non-tolerant drinker. This does not mean his functions are unimpaired-he will be a dangerous driver-but because of his tolerance he will (unfortunately) still be able to drive. Cross-tolerance will extend to other general depressants such as barbiturates and minor tranquillizers. The rate of development of tolerance is still unknown, but the heavy drinker who is not dependent will probably also show considerable tolerance. In later stages of dependence, for reasons which are unclear, the individual begins to lose his previously acquired tolerance and then becomes incapacitated by quantities of alcohol which he could previously handle; for the first time he may fall down in the street.

> *Patients themselves report on tolerance as "having a good head for it" or "being able to drink the other man under the table." Questioning often reveals the patient's awareness that "just one or two drinks are not any good"; he himself has sensed the crucial meaning of a change in the dose-response curve."*

15. Learned authors further considered the drink-related disabilities which may occur to an alcoholic person and ultimately make him suffer from dependence syndrome. Their observation is reproduced as under:

> ***"Drink-related disabilities***
>
> *A person may, for example, develop cirrhosis, lose his job, crash his car, or break up his marriage through his drinking without suffering from the dependence syndrome. The syndrome should therefore not monopolise medical and social concern. Nevertheless, physical, mental, and social disabilities often accumulate for the person who is dependent and are more likely to be incurred the greater his dependence. Greater dependence means both higher alcohol intake and diminished responsiveness to social controls. But the diagnosis of dependence itself and assessment of its degree should be made in relation to the primary symptoms listed at the start of this paper and not by reference to the secondary damage. The analogy is with the classic approach to diagnosis of schizophrenia and the astute recognition of first-rank symptoms."*

16. The research shows that alcoholic disorder can be cured by cutting down alcohol intake gradually. Research has also been made by the research scholars for its treatment. The relevant extract is reproduced as under:

"What Are the Treatments for Alcoholism?

The goal of treatment for alcoholism is quitting, though some people may be able to effectively cut down. Among alcoholics with otherwise good health, social support, and motivation, the likelihood of recovery is good. After treatment, about one-third of patients show no relapse or symptoms at 1 year. Many more report fewer alcohol-related social and health problems by cutting down alcohol intake. Poor social support, lack of motivation, and psychiatric disorders are all risk factors for relapsing. For some high-risk patients, success is measured by longer periods of abstinence, reduced use of alcohol, better health, and improved social functioning.

Conventional Medicine for Alcoholism

Treatment has three stages:

Detoxification (detox): Abruptly decreasing or discontinuing alcohol can lead to withdrawal symptoms, usually within 6-12 hours. Typical symptoms include tremors, agitation, and insomnia. Alcohol withdrawal can be dangerous, so if symptoms are severe, you may need medical treatment.

Rehabilitation: This involves counseling and medications to give the recovering alcoholic the skills needed for maintaining sobriety. This step in treatment can be done inpatient or outpatient. Depending on your support system and environment, both can be effective.

Maintenance of sobriety: This step's success requires an alcoholic to be self-disciplined. The key to maintenance is support, which often includes regular Alcoholics Anonymous (AA) meetings and getting a sponsor.

Because detoxification does not stop the craving for alcohol, recovery is often difficult to maintain. For a person in an early stage of alcoholism, discontinuing alcohol use may result in some withdrawal symptoms, including anxiety and poor sleep. Withdrawal from long-term dependence may bring the uncontrollable shaking, spasms, panic, and hallucinations of DTs. If not treated professionally, people with DTs have a mortality rate of more than 10%, so detoxification from late-stage alcoholism should be attempted under the care of an experienced

doctor and may require a brief inpatient stay at a hospital or treatment center.

Detox may involve one or more medications. The mainstay of treatment is benzodiazepines, anti-anxiety drugs used to treat withdrawal symptoms such as anxiety and poor sleep and to prevent seizures and delirium. These are the most frequently used medications during the detox phase, at which time they are usually tapered and then discontinued. They must be used with care, since they may be addictive.

In the rehabilitation and maintenance stages of recovery, there are several medicines used to help maintain sobriety. One drug, disulfiram, may be used once the detox phase is complete and the person is abstinent. It interferes with alcohol metabolism so that drinking a small amount will cause nausea, vomiting, blurred vision, confusion, and breathing difficulty. This medication is most appropriate for alcoholics who are highly motivated to stop drinking or whose medication use is supervised, because the drug can make you feel really sick if you drink.

Another medicine, naltrexone, reduces the craving for alcohol. Naltrexone can be given even if the individual is still drinking; however, as with all medications used to treat alcoholism, it is recommended as part of a comprehensive program that teaches patients new coping skills. It is now available as a long-acting injection that can be given on a monthly basis.

Acamprosate is another medicine that has been FDA-approved to reduce alcohol craving.

Finally, research suggests that the anti-seizure medicines topiramate and gabapentin may be of value in reducing craving or anxiety during recovery from drinking, although neither of these drugs is FDA-approved for the treatment of alcoholism.

Antidepressants may be used to control any underlying or resulting anxiety or depression, but because those symptoms may disappear with abstinence, the medications are usually not started until after detox is complete and there has been some period of abstinence.

Because an alcoholic remains susceptible to relapse and potentially becoming dependent again, the goal of recovery is total abstinence. Recovery typically takes a broad-based approach, which may include education programs, group therapy, family involvement, and participation in self-help groups. Alcoholics Anonymous (AA) is the most well known of the self-help groups, but other approaches have also proved successful.

Nutrition and Diet for Alcoholism

Poor nutrition goes with heavy drinking and alcoholism: Because an ounce of alcohol has more than 200 calories but no nutritional value, ingesting large amounts of alcohol tells the body that it doesn't need more food. Alcoholics are often deficient in vitamins A, B complex, and C; folic acid; carnitine; magnesium, selenium, and zinc, as well as essential fatty acids and antioxidants. Restoring such nutrients -- by providing thiamine (vitamin B-1) and a multivitamin -- can aid recovery and are an important part of all detox programs."

17. A perusal of the record comprising medical opinion shows that no efforts have been made by the respondents to provide adequate treatment to the applicant for his alcohol dependence syndrome by adopting some scientific methods of treatment (supra). The applicant's disability has been held to be only 11-14%, hence he could have been retained in service by change of trade, which seems to have not been done. Thus, the petitioner has been discharged without any justifiable cause. Due to omission and commission on the part of the respondents, as evident from above, gross injustice seems to have been done to the applicant. The respondents seem to have been swayed away by the earlier incidences of punishments awarded to the applicant. They ignored the fact that the applicant was thereafter kept in service and

remained there till he was discharged on account of medical disability referred to above. The second appeal preferred by the applicant assailing the discharge on the ground of medical disability, therefore, should have been decided only in that reference and not otherwise. While deciding the second appeal, the respondents have, thus, travelled beyond the ground raised by the applicant and did not consider the medical disability as the cause of his discharge, hence serious illegality has been committed by the respondents.

18. Apart from above, we have seen the manner and mode coupled with the circumstances under which the applicant became alcoholic while posted at field area Akhnoor near the active Pakistan boarder and involving even work at high altitude area of J & K for about three years, where he was discharging duties of MT driver, which is quite possible in view of the research referred to supra. Hence it is incorrect to say that the applicant's disability was not because of military service. We are of the view that the applicant's Alcohol Dependence Syndrome (F-10-2) was attributable to military service. Though *prima facie* we feel that the discharge was bad in law, but keeping in view the fact that the applicant has claimed the relief of disability pension only, we confine our order to the said relief as claimed in the petition.

19. The proposition of law with regard to disability pension has been settled by the Hon'ble Supreme Court and is no more a *res integra.* We, therefore, find that the petitioner has a case in his favour for grant of the relief of disability pension, in view of the settled proposition of law by Hon'ble Supreme Court in catena of decisions. (Vide:

Dharamvir Singh versus Union of India and others, *(2013) 7 SCC 316*; **Sukhvinder Singh Vs. Union of India,** *(2014) 14 SCC 364*; **Union of India and others versus Ram Avtar & others,** *Civil Appeal No. 418 of 2012 dated 10 December, 2014*; **Shiv Dass versus Union of India,** *2007 (3) SLR 445;* **Durga Prasad versus Chief Controller of Imports and Exports and others,** *AIR 1967 SC 769,* **K.J.S. Buttar versus Union of India and others** *(2011) 11 SCC 429 and* **Union of India and others versus Angad Singh Titaria,** *(2015) 12 SCC 257.)*

20. In **K.J.S. Buttar versus Union of India and others** reported in *(2011) 11 SCC 429***,** the Hon'ble Supreme Court held that a person, who was discharged by retirement in low medical category with a disability and invalided out, was entitled to the benefit of 'broad banding'. Relevant portion from the said judgment in the case of **K.J.S. Buttar** (supra) is reproduced as under:-

> *" 8. In our opinion, the restriction of the benefit to only officers who were invalided out of service after 1.1.1996 is violative of Article 14 of the Constitution and is hence illegal. We are fortified by the view as taken by the decision of this Court in Union of India & Anr. vs. Deoki Nandan Aggarwal 1992 Suppl.(1) SCC 323, where it was held that the benefit of the Amending Act 38 of 1986 cannot be restricted only to those High Court Judges who retired after 1986.*
>
> *9. In State of Punjab vs. Justice S.S. Dewan (1997) 4 SCC 569 it was held that if it is a liberalization of an existing scheme all pensioners are to be treated equally, but if it is introduction of a new retrial benefit, its benefit will not be available to those who stood*

retired prior to its introduction. In our opinion the letter of the Ministry of Defence dated 31.1.2001 is only liberalization of an existing scheme."

"11. In our opinion the appellant was entitled to the benefit of para 7.2 of the instructions dated 31.1.2001 according to which where the disability is assessed between 50% and 75% then the same should be treated as 75%, and it makes no difference whether he was invalided from service before or after 1.1.1996. Hence the appellant was entitled to the said benefits with arrears from 1.1.1996, and interest at 8% per annum on the same.

12. It may be mentioned that the Government of India Ministry of Defence had been granting War Injury Pension to pre-1996 retirees also in terms of para 10.1 of Ministry's letter No.1(5)/87/D(Pen-Ser) dated 30.10.1987 (p. 59 Para 8). The mode of calculation however was changed by Notification dated 31.1.2001 which was restricted to post 1996 retirees. The appellant, therefore, was entitled to the War Injury Pension even prior to 1.1.1996 and especially in view of the instructions dated 31.1.2001 issued by the Government of India. The said instruction was initially for persons retiring after 1.1.1996 but later on by virtue of the subsequent Notifications dated 16.5.2001 it was extended to pre 1996 retirees also on rationalisation of the scheme.

13. As per the Instructions, different categories have been provided by the Government for award of pensionary benefits on death/disability in attributable/aggravated cases. As per Para 10.1 of the Instructions dated 31.1.2001, where an Armed Forces personnel is invalided on account of disability sustained under circumstances mentioned in Category-E(f)(ii) of Para 4.1, he shall be entitled to War Injury Pension consisting of service element and war injury element. Para 4.1 provides for the different categories to which the pensionary benefits are to be awarded. Category-E(f)(ii) of Para 4.1 pertains to any death or disability which arises due to battle

inoculation, training exercises or demonstration with live ammunition."

"15. As per Para 6 of these instructions/letter dated 16.5.2001, any person, who is in receipt of disability pension as on 1.1.1996 is entitled to the same benefit as given in letter dated 31.1.2001. Further as per Para 7 of this letter w.e.f. 1.1.1996 the rates of War Injury element shall be the rates indicated in letter dated 31.1.2001. Thus, in our opinion in view of the instruction dated 31.1.2001 read with (sic the Instructions) dated 16.5.2001, the appellant was entitled to the War Injury Pension. It is pertinent to state that reading of Paras 6, 7 and 8 of the Notifications/Circular dated 16.5.2001 makes it absolutely clear that the said benefits were available to pre 1996 retirees also but the rates were revised on 31.1.2001 and the revised rates were made applicable to post-1996 retirees only. But subsequently by means of the Notification dated 16.5.2001 the revised rates were extended to pre-1996 retirees also.

16. At any event, we have held that there will be violation of Article 14 of the Constitution if those who retired/were invalided before 1.1.1996 are denied the same benefits as given to those who retired after that date."

21. Keeping in view the catena of decisions of the Hon'ble Supreme Court dealing with the principle for payment of disability pension and its rounding off, there appears to be no room for doubt that a person, who retires voluntarily or invalided out from service of Armed Forces, shall be entitled for disability pension and the fraction of disability shall be rounded off to 50% in case it is less than 50%. Disability of 50% but less than 75% be rounded off to 75% and if it is more than 75%, then it may be rounded off to 100%. Since the applicant's disability was assessed as 11-14%, prayer for its rounding off to 50% has also

been made orally, and in view of settled proposition of law as indicated above, we have no hesitation in granting the said relief.

22. So far as the applicant's prayer for erroneous diagnosis is concerned, after lapse of so many years, we are not in a position to assess or sit over the opinion of the Medical Board or send the applicant for re-examination by appropriate Board.

23. While parting with the case, we would like to observe that in cases of Alcohol Dependence Syndrome, members of the Armed Forces should not be discharged mechanically on the basis of opinion of Medical Board. Once it is detected that an individual is suffering from Alcohol Dependence Syndrome, then he or she must be treated by a psychiatrist or nutritionist, which is possible, keeping in view the recent research work (supra) and developments made in the field of treatment to minimise or wipe out the intake of liquor. The present one is a case where an army personnel was non-alcoholic at entry level but later he became alcoholic because of hard and tough life under field conditions and high altitude and easy availability of alcohol to remove the fatigue. Such cases must be dealt with sympathetically and all efforts should be made for his/her treatment by a psychiatrist with the help of nutritionists, followed by change of trade and place of posting. Right to life and livelihood is a fundamental right, which is available to armed forces personnel also. They must be given thorough treatment and option to change the trade.

24. Accordingly, the OA deserves to be allowed and is hereby allowed. The impugned order dated 11.10.2013 is set aside with all consequential benefits. The applicant's disability assessed as 11-14% is rounded off to 50% for life from the date of discharge with all consequential benefits. The applicant shall be entitled to interest at the rate of 10% per annum on the arrears of disability pension from the date of discharge till the date it is actually paid. Let this order be complied with by the respondents within a period of four months from today.

There would be no order as to costs.

Registry is directed to send copy of this order to Chief of Army Staff, Chief of Air Staff and Chief of Naval Staff to look into the matter and issue appropriate orders/directions to all concerned in view of the observations made in the present order.

(Air Marshal Anil Chopra)
Member (A)

(Justice D.P. Singh)
Member (J)

Dated: 28 August, 2017
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