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

+ **W.P.(C) 17812/2025 and CM APPL.73574-76/2025**

UNION OF INDIA ORS

.....Petitioners

Through: Ms. Archana Sharma, SPC with
Major Anish Muralidhar
Sgt Mritunjay and Sgt Manish Kumar Singh

versus

EX NK MITHUN KUMAR DUBEY

.....Respondent

Through:

CORAM:

HON'BLE MR. JUSTICE C. HARI SHANKAR

HON'BLE MR. JUSTICE OM PRAKASH SHUKLA

JUDGMENT (ORAL)

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24.11.2025

C. HARI SHANKAR, J.

1. We find from the record that this writ petition is highly belated. The order passed by the Armed Forces Tribunal¹ was passed as far back as on 31 October 2023 and this writ petition was filed before this Court on or before 31 January 2025.

2. This itself indicates the seriousness with which the petitioner was prosecuting this matter. Nonetheless, as Ms. Archana Sharma, learned SPC, insisted on contesting this matter, we have heard her and perused the record.

¹ "AFT", hereinafter



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3. The petition is directed against an order dated 31 October 2023 passed by the AFT allowing OA 1327/2019, whereby the respondent has been granted disability pension.

4. The prayer of the respondent was on the ground that he was suffering from Localisation Related Epilepsy (G40)² and Severe Depressive Episode (F32)³. The Release Medical Board⁴, which assessed the case of the respondent, assessed the disability attributable to LRE as 20% and SDE as 40% for life, with composite assessment of both disabilities at 50% for life.

5. Admittedly, if the disability is of 20% or more and is either attributable or aggravated by military service, the candidate would be entitled to disability pension.

6. The law in this regard has been settled by the Supreme Court in its judgment in *Dharamvir Singh v. Union of India*⁵, and *Bijender Singh v. Union of India*⁶. Following the said decisions, this Bench, as well as a Coordinate Bench of this Court, has passed several judgments, now running into hundreds, allowing claims of disability pension. Some of those cases have been carried to the Supreme Court. Appeals in certain cases stand dismissed. It is, however, not in dispute that as on date there is no interim order passed by the Supreme Court interdicting the operation of any of the orders passed by this Court.

² “LRE” hereinafter

³ “SDE” hereinafter

⁴ “RMB” hereinafter

⁵ (2013) 7 SCC 316

⁶ 2025 SCC OnLine SC 895



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7. We have nonetheless, addressed ourselves to Ms. Archana Sharma's submission that the record indicates that the disabilities on the basis of which the respondent was claiming disability pension are neither attributable nor aggravated by service.

8. We have with us the record of the RMB which had examined the case of the respondent. The RMB records the fact that the respondent had served with the petitioner herein for 16 years, before he was released on the ground of medical disqualification. The respondent had been commissioned with the petitioner on 30 January 2003. Even as per the report of the RMB, the dates of onset of the LRE and SDE, from which the respondent was found to be suffering, were May 2014 and 27 August 2015. Thus, even as per the report of the RMB, the respondent was not suffering from either of these ailments for a period of 11 years in the case of LRE and 12 years in the case of SDE, after he had joined military service.

9. We may note at this juncture that the AFT, too, has granted relief to the respondent only for the LRE from which he was suffering. As we have already noted, the onset of LRE was 11 years after he had joined military service. It is nobody's case that at the time when the respondent was enrolled with the petitioner, he was ever noted as suffering from any epileptic disorder.

10. We may now advert to the opinion of the RMB regarding the aspect of attributability and aggravation of the aforesaid disorder to military service. The opinion reads "Disability onset in peace Stn



NANA as per para 33 GMO-2008.”

11. The Supreme Court has, in case after case, held that the mere fact that the candidate may have been posted in a peace station is not a ground to disentitle him to disability pension. We have also followed the said decision in our judgment in *Union of India v. Ex Sub Gawas Anil Madso*⁷, which has been followed by the Coordinate Bench in *Union of India v. Balbir Singh*⁸.

12. The SLP preferred by the Union of India against the decision in *Balbir Singh* also stands dismissed by the Supreme Court.

13. As we have noted, the only ground cited by the RMB for holding that the respondent's LRE was not attributable to or aggravated by military service, is para 33 of the GMO.

14. Para 33 of the GMO reads thus:

“33. Epilepsy. This is a disease which may develop at any age without obvious discoverable cause. The persons who develop epilepsy while serving in forces are commonly adolescents with or without ascertainable family history of disease. The onset of epilepsy does not exclude constitutional idiopathic type of epilepsy but possibility of organic lesion of the brain associated with cerebral trauma, infections (meningitis, cysticercus, encephalitis, TB) cerebral anoxia in relation to service in HAA, cerebral infarction and hemorrhage, and certain metabolic (diabetes) and demyelinating disease should be kept in mind.

The factors which may trigger the seizures are sleep deprivation, emotional stress, physical and mental exhaustion, infection and pyrexia and loud noise. Acceptance 29 is on the basis of

⁷ 318 (2025) DLT 711

⁸ 2025 SCC Online Del 7873



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attributability if the cause is infection, service related trauma. Epilepsy can develop after time lag/latent period of 7 years from the exposure to offending agent (Trauma, Infection, TB). This factor should be borne in mind before rejecting epilepsy cases.

Where evidence exists that a person while on active service such as participation in battles, warlike front line operation, bombing, siege, jungle war-fare training or intensive military training with troops, service in HAA, strenuous operational duties in aid of civil power, LRP on mountains, high altitude flying, prolonged afloat service and deep sea diving, service in sub-marine, entitlement of aggravation will be appropriate if the attack takes place while serving in those areas.”

15. We find nothing in para 33 of GMO 2008 which can support the opinion of the RMB to the effect that the LRE from which the respondent was suffering was not attributable to or aggravated by military service.

16. Ms. Sharma, at this juncture, refers us to the opinion of the specialist, who had examined the case of the respondent which reads thus:

"Reason for present referral:-Self reported for his RMB vide EME Records Letter No.1529/T-9/112/LMC RO/CA-2(MP) dated 09.08.2018.

"Individual initially came into medical care on 27th Aug.2015 when, while on sick leave for Localisation Related Epilepsy granted from 174 MH, he was hospitalized at MH Ahmedabad for Breakthrough Seizures. On 25th Aug 2015 he has had One seizure in the morning which was the immediate trigger for his referral by his relatives. He was initially managed by Med Spl and thereafter referred for psy evaluation when he was noted to be dull and aloof in medical ward and revealed domestic stressors to treating physician. At the time of psy evaluation he complained of low mood, loss of interest, lack of energy, headache-left temporal region heaviness of head. 'chinta-'soch' and poor sleep. He revealed that his younger brother (who was living with his life in paternal home) and his wife(newly wed are very casual and not at all



looking after his mother in their home. He was also not giving any money to run the home. He allegedly would come later at night with wife and would not contribute even a single rupee to their mother. Because of this patient had to contribute a significant portion of his salary to his home. Patient revealed that because of this he always remained distressed as well as his wife and mother. He revealed that he would suffer clenching of teeth with a variable period of unresponsiveness whenever he worried a lot. Past history also revealed that about 7-8 yrs back he was distressed about divorce of his sister and would remain low and tensed all the time with poor sleep and appetite. He loss interest in all the activities,. He was so distressed that out of frustration he superficially slashed his wrist (left) and right forearm. He did not inform anyone about this nor seek any medical consultation. He gradually improved over the next few months. In 2012 also he reportedly tried to shoot himself with his service rifle because of his sister's ongoing martial discord. He was then counseled by his superior and sent on leave. Family history revealed h/o psy illness in younger sister. Patient revealed strained relation with his younger brother. There was no h/o any during or substance abuse. AFMSF-10 dt 19th Sep 15 was satisfactory. Physical and systematic exam at the time of psy evaluation revealed 3-4 superficial healed scar marks over left wrist and over right forearm. All relevant inv including TFT and NCCT head were normal (MRI brain dt 29th Jan 15 and EEG done in Jun 15 at Bathinda were normal). MSE revealed monotonous speech with latency of response, dull and depressed affect lack of self confidence and self esteem, pessimistic thinking, helplessness, hopelessness with significant pre-occupation about his domestic stressors. There was no delusion or hallucination. Insight and judgment were unimpaired. Biodrives were disturbed. BDI was 28. During subsequent interviews he complained of various somatic complaints with low blood and cognitions. During ward he has had 7-8 episodes of pseudo seizures/seizure soon after hearing about some stress at home. (He was on 02 AED-Leveteracetam and Phenytoin Sodium). Serum Prolactin was normal. He was thereafter managed with Escitalopram, Mirtazapine. Divalproex Sodium and Clonazepam in a supportive milieu. On improvement he was sent on 04 weeks of sick leave with advice to report at 174 MH for his review after expiry of sick leave being dependent hospital. On review after sick leave at 174 MH he was noted to have relapse of his illness hence managed with ECT and antidepressants and thereafter again sent on sick leave. After sick leave he was in remission hence retained in S3 (t 24) wef Feb 16 with advice to continue Mirtazapine 30mg, Aripiprazole 7.5 mg, Zolpidem 10mg and Leveteracetam gm/day. He has had 2-3 dissociative episodes thereafter for which he was hospitalized at 174 MH twice and managed with medicine optimization. During



his recat in July 16 he was noted to be in remission on medication with satisfactory unit report hence retained in S3 (T24+124) with advice to continue Mirtazapine 30 mg and Amisulpride 300 mg/day. During monthly reviews thereafter he was noted to have residual anxiety/somatic features. During his recat in Jan 2017 AFMSF-10 dt 02nd Jan 17 was satisfactory. Physical and systemic examination was normal. MSE revealed a kempt Co-operative individual with normal PMA. Speech was relevant and coherent. No feature of any mood, anxiety or psychotic illness noted. Insight and judgment were unimpaired. Biodrives were stable. Serial MSE on OPD basis did not reveal any psychopathology. He was thereafter retained in service in S2 (T 24) with advice to continue Sertraline 200 mg and Mirtazapine 30 mg/day. During his recat in July 17 he was noted to be complaint on medicine during the period of surveillance. Sertraline was stopped because of non-availability and dosage of Mirtazapine was increased upto 45 mg/day in Mar 17 when complained of forgetfulness in the background of alleged high expressed emotion in his unit. During surveillance period he was hospitalized twice for seizure/pseudoseizure in Feb 17/April 17 and managed in medical ward by physician. At the time of recat in July 17 he was asymptomatic. AFMSF-10 dt 22nd Jun 17 was satisfactory. Physical and systemic examination was normal. MSE revealed a kempt, cooperative individual with normal PMA. Speech was relevant and coherent. No feature of any mood, anxiety or psychotic illness noted. Insight and judgment were impaired. Biodrives were stable. Serial MSE on OPD basis did not reveal any psychopathology. He was then retained in service in S2 (T24+T24) with advice to continue Mirtazapine 45 mg/day. Mirtazapine was replaced by Duloxetine 20 mg in Aug 17 because of availability issue. During subsequent monthly review he was noted to have residual anxiety/depressive feature. He was also hospitalized thrice for seizure in medical ward and managed by Med Spl. During his recat in Dec 17 he was noted to be in remission on medication with satisfactory unit report hence retained in S2 (Pmt) with advice to continue Duloxetine 20 mg/day. During subsequent monthly reviews he was noted to have residual anxiety symptoms hence prescribed Sertraline and Mirtazapine with improvement.

Presently self reported for his RMB. He is presently asymptomatic on medicines. AFMSF-10 dt 26th Sep 18 is satisfactory. Physical and systemic examination is normal. MSE reveals a kempt, cooperative individual with normal PMA. Speech is relevant and coherent. No feature of any mood, anxiety or psychotic illness noted. Insight and judgment are unimpaired. Biodrives are stable. Presently he is asymptomatic and motivated enough for future drug



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compliance. In view of the above and as per DM memo 171, he is recommended to be released from service in S2 (Pmt) with following advice-

- 1) To continue following medicines under supervision of nearest hospital-
 - a) Tab Sertraline 50 mg 0-0-1
 - b) Tab Mirtazapine 15 mg 0-0-1
 - c) Tab Clonazepam 0.5 mg 1 SOS
- 2) Not to consume alcohol or any other substance of abuse"

17. We find, in the first place, that the opinion of the Specialist is not the basis of the opinion of the RMB. That apart, even when we go through the aforesaid opinion, it does not indicate that the LRE which, even as per the RMB report, commenced 11 years after the respondent had joined military service, has been attributed to any cause other than the military service undergone by him. The Report exclusively deals with the condition, status, and management of the respondent after he first reported with epileptic episodes.

18. We reiterate the position in law, which we have had an occasion to state earlier as well, that, in order to hold the officer not to be entitled to disability pension despite having been found to suffer from an ailment or disability years after he had joined military service, the opinion of the Medical Board or the opinion of the specialist, has to identify some other attributable cause for the said ailment or disability. Else, there would be a presumption, following the law laid down by the Supreme Court in ***Dharamvir Singh*** and ***Bijender Singh*** and of this Court in ***Gawas Anil Madso***, that the ailment was attributable to, or aggravated by, the military service undergone by the officer.



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19. We are not sitting in appeal over the decision of the AFT. We exercise *certiorari* jurisdiction, the parameters of which stand thus delineated in *Syed Yakoob v. K.S. Radhakrishnan*⁹, thus:

“7. The question about the limits of the jurisdiction of High Courts in issuing a writ of certiorari under Article 226 has been frequently considered by this Court and the true legal position in that behalf is no longer in doubt. A writ of certiorari can be issued for correcting errors of jurisdiction committed by inferior courts or tribunals: these are cases where orders are passed by inferior courts or tribunals without jurisdiction, or is in excess of it, or as a result of failure to exercise jurisdiction. A writ can similarly be issued where in exercise of jurisdiction conferred on it, the Court or Tribunal acts illegally or in properly, as for instance, it decides a question without giving an opportunity to be heard, to the party affected by the order, or where the procedure adopted in dealing with the dispute is opposed to principles of natural justice. There is, however, no doubt that the jurisdiction to issue a writ of certiorari is a supervisory jurisdiction and the Court exercising it is not entitled to act as an Appellate Court. This limitation necessarily means that findings of fact reached (sic) by the inferior Court or Tribunal as result of the appreciation of evidence cannot be reopened or questioned in writ proceedings. An error of law which is apparent on the face of the record can be corrected by a writ, but not an error of fact, however grave it may appear to be. In regard to finding of fact recorded by the Tribunal, a writ of certiorari can be issued if it is shown that in recording the said finding, the Tribunal had erroneously refused to admit admissible and material evidence, or had erroneously admitted inadmissible evidence which has influenced the impugned finding. Similarly, if a finding of fact is based on no evidence, that would be regarded as an error of law which can be corrected by a writ of certiorari. In dealing with this category of cases, however, we must always bear in mind that a finding of fact recorded by the Tribunal cannot be challenged in proceedings for a writ of certiorari on the ground that the relevant and material evidence adduced before the Tribunal was insufficient or inadequate to sustain the impugned finding. The adequacy or sufficiency of evidence led on a point and the inference of fact to be drawn from the said finding are within the exclusive jurisdiction of the Tribunal, and the said points cannot be agitated before a writ Court. It is within these limits that the

⁹ AIR 1964 SC 477



jurisdiction conferred on the High Courts under Article 226 to issue a writ of certiorari can be legitimately exercised.

8. It is, of course, not easy to define or adequately describe what an error of law apparent on the face of the record means. What can be corrected by a writ has to be an error of law; it must be such an error of law as can be regarded as one which is apparent on the face of the record. Where it is manifest or clear that the conclusion of law recorded by an inferior Court or Tribunal is based on an obvious misinterpretation of the relevant statutory provision, or sometimes in ignorance of it, or may be, even in disregard of it, or is expressly founded on reasons which are wrong in law, the said conclusion can be corrected by a writ of certiorari. In all these cases, the impugned conclusion should be so plainly inconsistent with the relevant statutory provision that no difficulty is experienced by the High Court in holding that the said error of law is apparent on the face of the record. It may also be that in some cases, the impugned error of law may not be obvious or patent on the face of the record as such and the Court may need an argument to discover the said error; but there can be no doubt that what can be corrected by a writ of certiorari is an error of law and the said error must, on the whole, be of such a character as would satisfy the test that it is an error of law apparent on the face of the record. If a statutory provision is reasonably capable of two constructions and one construction has been adopted by the inferior Court or Tribunal, its conclusion may not necessarily or always be open to correction by a writ of certiorari. In our opinion, it neither possible nor desirable to attempt either to define or to describe adequately all cases of errors which can be appropriately described as errors of law apparent on the face of the record. Whether or not an impugned error is an error of law and an error of law which is apparent on the face of the record, must always depend upon the facts and circumstances of each case and upon the nature and scope of the legal provision which is alleged to have been misconducted or contravened.”

20. With the limits of *certiorari*, we do not find that any case for interference with the decision of the AFT exists in the present case.

21. The petition is, accordingly, dismissed in *limine*.



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22. Let compliance with the direction of the AFT be ensured within eight weeks from today.

C. HARI SHANKAR, J

OM PRAKASH SHUKLA, J

NOVEMBER 24, 2025/yg