[2012] AATA 595

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| Division | **VETERANS' APPEALS DIVISION** |
| File Number | 2010/5005 |
| Re |  |
|  | APPLICANT |
| And |  |
|  | RESPONDENT |

# Decision

|  |  |
| --- | --- |
| Tribunal | **Mr Egon Fice, Senior Member****Dr Kerry Breen, Member** |
| Date | **5 September 2012**  |
| Place | **Melbourne** |

The Tribunal sets aside the reviewable decision of the Veterans’ Review Board dated
1 September 2010 and in substitution determines that the death of Mr John Chambers was war-caused as that expression is defined in the *Veterans' Entitlements Act 1986* (Cth).

....[sgd Egon Fice]....................................................................

**Mr Egon Fice, Senior Member**

**VETERANS’ AFFAIRS** – widows’ pension – Australian Army – kind of death – whether the death of the veteran was war-caused – operational service – reasonable hypothesis – alternative hypothesis – sub-hypothesis regarding ulcerative colitis – inflammatory bowel disease – amoebic dysentery –ulcerative colitis – primary sclerosing cholangitis – cholangiocarcinoma – irritable bowel syndrome – malaria – yellow jaundice

Veterans' Entitlements Act 1986 (Cth) ss 7, 8, 13, 120(1), 120(2), 120(3), 120(4), 120(5), 120A, 120A(3), 120A(4), 180A(2), 196B(2), 196B(11)

Bushell v Repatriation Commission (1992) 175 CLR 408

Byrnes v Repatriation Commission (1993) 177 CLR 564

Collins v Repatriation Commission (2009) 258 ALR 204

Commissioner for Government Transport v Adamcik (1961) 106 CLR 292

East v Repatriation Commission (1997) 16 FCR 517

McKenna v Repatriation Commission (1999) 86 FCR 144

Re Dell and Repatriation Commission (1986) 5 AAR 253

Repatriation Commission v Deledio (1998) 83 FCR 82

Repatriation Commission v Gorton (2001) 110 FCR 321

Repatriation Commission v Hancock (2003) 37 AAR 383

Repatriation Commission v Law (1980) 31 ALR 140

Repatriation Commission v Law (1981) 147 CLR 635

Trevena v Repatriation Commission [2001] AATA 707

Statement of Principles - Inflammatory Bowel Disease – Instrument No 21 of 2001

Statement of Principles - Inflammatory Bowel Disease – Instrument No 19 of 2012

# REASONS FOR DECISION

**Mr Egon Fice, Senior Member**

**Dr Kerry Breen, Member**

1. Mr John Alexander Chambers was born on 29 June 1914. He served with the Australian Army between 1 August 1940 and 24 April 1946. Mr Chambers had 12 months service in the Middle East between 1941 and 1942 with the 2/3rd Light Anti-Aircraft Regiment. He also served in Dutch New Guinea, the Philippines and Morotai. All of his overseas service constitutes operational service for the purposes of the *Veterans' Entitlements Act 1986* (the VE Act).
2. Mr Chambers died on 11 April 1999. He was aged 84 years. The cause of death certified by Dr A Murray was: Carcinoma of Bile Duct – 5 months.
3. Mr Chambers' widow, Mrs Joan Chambers, lodged a claim for the widows' pension on 15 May 2009. On 23 June 2009 a delegate of the Repatriation Commission (the Commission) determined that Mr Chambers' death was not war-caused and that the pension was not payable to her.
4. On 7 July 2009 Mrs Chambers lodged an application for review by the Veterans' Review Board (the VRB). On 1 September 2010 the VRB affirmed the decision of the delegate of the Commission. Mrs Chambers was notified of that decision on 6 September 2010.
5. On 11 November 2010 Mrs Chambers lodged an application with the Tribunal seeking review of the VRB decision.
6. The issues which we are required to determine are:
	1. the kind of death suffered by Mr Chambers; and
	2. whether Mr Chambers' death was war-caused.

# KIND OF DEATH

1. Where the death of a veteran is war-caused, the Commonwealth is, subject to the VE Act, liable to pay a pension by way of compensation to the dependants of the veteran in accordance with the VE Act (s 13). To be eligible to receive the pension, Mrs Chambers must establish that her husband's death was war-caused.
2. Section 8 of the VE Act provides that, for the purposes of the Act, the death of a veteran is taken to have been war-caused if, among other things, the death arose out of, or was attributable to, any eligible war service rendered by the veteran. The meaning of the expression *eligible war service* is set out in s 7(1) of the VE Act. A person who has rendered operational service is taken to have rendered eligible war service while the person was rendering operational service.
3. Before embarking upon enquiry into the claimed connection between Mr Chambers' death and his operational service, we must first determine the cause of death or, as it is referred to in the VE Act, the *kind of death* met by Mr Chambers. As Selway J said in *Repatriation Commission v Hancock* (2003) 37 AAR 383 at 385-386:

… But in cases such as the present, the identification of the "kind of death" is the critical step in the analysis. In determining the "kind of death", proof is on the balance of probabilities: see section 120(4) of the Act and see Fogarty v Repatriation Commission [2003] FCAFC 136 at [34]; Benjamin v Repatriation Commission (2001) 34 AAR 270 at 282-283 [53]-[54].

1. The Full Court of the Federal Court (Mansfield, Stone and Edmonds JJ) in *Collins v Repatriation Commission* (2009) 258 ALR 204 dealt comprehensively with how the expression *kind of death* should be interpreted. It said, at 211:

Sections 8 and 13 [VE Act] look to the "death" of a veteran, but do not use the term "kind of death". Similarly, s 120 refers to the relationship of the veteran's death with the operational service of the veteran. It also does not use the term "kind of death". The term "kind of death" is introduced by ss 120A(2) and (4) and 196B(2) in the expression "particular kind of injury disease or death". That expression refers to the circumstances in which a Statement of Principles may be determined and then applied to decide whether an hypothesis connecting an injury or disease or death is reasonable as assessed under ss 120(1) and (3) as informed by s 120A(3).

The proper construction of those different terms was not a matter of debate on the appeal. It was common ground that, where the word "death" appears in ss 8 and 13 it means the medical cause of the death.

1. As the Full Court said, the question regarding the nature of the death of a veteran is anterior to and distinct from the question of the relationship of the death to the service of the veteran and the extent of entitlements to benefits under the VE Act in respect of that death. As to determination of the first question, the Full Court said, at 212:

In our view, the word "death" used in s 8, and in the phrase "injury, disease or death" in s 13 has the same meaning, that is the nature of the condition which causes the death. To be more precise, it is the medical cause or causes of the death.

1. The fact that there may be more than one medical cause for a veteran's incapacity or death was recognised by the Full Court of the Federal Court (Bowen CJ, Brennan and Lockhart JJ) in *Repatriation Commission v Law* (1980) 31 ALR 140. This decision was upheld on appeal to the High Court (see *Repatriation Commission v Law* (1981) 147 CLR 635). The Full Court said, at 151:

It seems clear that the expression "attributable to" in each case involves an element of causation. The cause need not be the sole or dominant cause: it is sufficient to show "attributability" if that cause is one of a number of causes provided it is a contributing cause.

1. After close examination of the sections dealing with death and the kind of death, their Honours in *Collins* said it is clear that the sections ask a *causative question.* They then said, at 220:

Those provisions support the conclusion that the inquiry about the death or kind of death for the purposes of the VE Act is, in essence, a question of fact about the medical cause or causes of the death. It does not support the proposition on behalf of Mrs Collins that there is a legislative intention that any medical condition which hastens the time of death of a veteran by a measurable period, even a short one, where in medical terms another medical condition is clearly the medical condition which accounts for the pathological changes leading to death, is itself a medical cause of death.

1. The standard of proof which applies in determining the kind of death met by Mr Chambers is that set out in s 120(4) of the VE Act. It provides that, except in making a determination to which s 120(1) or (2) applies, the Commission, and this Tribunal standing in its shoes, in making any determination or decision in respect of the matter arising under the VE Act, must decide the matter to its reasonable satisfaction. As Selway J said in *Hancock*  at 386:

…

(b) Next, the AAT was required to determine on balance of probabilities what "kind of death" Mr Hancock had suffered. This involved the identification, on balance of probabilities, of any and all statement of principles and/or determinations under s 180A(2) of the Act and any other "kinds of death" which were applicable to that death.

…

1. Mrs Chambers provided evidence in the form of a statement dated 22 October 2011 and she also gave oral evidence at the hearing. In her statement, Mrs Chambers said that she believed her husband had been exposed to poor hygiene, poor diet, uncomfortable living conditions, uncomfortable weather conditions and uncomfortable sleeping conditions during his service. She first met her husband in 1952 when they were both teaching in the Kyabram region of Victoria. They were married on 21 November 1953. She said that during the first few years of their marriage, they had a country *dunny* and she noticed there was quite a lot of blood and mucus clinging to his stools every time she followed him to the toilet. When she asked him about that he told her not to worry and that prior to becoming married, a doctor had told him that his condition was due to amoebic dysentery. She said that the bleeding continued for the rest of his life as far as she was aware and that her husband complained about stomach pain, often after a meal. In the course of her oral evidence Mrs Chambers also mentioned that her husband had a few bouts of malaria after the war. She said he did get yellow jaundice on one occasion and was diagnosed with that complaint.
2. In her examination-in-chief, Mrs Chambers testified that her husband did not often seek medical attention and, in fact, he doggedly avoided it. She said that when he complained of pain at home, she told him to go to the doctor but he told her: *don't be so bloody silly*. She said that expressed his attitude throughout his life. Mrs Chambers also said that her husband used to go to the pub often to drink at night and he would meet the local doctor. When she asked him why he had not gone to see the doctor he explained that the doctor was in the pub and told him that he probably had a stomach ulcer. She said that made her cross because he used to *whinge* at home about the pain all the time. In her written statement, Mrs Chambers said that her husband's last treating general practitioner was Dr J Sowerby. Dr Sowerby was retired. His treating gastroenterologist was Dr Emily Prewett. For the last period of his life he was treated by a local gastroenterologist, Dr J Watson.
3. Prior to examining the medical evidence, it will be of assistance to the reader if we define the significant medical terms used in the various reports which were in evidence.

**Dysentery -** a term used to cover an illness, it usually of sudden onset, with symptoms of fever, bloody diarrhoea and abdominal pain. It is distinguished from the more common conditions of gastroenteritis and traveller's diarrhoea by the fact that the latter conditions do not usually cause fever and are not accompanied by rectal bleeding. Dysentery is usually caused by exposure to one of a range of pathogens including in entamoeba histolytica and the bacterial pathogens, shigella, salmonella and some strains of E. coli. Dysentery due to the latter pathogens is usually of short duration whereas entamoeba dysentery can be prolonged and/or recurrent.

**Colitis -** refers to an inflammation of the colon. This can be caused by infection (as outlined above) and then is diagnosed as infectious colitis or dysentery.

**Ulcerative colitis -** this illness causes symptoms of bloody diarrhoea and abdominal pain, usually but not always of more gradual onset than dysentery. The cause of ulcerative colitis is not known.

**Primary Sclerosing Cholangitis -** a progressive chronic fibrosing inflammation of the bile ducts of unknown cause, frequently in association with chronic ulcerative colitis.

**Cholangiocarcinoma -** malignancy of the bile ducts.

**Amoebic Dysentery -** dysentery due to amoebas (one-celled protozoan animal forms).

**Irritable Bowel Syndrome -** a disturbance of intestinal function of unknown cause. Clinically, the patient has intermittent symptoms of abdominal discomfort, including cramping an altered bowel activity. The syndrome does not produce fever, weight loss or rectal bleeding.

1. Mr Chambers' Army Medical History Sheet is unremarkable. He was hospitalised suffering with a bout of malaria on 29 July 1943 when in New Guinea. He appears to have remained in hospital for a little over two weeks. In fact, his Medical Case Sheet states: *[He] has had several attacks of an illness which was regarded as malaria, but did not have any smear done*.
2. We also had in evidence an earlier claim made by Mr Chambers in 1955. The application appears to have been referred to as *stomach trouble*. In the particulars of the claim it appears as a claim in respect of ulcerative colitis. Dr JL Diggle, who appeared to have taken a history in 1953, wrote that Mr Chambers suffered periodic attacks of diarrhoea lasting 2-3 days over the past 12 months and that he had minor attacks of dysentery in 1940 and 1945. Mr Chambers said he had a pain in the left hip and in the small of his back. He said his stools were associated with mucus but no blood. In a record which appears to have been made in February 1953, Dr Diggle stated that Mr Chambers had haemorrhage for the past two days and that he passed blood over the past 2-3 weeks.
3. In March 1953 Mr Chambers had a sigmoidoscopic examination which revealed no ulcers. The mucous membrane appeared glazy and redder than normal. Dr Diggle said that cotton wool swabs were tinged with blood. A treatment and report form dated 30 March 1955 from the Repatriation Department by a specialist whose name appears to be Douglas Donald, discloses that Mr Chambers had occasional passage of a *frothy* stool. The report also indicates the doctor having conducted another sigmoidoscopy which he described as absolutely clear – no blood on the faeces. The medical officer said that in his opinion, the blood was from haemorrhoids. He reported that he thought of ulcerative colitis but there was no abnormality of the sigmoid. We also note that Dr Diggle prescribed the drug Enterovioform which was used at that time to treat amoebic dysentery.
4. Another unnamed doctor who saw Mr Chambers in March 1955 reported that he *had Palestine tummy in the ME & again at Manila at the end of the war – was passing slime but no blood*.
5. We also had a medical report signed by Dr JH Coto dated 16 February 1955. Dr Coto recorded that during the past 12 years (that is from 1942), Mr Chambers had *passing of slime, blood and mucous per rectum*. He also said that was *associated with colicky pain across the centre of the abdomen*. He recorded a history of dysentery in Palestine, Manila and New Guinea. Dr Coto also wrote: *As the symptoms of this ex-serviceman are traceable back to his days when he served overseas – I consider his case should be investigated and diagnosed, and a board held to decide if it is attributable.*
6. According to Mrs Chambers, her husband first became ill with his final condition on 27 December 1998. He was unable to get out of bed or walk. She said the family enjoyed Christmas together and her husband had been in good spirits although he had violent diarrhoea during the night. Apparently Dr Sowerby was called and he made light of Mr Chambers' condition. He was about to prescribe antibiotics when Mr Chambers vomited *coffee grounds*. She then decided to call an ambulance and to have him hospitalised. Mrs Chambers said that within a few hours of being admitted to Geelong Hospital, he was diagnosed with pancreatitis and clots in his legs. On the following day, the diagnosis was altered to a blockage of the bile duct and her husband became more jaundiced. She said this took Dr Sowerby by surprise.
7. Following Mr Chambers' admission to the Geelong Hospital, he was treated by Dr Prewett. In March 1999 it was decided to transfer Mr Chambers to Ballarat, where he was to be cared for by Dr Watson. On his transfer, Dr Prewett wrote a letter to Dr Watson on 1 March 1999 in which she set out Mr Chambers' medical history as far as she was aware of it. She said he was admitted to Geelong Hospital urgently on 30 December 1998 with acute illness comprising vomiting, diarrhoea, and possibly some abdominal pain. He was unwell and febrile on admission. A presumptive diagnosis of pancreatitis was made.
8. However, because of increasing jaundice, Dr Prewett said she was asked to perform an ERCP (endoscopic retrograde cholangiopancreatography). This revealed a tight stricture at the lower end of his common bile duct, which was stented. The appearances were most consistent with cholangiocarcinoma. Dr Prewett then said that unfortunately Mr Chambers' jaundice increased despite stenting and he therefore underwent choledochojejunostomy. However his jaundice still failed to settle and she said that this is most likely due to an underlying diagnosis of primary sclerosing cholangitis (PSC).
9. While hospitalised, Mr Chambers had two liver biopsies, the first prior to surgery and the second on 25 February 1999. Dr Prewett said the initial biopsy was consistent with large duct obstruction, but on review that biopsy and the more recent biopsy both disclosed features of pericholangitis and cholangiolitic change. In her opinion, this and his clinical course suggested a diagnosis of PSC, probably with a cholangiocarcinoma complicating it. Dr Prewett also said that Mr Chambers had no past history to suggest inflammatory bowel disease.
10. In a letter dated 12 January 2010 to Mrs Chambers, Dr Prewett said that she believed her husband had cholangiocarcinoma secondary to PSC. She said that although PSC is often difficult to diagnose, the liver biopsies and the ERCP were supportive of the diagnosis without being absolutely diagnostic. This letter followed an earlier letter which she wrote to Mrs Chambers on 10 May 1999 where she said it was difficult to be absolutely precise about Mr Chambers' final diagnosis and cause of death. She nevertheless said she had a strong belief that Mr Chambers had PSC, an inflammatory condition affecting the small and large bile ducts of the liver, of unknown aetiology. She said this condition predisposes patients to the development of cholangiocarcinoma and that her husband's clinical course and radiological findings were strongly suggestive that he had in fact developed a cholangiocarcinoma in the lower bile duct.
11. Dr LP Moran, a treating gastroenterologist, provided a written report to the Tribunal dated 20 February 2012. He also gave evidence at the hearing. Dr Moran said he had practised in the field of gastroenterology since about 1976. We accept that Dr Moran is qualified as an expert in the field of gastroenterology.
12. In his written report, Dr Moran referred to the treatment provided by Dr Prewett and the failure of Mr Chambers' jaundice to settle. Dr Moran said Dr Prewett's opinion that the jaundice was due to a diffuse process of cholestasis within the liver which was most likely PSC was reasonable. He also referred to cholangiocarcinoma as a well-known complication of PSC. Dr Moran agreed with Dr Prewett that the stricture of the common bile duct most likely did represent cholangiocarcinoma although, as was Dr Prewett's opinion, it was an unlikely cause of Mr Chambers' jaundice and demise. That was because the stricture was initially bypassed by a stent and then secondly by surgical anastomosis, without any improvement in his jaundice. Dr Moran also observed that there was only mild dilatation of the bile duct proximal to the stricture suggesting that it had not been there for a long period of time. In his opinion, the cause of Mr Chambers' death was likely related to the progression of PSC.
13. Dr Moran also commented on some differential diagnoses of Mr Chambers' bowel symptoms. These included irritable bowel syndrome (IBS) and haemorrhoidal bleeding; inflammatory bowel disease such as ulcerative colitis; and intestinal amoebiasis.
14. As to IBS, Dr Moran said that this was the most likely cause of long standing, intermittent mild bowel symptoms. He also noted that simple haemorrhoids were observed on sigmoidoscopy.
15. Regarding ulcerative colitis, Dr Moran said that the true incidence of this disease in PSC is close to 90%. He also said that the colonic mucosa may be grossly normal in appearance in inflammatory bowel disease, particularly that associated with PSC, and it is only on biopsy in such cases that a diagnosis of inflammatory bowel disease is made.
16. Dr Moran said that intestinal amoebiasis is often asymptomatic. When it produces clinical features, they can be mild diarrhoea or quite severe dysentery causing abdominal pain, diarrhoea and bloody stools and rarely fulminant amoebic colitis. He said he was unaware that any evidence of amoebiasis was detected in Mr Chambers.
17. Dr Moran concluded that Mr Chambers died from chronic cholestatic liver disease, most likely PSC, which was likely complicated by an incidental cholangiocarcinoma. He also concluded that Mr Chambers probably had subclinical ulcerative colitis. His intermittent, frothy, mucoid stools associated with some blood suggested IBS and the bleeding was from his known haemorrhoids.
18. In his examination-in-chief, Dr Moran was asked whether, if Mr Chambers did suffer from amoebic dysentery at some time, he would regard that as a condition which could cause PSC. Dr Moran said that he could not find any evidence that there was a connection between those two conditions. When it was put to Dr Moran that Dr Goodwin, a physician, gave evidence in another veteran's case before the Tribunal in 2001 that PSC is known to follow an amoebic infection, he disagreed. He said he had examined the textbooks of medicine, including Schiff's Liver Disease and Oxford Textbook of Liver Disease, which is revised every four months or so, and there was no mention of the connection between those two conditions.
19. In cross-examination it was put to Dr Moran that given the history provided by Mrs Chambers of her husband's illness, there was an outside chance that he in fact had amoebic dysentery for some time, Dr Moran said that while there was an outside chance that could be the case, he nevertheless considered that the commonest cause of the symptoms described in somebody who was otherwise well was IBS, which can cause pain and lots of mucous per rectum. He nevertheless said there is a small chance that this could be amoebic disease or amoebic colitis. However Dr Moran also added if that were a possibility, there would be lots of cases of PSC in countries where amoebiasis was rife, which in fact was not the case. He said that the medical profession tended to see PSC in Western countries so he did not think it was a likely cause. Dr Moran also said that idiopathic ulcerative colitis had been associated with PSC, but the amoebic form of colitis has not to his knowledge.
20. The Tribunal in this case was constituted, in part, by a very experienced gastroenterologist. When the Tribunal asked Dr Moran to explain Dr Diggles' report of March 1953 where he said cotton wool swabs were tinged with blood, Dr Moran assumed Dr Diggle was cleaning the lining of the bowel although initially he thought he might have been taking a sample to send off to the laboratory. Dr Moran was then asked if he was trained to do the old-fashioned sigmoidoscopy to which Dr Moran answered he was. He also said he was trained to test for friability. Dr Moran was then asked whether he had ever seen a surgeon or physician rub the mucosa with the cotton wool swab to see if it was friable, he answered: *not to see if it was friable, but mostly to clean the bowel wall*. When the same question was put to Professor JF Cade, a physician and currently a Principal Specialist in Intensive Care at the Royal Melbourne Hospital, he answered: *he has sigmoidoscopy to 40 cm, and although there are no ulcers, the mucosa is not normal. It's reddened and friable*. Prof Cade explained that the friability comes from rubbing the cotton wool swab and that it has come away with blood on it. Although Dr Moran was seemingly unaware of the technique of lightly rubbing the bowel lining with the cotton tipped swab via the sigmoidoscope which was used prior to the introduction of colonoscopy in the 1970s, the Tribunal is aware that this was a commonly used method of demonstrating friability of the bowel lining and this was evidence of inflammation.
21. Dr Moran was also asked about the rate of progression of PSC. He mentioned in evidence that patients with PSC can have the disease for a long time before they go to a doctor. When asked how that came about, Dr Moran said that it was a slowly progressive disease in most people and that many doctors treating such patients observed that the condition has gone on for 10 years or so, even 10 years up to that period of time without the patient worsening and perhaps developing jaundice. He explained that it is a slowly progressive replacement of bile ducts with fibrous tissue. The longest duration that Dr Moran had experienced in clinical practice was around 8 to 10 years but he said it could be longer than that. When asked if he had a patient with a firm or likely diagnosis of PSC from whom he obtained a history that five or six times over some years they had two or three days of fever and chills and shaking, and put themselves to bed, what he would make of that condition, he said the patient is getting obstructive biliary symptoms due to PSC.
22. Prof Cade provided a brief written report dated 5 April 2011 which was taken into evidence and he also gave oral evidence at the hearing. Although Prof Cade is not gastroenterologist, we accepted his evidence as an experienced medical practitioner. Where his opinions differ from those of Dr Moran, we have given greater weight to Dr Moran's evidence.
23. In his written report, Prof Cade said that the direct cause of Mr Chambers' death was undoubtedly as is listed on his death certificate. He explained that this was because the diagnosis of advanced and incurable cancer had been confirmed following specialist investigation and because its time-course was in accord with expectations of this form of cancer. He also opined that the death certificate should also have listed PSC as an antecedent cause of death.
24. In the paragraph headed *Other comments* in his written report, Prof Cade said that the only possible link which he could think of which might connect Mr Chambers’ death with his prior service would be via ulcerative colitis. He explained that his military service may be linked to ulcerative colitis which in turn was linked to cholangiocarcinoma which led to his death. Prof Cade said that Mr Chambers was reported to have had dysentery during service. This was thought to have been amoebic dysentery. However, the description given by Mrs Chambers of her husband’s subsequent long-standing bowel symptoms was consistent with mild chronic inflammatory bowel disease (ulcerative colitis).
25. When asked to give his opinion about the cause of Mr Chambers' death, Prof Cade said he relied on the opinions given by the two specialists who had been caring for him at the time and it was their opinion that he had died of cancer of the bile duct. He saw no reason to disagree with that diagnosis. He also saw no reason to disagree with the diagnosis of PSC given that it was supported, although not absolutely proven, by a liver biopsy. When asked in examination-in-chief whether it was his view that PSC was a cause of death, directly or indirectly, Prof Cade said: *Yes. It would appear that it was the antecedent cause of death, either directly or via a complication of cholangiocarcinoma.*
26. Prof Cade was also asked about the existence of ulcerative colitis. He said that he raised it because of its potential linkage although he was rather concerned that Dr Prewett specifically noted no past history of inflammatory bowel disease, and this was hardly an item that a specialist gastroenterologist would overlook.
27. In cross-examination Prof Cade was referred to the brief report made by Dr Donald on 30 March 1955 where he expressed the opinion that at first he thought of ulcerative colitis although there was no abnormality of sigmoid. When asked whether that examination ruled out ulcerative colitis, he said it did not. He said it was unable to be confirmed and left the diagnosis open. That was why he raised it as a possibility. Prof Cade was also asked to comment on the possible connection between amoebic dysentery and PSC. Prof Cade said that was outside his area of expertise but his understanding from the literature was there was no known association.
28. The Tribunal asked Prof Cade, from his general medical knowledge; whether he was aware that ulcerative colitis can go spontaneously into remission. Prof Cade said: *it is one of the recognised mysteries of ulcerative colitis, as I understand it. Fortunate for that patient, but not very common*. Prof Cade was also referred to Dr Prewett's letters where she spoke of there being no evidence of inflammatory bowel disease. He was asked whether, in the real world, specialists sometimes overlook things and he answered: *Yes, yes. That is unfortunately a human inevitability*. Prof Cade was also asked to assume that there was a reasonably firm diagnosis of PSC in a fairly advanced form and there emerged another history that there was almost daily red-blood and mucous per rectum, and if a specialist gastroenterologist knew about that, would they firmly write a note to say there was no history of inflammatory bowel disease? His answer was that it would be very unlikely that a specialist gastroenterologist would have said that. He said that discrepancy had bothered him and that's why he raised the suggestion of a possibility of ulcerative colitis.
29. In further cross-examination, Prof Cade was also asked whether, in the two reports from 1953 and 1955, he found anything which was inconsistent with amoebic dysentery. Prof Cade said that the only inconsistency which he was uncomfortable about was that, amoebic dysentery having been raised previously in military documentation; it is not normally a difficult diagnosis from stool examination. However, there was no documentation to say that the amoebic dysentery had been confirmed by a relatively simple stool examination. It therefore left that open as a possibility. He was also asked about the drug, Enterovioform. Prof Cade said that it was a classic anti-bacterial medication for diarrhoea. He did not recall the spectrum of organisms that it covered but he thought it was *pretty weak stuff*.
30. As is apparent from the above evidence, neither the gastroenterologists who treated Mr Chambers nor the medical experts who gave evidence regarding the cause of his death are able to identify with any precision the medical cause of death. In fact, as the Full Court said in *Collins'* case and in *Law's* case, there may be multiple medical causes of death. Dr Prewett was of the opinion that because, despite stenting, Mr Chambers' jaundice increased and subsequent surgery did not result in the jaundice settling, it was most likely that Mr Chambers had PSC. She was of the opinion that the two liver biopsies and his clinical course suggested a diagnosis of PSC, probably with cholangiocarcinoma complicating it. Dr D R Trethewie, the pathologist who reported on the liver biopsies, said that the biopsy showed severe cholestasis with portal fibrosis and evidence of cholangiolitic change. Dr Prewett was also of the view that the stricture at the lower end of Mr Chambers' common bile duct was consistent with cholangiocarcinoma. While she was of the view that this was the ultimate cause of his death, she said PSC is often complicated by and causes cholangiocarcinoma.
31. Although Dr Moran said that the median age for the diagnosis of PSC was around 40 years, he nevertheless believed that the liver biopsies were certainly consistent with PSC. He believed that a diagnosis of PSC was highly likely in this case. He was of the view that Mr Chambers probably died of liver failure secondary to PSC. While he probably had a cholangiocarcinoma in addition to PSC, the cancer was more an incidental finding rather than a significant contributor to his illness and subsequent death.
32. Prof Cade was the only witness who was certain that Mr Chambers' death was undoubtedly caused by his cholangiocarcinoma. The reason he gave for arriving at that conclusion was because the diagnosis of cholangiocarcinoma had been confirmed following specialist investigation and because its *time course* was in accordance with the expectations of this form of cancer. However, we have two problems with Prof Cade's evidence about the cause of death. The first is that Prof Cade, as he had freely admitted, lacked expertise in this field. The second is that the evidence does not disclose a confirmed diagnosis of cholangiocarcinoma. In fact, as Dr Moran said in his written statement, there was only mild dilatation of the bile duct proximal to the stricture suggesting that it had not been there for a long period of time.
33. All of the medical experts agreed that Mr Chambers probably had PSC. We find, on the balance of probabilities, Mr Chambers did have PSC. In our opinion, based on the Tribunal's medical expertise and on the evidence before us on the hearing of this matter, on the balance of probabilities, Mr Chambers died from liver failure secondary to PSC. The evidence does not establish that, if a cholangiocarcinoma was present, it caused his death. In fact, although Mr Chambers underwent an abdominal operation to surgically bypass the stricture or narrowing at the end of the common bile duct, there is nothing in the hospital records to indicate that the surgeon found any abnormality at the operation which confirmed the diagnosis of cholangiocarcinoma. In fact, the operation did not relieve Mr Chambers' jaundice, an observation used by Dr Prewett to conclude that if a cholangiocarcinoma was indeed present, it was not causing any significant degree of blockage of the bile duct. Therefore, we find that if Mr Chambers in fact had cholangiocarcinoma, it was not a contributing cause of his death.

# Was Mr Chambers' death war-caused

1. There was no doubt at all about the fact that Mr Chambers had operational service. Therefore, the standard of proof which applies in his case is that set out in s 120(1) of the VE Act. It provides:

**120 Standard of proof**

(1) Where a claim under Part II for a pension in respect of the incapacity from injury or disease of a veteran, or of the death of a veteran, relates to the operational service rendered by the veteran, the Commission shall determine that the injury was a war‑caused injury, that the disease was a war‑caused disease or that the death of the veteran was war‑caused, as the case may be, unless it is satisfied, beyond reasonable doubt, that there is no sufficient ground for making that determination.

Note: This subsection is affected by section 120A.

1. Although the hypothesis advanced on behalf of Mrs Chambers was that her husband died from cholangiocarcinoma secondary to PSC, and that the PSC in turn was secondary to amoebic dysentery, given our findings regarding the cause of death, we accept a modification to the hypothesis. The hypothesis must now be that Mr Chambers' death was caused by PSC secondary to amoebic dysentery. We should also add that the evidence before us may also point to another secondary cause, that being ulcerative colitis. That is reinforced by the evidence of Dr Moran who said the true incidence of ulcerative colitis in PSC is close to 90%.
2. Our first task is to determine whether the causal hypothesis advanced on behalf of Mrs Chambers is reasonable. That is because s 120(3) of the VE Act provides that:

(3) In applying subsection (1) or (2) in respect of the incapacity of a person from injury or disease, or in respect of the death of a person, related to service rendered by the person, the Commission shall be satisfied, beyond reasonable doubt, that there is no sufficient ground for determining:

* 1. that the injury was a war‑caused injury or a defence caused injury;
	2. that the disease was a war‑caused disease or a defence‑caused disease; or
	3. that the death was war‑caused or defence‑caused;

as the case may be, if the Commission, after consideration of the whole of the material before it, is of the opinion that the material before it does not raise a reasonable hypothesis connecting the injury, disease or death with the circumstances of the particular service rendered by the person.

Note: This subsection is affected by section 120A.

1. We must also bear in mind the distinction between a mere hypothesis and a reasonable hypothesis. The Full Court of that Federal Court in *East v Repatriation Commission* (1997) 16 FCR 517 at 532, referred with approval to the Tribunal decision in *Re Dell and Repatriation Commission* (1986) 5 AAR 253,where it is said, at 254-255:

The addition of the word "reasonable" would however seem to imply that what is required is more than a mere hypothesis. In the opinion of the Board, to be reasonable, a hypothesis must possess some degree of acceptability or credibility – it must not be obviously fanciful, impossible, incredible or not tenable or too remote or too tenuous. For a reasonable hypothesis to be "raised" by the material before the Board, we think it must find some support in that material – that is, the material must point to, and not merely leave open, a hypothesis as a reasonable hypothesis.

1. Section 120A of the VE Act deals with the reasonableness of a hypothesis advanced by a veteran, indicating that it is to be assessed by reference to the relevant Statements of Principles (SoP). Section 120A(3) of the VE Act provides that, for the purposes of s 120(3), a hypothesis connecting the death of the person with the circumstances of any particular service that person has rendered is reasonable only if there is in force a SoP determined under s 196B(2) or (11) the VE Act; or a determination made by the Commission under s 180A(2), which upholds the hypothesis.
2. However, that section is qualified by s 120A(4) the VE Act. It provides that s 120A(3) does not apply in relation to a claim in respect of the death of the person if the Repatriation Medical Authority (RMA) has neither determined a SoP under s 196B(2) of the VE Act, nor declared that it does not propose to make such a SoP in respect of, amongst other things, the kind of death met by the person.
3. The RMA has not determined a SoP concerning PSC. Nor has the RMA declared that it does not propose to make a SoP concerning PSC. In that case, we must go back to the position which existed prior to the introduction of the SoPs.
4. It is important, at this stage, to bear in mind that a hypothesis is merely a proposition made as a basis for reasoning without the assumption of its truth. Nevertheless, a hypothesis must have a sound basis. As the High Court of Australia (Mason CJ, Deane, McHugh JJ) said in *Bushell v Repatriation Commission* (1992) 175 CLR 408, at 412: *There is no presumption that the injury, disease or death of a veteran was war caused: s 120(5)*. The Court pointed out that the purpose of s 120(3) is to ensure that a claim to which s 120 applies is not met unless there is some material which raises the relevant causal hypothesis.
5. In determining whether a hypothesis is reasonable, the Court said, at 414:

 The material will raise a reasonable hypothesis within the meaning of s 120(3) if the material points to some fact or facts ("the raised facts") which support the hypothesis and if the hypothesis can be regarded as reasonable if the raised facts are true. . . However, a hypothesis may still be reasonable even though such an accompaniment or association is not demonstrated or even if it is shown to be uncommon. So, in determining whether a hypothesis is reasonable for the purpose of s 120(3), it is not decisive that a connexion has not been proved between the kind of injury which occurred and circumstances of the kind which constitute the relevant incidents of the veteran's service. Nor is it decisive that the medical or scientific opinion which supports the hypothesis has little support in the medical profession or among scientists. …

1. The Court then referred to the decision in *Commissioner for Government Transport v Adamcik* (1961) 106 CLR 292 and, quoting from that case, said at 414:

 However, a hypothesis cannot be reasonable if it is "contrary to proved scientific facts or to the known phenomena of nature" (13).

1. The Court in its decision then referred to *East’s* case, and quoting from that case at 414 said:

Nor can it be reasonable if it is "obviously fanciful, impossible, incredible or not tenable or too remote or too tenuous" (14).

1. The Court then stated the following at 414-415:

 But leaving aside cases of those kinds, the case must be rare where it can be said that a hypothesis, based on the raised facts, is unreasonable when it is put forward by a medical practitioner who is eminent in the relevant field of knowledge. Conflict with other medical opinions is not sufficient to reject a hypothesis as unreasonable. As we have earlier pointed out, it is not the function of s 120(3) to require the Commission to choose between competing hypotheses or to determine whether one medical or scientific opinion is to be preferred to another. This does not mean, however, that in performing its functions under s 120(3) the Commission cannot have regard to the medical or scientific material which is opposed to the material which supports the veteran's claim. Indeed, the Commission is bound to have regard to the opposing material for the purpose of examining the validity of the reasoning which supports the claim that there is a connexion between the incapacity or death and the service of a veteran. But it is vital that the Commission keep in mind that that hypothesis may still be reasonable although it is unproved and opposed to the weight of informed opinion.

1. After determining whether a hypothesis raised by a veteran is reasonable, the claim must then be dealt with in accordance with s 120(1) of the VE Act. It is only then that we should embark upon a fact-finding exercise. As the High Court said, at 416:

 The Commission will be satisfied beyond reasonable doubt "that there is no sufficient ground for making [the] determination" if it is satisfied beyond reasonable doubt that it cannot accept the raised facts or so many of them as are necessary to support the hypothesis. Thus, if the Commission is satisfied beyond reasonable doubt that it cannot accept the raised facts because of the unreliability of the material which is claimed to support them or because of the superior reliability of other parts of the material before the Commission or because the raised facts depend on inferences which the Commission is satisfied cannot be drawn, the Commission will be satisfied that there is no sufficient ground for making the determination … Indeed, once there is sufficient factual material to point to a reasonable hypothesis connecting the injury etc with the operational service, it seems convenient simply to treat the case as governed by the application of s 120(1). If that is done, the claim will succeed unless the Commission is satisfied beyond reasonable doubt that the factual foundation upon which the hypothesis can operate does not exist (16).

1. The Full Court in *East's* case also referred to the following statement made in *Re Dell* regarding the establishment of a reasonable hypothesis. It said, at 534:

 … Accordingly a connection asserted by a hypothesis to exist between death or incapacity and service may still be reasonable, even though theoretical, and it may be theoretical in either or both of at least two senses: by postulating a known medical fact but in circumstances not known to have definitely existed in the instant case; or by postulating a medical principle which science is not yet able to definitely prove but is unable to describe as unreasonable.

It is the second proposition which is relevant in this matter.

1. If we were to find that there was a reasonable hypothesis linking Mr Chambers' PSC with his operational service, it is at that point we need to go to the second step, that is s 120(1) of the VE Act. As the High Court (Mason CJ, Gaudron and McHugh JJ) in *Byrnes v Repatriation Commission* (1993) 177 CLR 564 said, at 570:

 Once a reasonable hypothesis is raised, the question for the Commission is then whether it is satisfied beyond reasonable doubt that there is no sufficient ground for making a determination that the injury was war-caused. The Commission will be so satisfied if it is satisfied beyond reasonable doubt that the factual foundation of the hypothesis has been disproved (10), either by proof beyond reasonable doubt that a fact or fact relied upon to support the hypothesis is not true, or by proof beyond reasonable doubt of the truth of a further fact, inconsistent with the hypothesis (11).

1. The cause of PSC is unknown. In her letter to Mrs Chambers dated 10 May 1999, Dr Prewett said that she strongly believed Mr Chambers had PSC which she described as an inflammatory condition affecting the small and large bile ducts of the liver, of unknown aetiology. In his cross-examination, Dr Moran was asked whether malaria tended to affect the liver. This was because Mr Chambers had a history of malarial attacks and in fact he was conclusively diagnosed with the disease and hospitalised as a consequence of that on one occasion. Dr Moran replied: *not to my knowledge*.
2. Dr Moran was then asked about the possibility of amoebic dysentery. When it was put to him in cross-examination that dysentery was common in the areas where Mr Chambers had operational service, the problems he complained of in the early 1950s, and it was suggested that he had amoebic dysentery that had been *hanging around*, Dr Moran said it was an outside chance that could be the case. However, he then said that the most common cause for those symptoms in somebody who is otherwise well is irritable bowel syndrome, which can cause pain and lots of mucous per rectum. However, he conceded there was a small chance that Mr Chambers may have had amoebic colitis plus haemorrhoids. Dr Moran agreed that some research or experiments had been done on animals but that this research involved examining the consequences of the entry of bacteria from an inflamed bowel in ulcerative colitis into the portal circulation which drains the large bowel and goes into the liver. He said those experiments were not looking at amoebic colitis but rather whether the entry of bacteria from the bowel of a person with ulcerative colitis could lead to inflammation of the liver and therefore PSC. However, he said that was not a favourite theory and current thinking about the causes of PSC. He said it was thought, probably, to be an autoimmune disorder.
3. Dr Moran did agree with the suggestion that if Mr Chambers developed amoebic colitis while on operational service, because the medical facilities were rudimentary and he had little time to seek rest and proper treatment, that period of time would have contributed to the longer term development of colitis. He said that if Mr Chambers developed it, then it could go on to a chronic form of amoebic colitis. However, Dr Moran said that ulcerative colitis is a disorder of unknown cause, thought to be an autoimmune disease and it was a separate entity from amoebic bowel disease, which can manifest as amoebic colitis. Dr Moran testified that while idiopathic ulcerative colitis had been associated with PSC, the amoebic form of colitis has not, to his knowledge, except for the statement made by Dr Goodwin in an earlier Repatriation medical case. We have already referred to Dr Moran's evidence-in-chief where he said he was not able to locate any mention of the connection between amoebic dysentery or amoebic colitis leading to PSC in specialist textbooks dealing with liver disease. In any event, as Dr Moran pointed out, there was in fact no evidence that Mr Chambers had amoebic dysentery at any time or that he suffered from chronic amoebic colitis.
4. Although Prof Cade was asked in cross-examination to comment about the connection between amoebic dysentery and PSC, he said that was out of his area of expertise, although his understanding from literature was that there was no known association. Although it was suggested to Prof Cade that he was not in a position to say that the connection was fanciful or untenable, he responded by saying that anything which has no literature to support it has difficulty with plausibility.
5. It is clear from Mrs Chambers' Statement of Facts and Contentions and the opening submissions made by Mr C Thompson of counsel, who appeared on behalf Mrs Chambers, that her case was squarely based on the medical evidence given by Dr Goodwin in an earlier Tribunal case *Trevena v Repatriation Commission* [2001] AATA 707. With respect to Mr Thompson, the evidence given by Dr Goodwin in that case cannot be relied upon as evidence in this particular case. While of course this Tribunal is not bound by the rules of evidence, and therefore, as is common, hearsay evidence is frequently admitted, it would be unsafe for us to accept that evidence which is now some 11 years old and without having the opportunity to cross-examine Dr Goodwin. It is reasonable to expect that medical science has moved on since then. We had no evidence from any medical practitioner in this case which pointed to any connection between amoebic dysentery and PSC. In fact, the evidence which we had was that there was no connection between the two conditions.
6. There is nothing in the evidence quoted from Dr Goodwin to establish the basis upon which he arrived at the conclusion that a parasitic intestinal infection is associated with PSC which, in turn, is associated with cholangiocarcinoma. Although the Tribunal in that case found that the material before it pointed to a hypothesis connecting a condition of PSC and the circumstances of his military service, it did not explain why that was the case. It simply said that it had considered all the material before it and came to that conclusion. It is unhelpful.
7. The Tribunal makes the following statements from its own knowledge. The definition of dysentery, which we have set out above, is distinguished from more common conditions of gastroenteritis and the like for the reasons we have already stated. Colitis simply refers to an inflammation of the colon. Infectious colitis is usually diagnosed by testing stools. The infectious agent is usually readily detected in the stools. If testing is not done, the diagnosis of infectious colitis usually becomes clear when the illness proves to be self-limiting.
8. The cause of ulcerative colitis is not known. It is described under the heading of inflammatory bowel disease (IBD) in the SoP for IBD (no 19 of 2012) as:

a chronic, autoimmune disorder of the gastrointestinal tract, characterised by diarrhoea and abdominal pain and sometimes associated with extra-intestinal manifestations, including peripheral arthritis, episcleritis, aphthous stomatitis, erythema nodosum and pyoderma gangrenosum.

1. As is clear from the SoP, IBD is a term used to encompass three conditions, ulcerative colitis, Crohn's disease and inflammatory bowel disease of unspecified type; thereby emphasising that these diseases have much in common and that they are not infectious in origin. The definition is not complete as was demonstrated by the evidence of Dr Moran and Prof Cade who both testified that PSC can be seen as an additional *extra-intestinal manifestation* of ulcerative colitis. The definition is incomplete in that it makes no mention of the common symptom of rectal bleeding, nor any mention of the very wide range of the extent and severity of the inflammation of the colon and rectum (and the related severity of the symptoms experienced) in patients who suffer from ulcerative colitis. Further it makes no mention of the association between ulcerative colitis and sacroilliitis (an inflammation of one or both sacroiliac joints).
2. Ulcerative colitis can be seen for the first time at almost any age. However, the peak age for the disease presenting to doctors is in early adult life. Dr Moran was not asked about this aspect but he did say that its associated disease, PSC, is most commonly diagnosed at around the age of 40 years. Dr Moran raised the possibility that Mr Chambers suffered from IBS as the cause of his altered bowel habit and abdominal pain, with any rectal bleeding being ascribed to haemorrhoids. Although IBS typically causes variable episodic diarrhoea and abdominal pain, it cannot be adhered to as a diagnosis if the lower bowel is shown to be inflamed as evidenced by frequent passage of blood and mucus or as evidenced by inflammation seen whenever the lower bowel is inspected by sigmoidoscopy.
3. The possibility of amoebic dysentery is identified from Mr Chambers' records on a number of occasions as follows:
	1. in 1953 Dr Diggle mentioned *PH minor attacks of ?Dysentery 1940 & 1945*;
	2. on two occasions Dr Diggle mentioned the prescribing of the drug Enterovioform which was used at that time to treat amoebic dysentery;
	3. the unnamed doctor who saw Mr Chambers on 29 March 1955 wrote *had Palestine tummy in the ME & again at Manila at the end of the war – was passing ? Slime but no blood*;and
	4. Dr Coto wrote in 1955 *History of Dysentery in Palestine, Manila and New Guinea*.
4. As far as we are able to ascertain, there is no record of dysentery being diagnosed by a medical officer during Mr Chambers' active service and it is unclear from the form headed *Medical Examination Prior to Discharge* dated 29 March 1946 if Mr Chambers reported attacks of dysentery. It is clear that a diagnosis of amoebic dysentery was never confirmed by tests which were available in hospitals in the 1940s and 50s; by a microscopic examination of the stools looking for amoebae; or biopsy of inflamed lower bowel. While it might have been possible to use the trials of Enterovioform as prescribed by Dr Diggle as a form of evidence to support a diagnosis of amoebic colitis, this would only have been so if his bowel symptoms had cleared permanently. However, the evidence was to the contrary. Mrs Chambers reported that her husband had bleeding, passage of mucus, diarrhoea and abdominal pains which continued unabated after the date of the prescription of this drug. For all of these reasons, we find, on the balance of probabilities, that Mr Chambers did not have amoebic dysentery. The bowel symptoms he experienced after leaving the army were not due to persistent amoebic colitis.
5. As a consequence of our analysis, there are two grounds upon which we find that the hypothesis advanced by Mrs Chambers connecting her husband's death with a war-caused disease is not reasonable. The first is that the evidence before us on the hearing of this matter positively discounted the connection between amoebic dysentery and PSC. The textbooks dealing with liver disease do not list amoebic dysentery or amoebic colitis as being associated with PSC. The second ground is that the evidence does not permit us to find that Mr Chambers in fact had amoebic dysentery. As will become apparent presently, the evidence and the Tribunal's experience with diseases of the kind in question in this matter supports a more likely alternative cause of the symptoms experienced by Mr Chambers.

# Alternative Hypothesis

1. In our opinion, the evidence points strongly towards a diagnosis of ulcerative colitis. Although Mrs Chambers' case did not include a hypothesis based on the presence of ulcerative colitis, that does not mean the Tribunal is not required to examine this alternative possibility. In fact, it must do so because the material accepted into evidence points to that diagnosis. As the Full Court of the Federal Court said in *Grant v Repatriation Commission* (1999) 57 ALD 1, at 6:

An inquisitorial review conducted by the AAT, as with the Refugee Review Tribunal, is one in which the tribunal is required to determine the substantive issues raised by the material and evidence advanced before it and, in doing so, it is obliged not to limit its determination to the "case" articulated by an applicant if the evidence and material which it accepts, or does not reject, raises a case on a basis not articulated by the applicant: see Sellamuthu v Minister for Immigration and Multicultural Affairs [1999] FCA 247 at [23] and Satheeskumar v Minister for Immigration and Multicultural Affairs [1999] FCA 1285 at [15].

1. Working backwards from the final diagnosis of PSC and probable cholangiocarcinoma, the firm evidence of Dr Moran was that 90% of sufferers of PSC also have underlying ulcerative colitis. This evidence alone indicates a very strong likelihood that Mr Chambers had suffered ulcerative colitis. The usual symptoms of ulcerative colitis are diarrhoea with the passage of blood and mucus, with or without abdominal pain. We had evidence of those symptoms from Mrs Chambers. Mrs Chambers also testified that her husband was strongly opposed to the notion of attending for medical help. He also appeared to be very dissatisfied by the diagnosis of haemorrhoids which he was given when he did seek medical attention in 1955. She also suggested that he was satisfied that he did not have bowel cancer. This evidence is consistent with a man being prepared to simply live with his symptoms and not seek medical help.
2. We also refer to the report written by Dr Coto on 16 February 1955 which we have summarised above. In that report, next to the heading Diagnosis, Dr Coto wrote *ulcerative colitis* and recommended a two week stay in Heidelberg (Repatriation Hospital) for this to be investigated. Although we had no record of Mr Chambers being admitted to the Repatriation Hospital, there is a long hand-written medical report dated 29 March 1955 which recommends that Mr Chambers be examined by a surgeon and that a report be obtained from Dr Diggle. The Treatment and Report Form is clearly a referral to a specialist by the doctor who wrote the 29 March 1955 report. There is also an earlier report written by Dr Diggle about Mr Chambers addressed to the Deputy Commissioner, Repatriation Department which refers to a consultation date of 8 January 1953. Then there appears to be an approval to pay Dr Diggle's account dated 19 April 1953 and below that is a stamp which indicates approval on 21 April 1955. It is quite possible that this represents approval to release the letter as has been requested. If this is so, then it is unlikely that Dr Donald was aware of Dr Diggle's findings when he wrote his report. The point about the timing is that the Tribunal has three independent written records of Mr Chambers' medical history given to three doctors in 1953 and 1955.
3. The three reports can be summarised as follows:
	1. the unidentified doctor wrote on 25 March 1955 – *C/o. Every month or so has had some haemorrhage from the bowel-following frothy faeces-lasts for 2-3 days – has a couple of spoons of bright red – this may or may not be associated with mucus like discharge – occasionally some diarrhoea – has thought of piles but 2 doctors who examined him have not mentioned piles. States has had bleeding since 1942 – did not report sick with it – pt worse in 1947 or 194? Seen by Dr J Diggle, in Collins St in 1953 – sigmoidoscopy. Almost every year has had a couple of bouts of fever – tests for (unclear? Malaria? 1 – 7). These bouts are intermittent influenza – last attack finished up jaundiced – had Palestine tummy in the ME & again at Manila at the end of the war – was passing? slime but no blood*;
	2. on 30 March 1955, Dr Donald, probably without the benefit of Dr Diggle's findings, wrote – *history of occasional high fever – of occasional passage of "frothy" stool but never a true diarrhoea – of occasional tenderness of abdo. Blood PR is small amounts of bright blood – has not regarded it as blood in the stool*. Dr Donald noted that a sigmoidoscopy examination showed the lower bowel to be absolutely clear and observed *haemorrhoids – would benefit from inj*. He added – *in my opinion blood is from haemorrhoidal region – it being aggravated by some proximal disorder – at first I thought of ulc. Colitis but there is no abnormality of sigmoid*; and
	3. two years earlier, in 1953, Mr Chambers had been seen several times by Dr Diggle who wrote – *periodic attacks of diarrhoea lasting 2-3 days of the past 12/12. Stools associated with mucus but no blo* (blood). *PH minor attacks of ? Dysentery 1940 & 1945. Malaria 1942 – 44 (? Recurrence 1948 & 1951). – aching L hip and small of back – equivocal evidence of L sacro-iliac arthritis* [sacro-iliac inflammation has a well-recognised association with ulcerative colitis]. On 7 February 1953 he wrote – *diarrhoea cleared*. At the next visit he recorded – *had haemorrhage PR last 2 days*. *PH on enquiry 1952 July-Aug passed bld every 2-3 weeks. 1949 – 1951 passed bld every month*. On 3 March 1953 Dr Diggle undertook a sigmoidoscopy examination and recorded – *no ulcers seen*. *M. m. Appeared the glazy & redder than normal. Cotton wool swabs tinged with blood*. On the next visit he recorded *– past bld PR once since last visit – Entero-vioform tds for 10 days*. Mr Chambers was subsequently discharged as satisfactory. No note was made of any formal diagnosis and no reason for prescribing Enterovioform was provided.
4. When Mr Chambers was transferred from Geelong to Ballarat Hospital, Dr Prewett wrote *John has no past history to suggest inflammatory bowel disease*. We explain that partly because of Mr Chambers' attitude to his health and partly because of the circumstances surrounding his sudden admission to Geelong Hospital, as acutely unwell. Immediately prior to admission, Dr Prewett described him as being quite well, in fact playing golf. It is likely that Mr Chambers did not tell Dr Prewett about his previous bowel symptoms or that he was not asked.
5. The evidence leaves little room for doubt that Mr Chambers experienced frequent passage of blood and mucus per rectum beginning during his operational service, continuing during the first eight years of his marriage and possibly for most of the remainder of his life. Those symptoms must have an underlying disease to cause them. The medical records indicate that those symptoms had commenced in around 1942 or 1943. Dr Coto wrote in 1955: *intermittently during the past 12 years has had passing of slime, blood & mucus per rectum associated with colicky pain across the centre of the abdomen*. The unnamed doctor reported: *states has had bleeding since 1942 – did not report sick with it – pt worse in 1947*.
6. Even without the material contained in Dr Diggle's notes that indicate the rectal mucosa was abnormal, this set of symptoms commencing when Mr Chambers was quite young, make a diagnosis of ulcerative colitis a real and not fanciful possibility. The presence of PSC in the clinical picture makes the possibility overwhelmingly likely. In addition, Dr Diggle's mention of aching L hip and small of back and an x-ray of this region which showed equivocal evidence of L sacro-iliac arthritis is another pointer towards the diagnosis of ulcerative colitis. It is medically arguable and feasible that the symptoms described by the various medical practitioners who examined him represent the onset of ulcerative colitis during his years of active service in the Army. He was of the age that ulcerative colitis is most likely to commence. There is no other probable cause of the symptoms of bleeding and mucus, altered bowel habit and abdominal pain. It is also medically arguable and feasible that his illness was complicated by the onset of PSC in the early years after the end of World War II.
7. As Dr Moran agreed, brief episodes of otherwise unexplained fever and malaise in a person of Mr Chambers' age who was already known to have PSC would immediately raise suspicion of a complication of PSC, namely bacterial infection of the narrowed bile ducts, a condition known as ascending cholangitis. This latter illness typically causes short-lived and usually self-limiting episodes of fever and malaise. As no other explanation for these episodes of fever emerges from the material before us, ascending cholangitis becomes more than just a mere possible explanation; indeed it is the most likely explanation.
8. We have already mentioned that Dr Moran, when questioned about the possibility of ulcerative colitis being present and undiagnosed for so many years, was hesitant to admit this possibility. We note that in contradistinction to Prof Cade, Dr Moran was seemingly unaware that the technique of lightly rubbing the bowel lining with a cotton-tipped swab via the sigmoidoscope was, prior to the introduction of colonoscopy in the 1970s, a commonly used method of demonstrating friability of the bowel lining and this was evidence of inflammation. This aspect of Dr Moran's evidence combined with the Tribunal's knowledge causes us to discount Dr Moran's view that such a prolonged course of the disease of ulcerative colitis is unlikely. We find, on the balance of probabilities, that Mr Chambers had ulcerative colitis, from the early 1940s. Given the very high proportion of soldiers experiencing dysentery-like symptoms and who remained at their stations, it is not surprising that Mr Chambers had not reported to sick bay. It is also very likely that if he did experience symptoms, even repeatedly, he would have assumed they were due to dysentery. Furthermore, as Dr Moran said in evidence, a worsening of underlying ulcerative colitis may be triggered by an amoebic or bacterial infection.
9. Given that the RMA has determined a SoP concerning inflammatory bowel disease, which includes ulcerative colitis, Mrs Chambers' hypothesis that her husband's PSC was war-caused will be reasonable if the sub-hypothesis regarding ulcerative colitis can be regarded as reasonable taking into account the SoP. As the Full Court of the Federal Court said in *McKenna v Repatriation Commission* (1999) 86 FCR 144, at 152*:*

However, the sub-hypothesis linking Mr McKenna's hypertension with stress and anxiety attributable to his service was crucial to the hypotheses raised by the material before the Tribunal. In our view, neither of these hypotheses could be said to be upheld unless the sub-hypothesis was also upheld.

1. We should make it clear that at this stage of the analysis, we are not concerned with fact-finding. We are simply required to consider all of the material before us and determine whether that material points to a hypothesis connecting, in this case, the disease or death of Mr Chambers with the circumstances of the particular service he rendered (*Repatriation Commission v Deledio* (1998) 83 FCR 82).
2. We should also point out that although Mrs Chambers first lodged her claim with the Department of Veteran' Affairs on 15 May 2009, at which time the current SoP dealing with inflammatory bowel disease was Instrument No 21 of 2001, and the RMA issued a new SoP (No 19 of 2012) commencing on 24 February 2012, in accordance with s 120A(3) we are required to apply the SoP in force at the time of making this decision. This was clearly stated by the Full Court of the Federal Court in *Repatriation Commission v Gorton* (2001) 110 FCR 321, at 331 and 336. If the earlier SoP is more favourable to Mrs Chambers, we may refer to that SoP. However, in this matter, that does not appear to be the case.
3. As we have already said, the SoP concerning inflammatory bowel disease includes ulcerative colitis. Clause 5 of the SoP provides that, subject to clause 7, at least one of the factors set out in clause 6 must be related to any relevant service rendered by the person. Clause 6 provides:

6. The factor that must as a minimum exist before it can be said that a reasonable hypothesis has been raised connecting **inflammatory bowel disease** or **death from inflammatory bowel disease** with the circumstances of a person’s relevant service is:

* 1. for ulcerative colitis only, in a person with a history of a regular smoking habit,
		1. ceasing to smoke within the ten years before the clinical onset of inflammatory bowel disease; and
		2. continuing not to smoke for the three months before the clinical onset of inflammatory bowel disease; or
	2. for Crohn’s disease only,
		1. smoking at least one pack-year of cigarettes, or the equivalent thereof in other tobacco products, before the clinical onset of inflammatory bowel disease, and where smoking has ceased, the clinical onset of inflammatory bowel disease has occurred within four years of cessation; or
		2. immersion in an atmosphere with a visible tobacco smoke haze in an enclosed space for at least 5000 hours before the clinical onset of inflammatory bowel disease, and where exposure to tobacco smoke haze has ceased, the clinical onset of inflammatory bowel disease has occurred within four years of cessation of exposure; or
	3. using the combined oral contraceptive pill for a period of at least six months before the clinical onset of inflammatory bowel disease, and where use of the oral contraceptive pill has ceased, the clinical onset of inflammatory bowel disease has occurred within one year of cessation; or
	4. being treated with a drug or a drug from a class of drugs in the specified list, for at least the seven days before the clinical onset of inflammatory bowel disease; or
	5. undergoing solid organ, bone marrow or stem cell transplantation before the clinical onset of inflammatory bowel disease; or
	6. for Crohn’s disease only,
		1. smoking at least one pack-year of cigarettes, or the equivalent thereof in other tobacco products, before the clinical worsening of inflammatory bowel disease, and where smoking has ceased, the clinical worsening of inflammatory bowel disease has occurred within four years of cessation; or
		2. immersion in an atmosphere with a visible tobacco smoke haze in an enclosed space for at least 5000 hours before the clinical worsening of inflammatory bowel disease, and where exposure to tobacco smoke haze has ceased, the clinical worsening of inflammatory bowel disease has occurred within four years of cessation of exposure; or
	7. being treated with a drug or a drug from a class of drugs in the specified list, for at least the seven days before the clinical worsening of inflammatory bowel disease; or
	8. undergoing solid organ, bone marrow or stem cell transplantation before the clinical worsening of inflammatory bowel disease; or
	9. experiencing a category 1A stressor within the three months before the clinical worsening of inflammatory bowel disease; or
	10. experiencing a category 1B stressor within the three months before the clinical worsening of inflammatory bowel disease; or
	11. experiencing a category 2 stressor within the one month before the clinical worsening of inflammatory bowel disease; or
	12. having a clinically significant depressive disorder for at least the one year before the clinical worsening of inflammatory bowel disease; or
	13. having clinical or laboratory evidence of a bowel infection in the one month before the clinical worsening of inflammatory bowel disease; or
	14. inability to obtain appropriate clinical management for inflammatory bowel disease.
1. Clause 7 of the SoP provides:

7. Paragraphs 6(f) to 6(n) apply only to material contribution to, or aggravation of, inflammatory bowel disease where the person’s inflammatory bowel disease was suffered or contracted before or during (but not arising out of) the person’s relevant service.

1. We also note that in clause 9, the expression *death from inflammatory bowel disease* is defined in the following way:

**"death from inflammatory bowel disease"** in relation to a person includes death from a terminal event or condition that was contributed to by the person’s inflammatory bowel disease;

1. Clause 6(a) of the SoP deals only with ulcerative colitis. It applies only to a person with a history of a regular smoking habit. However, Mr Chambers did not have a history of smoking and in fact as we understood Mrs Chambers' evidence, she was unaware that he smoked at all. There was no evidence at all before us that Mr Chambers smoked. Therefore, we find that the factor in clause 6(a) is not met.
2. Category 1A and 1B stressors are defined at clause 9 of the SoP. It provides:

**"a category 1A stressor"** means one or more of the following severe traumatic events:

* 1. experiencing a life-threatening event;
	2. being subject to a serious physical attack or assault including rape and sexual molestation; or
	3. being threatened with a weapon, being held captive, being kidnapped, or being tortured;

**"a category 1B stressor"** means one of the following severe traumatic events:

* 1. being an eyewitness to a person being killed or critically injured;
	2. viewing corpses or critically injured casualties as an eyewitness;
	3. being an eyewitness to atrocities inflicted on another person or persons;
	4. killing or maiming a person; or
	5. being an eyewitness to or participating in, the clearance of critically injured casualties;
1. Mr Chambers' service records disclose that he embarked for overseas service in the Middle East on 29 December 1940. He left the Middle East in February 1942 returning to Townsville for a brief period before returning to operational service in New Guinea in May 1942. He returned from New Guinea in July 1943. Mrs Chambers also provided to the Commission an extract from a book kept by Mr Chambers entitled *On Target* which was compiled by members of his unit, the 2/3 Light AA. There are a number of references to Mr Chambers in that book. The extracts record the light anti-aircraft battery being *plastered* by a high-level bombing raid where two second lieutenants were killed when they suffered a direct hit from a Stuka bomb. There is a reference to men searching with trenching tools and sandbags looking for sufficient charred remains of the two lieutenants for burial. There is a graphic description of injuries. There is also a description of two days leave at a beach where various parts of human bodies could be seen coming ashore on the waves. The Allied losses in Syria was said to be 382 killed and 1129 wounded.
2. In May 1942 the 2/3 Light Anti-aircraft battery was transferred to Milne Bay after initially landing at Port Moresby. The book records that in about July 1942, Mr Chambers, the popular commander of C Troop, was sent out on a reconnaissance trip. The book records a number of Japanese aircraft brought down by the anti-aircraft battery and subsequent air raids, continual bombing and strafing. The anti-aircraft battery claimed many hits with almost certain destruction of six enemy aircraft including one bomber. The battle to save Milne Bay went on for several days. Mr Chambers gave an account of being under fire with bombs and shelling. In 1943 there were day and night bombing raids and one large air raid said to consist of 105 Japanese aircraft. After some 12 months on active service in Milne Bay, the anti-aircraft battery returned to Australia. We also had evidence of the reported living conditions and hardship experienced by all of the soldiers on operational service in the Middle East and in New Guinea.
3. The evidence discloses that Mr Chambers experienced a category 1A stressor and a category 1B stressor on numerous occasions in the course of his operational service. In fact, from the material before us, these stressors appear to have been frequent and ongoing throughout his operational period. To fit within factors 6 (i) and (j), those stressors need to have been experienced within three months before the clinical worsening of inflammatory bowel disease. The evidence also discloses that Mr Chambers had dysentery from as early as 1940 and experienced bleeding and mucus per rectum with diarrhoea, and colicky pain in the abdomen from about 1942.
4. Having regard to clause 7 of the SoP, clauses 6 (i) and (j) can only apply to a material contribution to, or aggravation of, ulcerative colitis where the person's inflammatory bowel disease was suffered or contracted before or during (but not arising out of) the person's relevant service. The expression *relevant service* in this case means operational service.
5. The evidence was that Mr Chambers did not seek to obtain clinical management for ulcerative colitis during his period of service, and there was no evidence before us to even suggest that he had ulcerative colitis prior to this operational service. His Medical History Sheet on enlistment discloses that he had not previously had dysentery. That indicates he did not have ulcerative colitis on enlistment.
6. We do not understand the factors set out in the SoP which refer to the clinical worsening of inflammatory bowel disease to mean that the veteran is required to be clinically assessed at or about the time of experiencing the stressors. In fact, given the wartime operational conditions as described by Mr Chambers, the facilities were probably not available to conduct such an assessment in any event. However, that does not mean that we must not, with the benefit of all of the evidence and medical opinions obtained at the time of hearing this matter, determine whether the evidence is consistent with a clinical worsening of inflammatory bowel disease within three months of experiencing the requisite stressor. To the contrary, we are of the view that we can and should do so.
7. There was no evidence that so much as suggests that Mr Chambers had ulcerative colitis prior to his long period of operational service. However, the material strongly points to the fact that at some time during his operational service, he acquired ulcerative colitis. The history provided to Dr Coto points to him contracting the disease in about 1942. Dr Coto stated in his medical report that the symptoms of his examination of Mr Chambers were traceable back to his days when he was overseas. The unnamed doctor who reported on Mr Chambers on 29 March 1955 said the symptoms had commenced in around 1942. He also said that Mr Chambers told him he had bleeding since 1942 but did not report sick with it. He said it became worse in 1947. In fact the material discloses that it must have become considerably worse as in 1953, Mr Chambers resorted to making an application to the then Repatriation Board for what he described as *stomach trouble.*
8. As Dr Moran testified, ulcerative colitis has no known cause. However, the Tribunal is aware it is well-known that in people who already have ulcerative colitis, an inter-current or superimposed bowel infection is likely to aggravate the underlying colitis, and this was acknowledged by Dr Moran. In fact, this possibility is acknowledged in the SoP where factor 6 (m) refers to having clinical or laboratory evidence of a bowel infection in the one month before the clinical worsening of inflammatory bowel disease. The history taken by Dr Diggle included the fact that Mr Chambers had dysentery from about 1940. The symptoms which point to ulcerative colitis are recorded as having occurred in about 1942.
9. Given that there is a SoP which deals with ulcerative colitis, in accordance with *Deledio's* case, we must now form the opinion whether the hypothesis raised is a reasonable one. It will be reasonable if the hypothesis fits or is consistent with the *template* to be found in the SoP. The hypothesis raised must contain one or more of the factors which the RMA has determined to be the minimum which must exist and be related to the persons service (s. 196B(2) (d) and (e) of the VE Act). In our opinion, the ulcerative colitis hypothesis is reasonable. The material in evidence before us fits within factors 6 (i), (j), (k) and (m). These factors of course are subject to clause 7 in the SoP. In our opinion, the material before us in evidence points to the fact that Mr Chambers' inflammatory bowel disease was suffered or contracted during his operational service, but it did not arise out of that service. The material points to the probability of a bacterial infection which likely aggravated his ulcerative colitis which developed or was developing at that time. Therefore, it satisfies clause 7 of the SoP.
10. The only remaining matter is to consider whether the standard of proof in s 120(1) is met. Mrs Chambers will succeed in her application unless we are satisfied beyond reasonable doubt that the factual foundation upon which the hypothesis can operate does not exist.
11. There was no evidence before us which contradicted the factual basis upon which Mrs Chambers' claim was based. Accordingly, we make the following findings based on the evidentiary material to which we have already referred:
	1. Mr Chambers acquired ulcerative colitis during his operational service in World War II;
	2. Mr Chambers suffered from intermittent bouts of dysentery commencing in 1941 while on operational service;
	3. based on the symptoms reported by Mr Chambers when he sought medical assistance in 1953, we find that the clinical onset of ulcerative colitis occurred between 1942 and 1945;
	4. Mr Chambers experienced numerous episodes of category 1A stressors and category 1B stressors in the course of his operational service, and he experienced a clinical worsening of his ulcerative colitis within three months of those episodes;
	5. Mr Chambers had a bowel infection within one month of the clinical worsening of his ulcerative colitis;
	6. the bowel infection acquired by Mr Chambers prior to the onset of his ulcerative colitis resulted in an aggravation of the ulcerative colitis during his operational service;
	7. ulcerative colitis is associated with PSC and is sometimes described as an extra-intestinal manifestation of PSC; and
	8. Mr Chambers died from PSC which ultimately caused liver failure.
12. Therefore, in accordance with s 120 of the VE Act, we find that the death of Mr Chambers was war-caused as we cannot be satisfied beyond reasonable doubt that there is no sufficient ground for making that determination.

# Conclusion

1. There was no dispute about the fact that Mr Chambers had extensive operational service in the Australian Army between 1940 and 1946. Mr Chambers died on 11 April 1999 and his death certificate recorded the cause of his death as carcinoma of bile duct – five months.
2. After careful examination of all documents in evidence and taking oral evidence from expert medical practitioners, we have found that the medical condition PSC was the condition which accounted for the pathological changes leading to Mr Chambers' death. On the balance of probabilities, we have found that Mr Chambers died from liver failure secondary to PSC.
3. The hypothesis advanced on behalf of Mrs Chambers linking her husband's death with his operational service was that he died from cholangiocarcinoma secondary to PSC and that the PSC in turn was secondary to amoebic dysentery. We have found that Mr Chambers did not, on the balance of probabilities, have cholangiocarcinoma. If we are wrong about that, it was nevertheless not a contributing cause of his death. In any event, we have found that there is no link known to medical science between amoebic dysentery and PSC. Furthermore, there is insufficient evidence to support a finding that Mr Chambers ever had amoebic dysentery. Therefore, we have found that the hypothesis advanced on behalf of Mrs Chambers cannot be reasonable.
4. However, we have found that Mr Chambers had acquired ulcerative colitis during his operational service. Furthermore, prior to reported symptoms consistent with ulcerative colitis, Mr Chambers also reported he had dysentery. We have found that Mr Chambers had a bowel infection before the clinical worsening of his ulcerative colitis. We have also found that Mr Chambers experienced numerous category 1A stressors and category 1B stressors within the three months before the clinical worsening of his ulcerative colitis. Therefore, we have found that Mr Chambers suffered an aggravation of ulcerative colitis during his operational service. Accordingly, he satisfies a number of factors related to his operational service which are set out in the SoP dealing with inflammatory bowel disease. It follows that there is a reasonable hypothesis linking Mr Chambers' operational service and his ulcerative colitis.
5. Ulcerative colitis is strongly linked to PSC as some 90% of persons who have PSC also have underlying ulcerative colitis. In fact it is described as an extra-intestinal manifestation of PSC. It follows, in our opinion, that Mrs Chambers has established a causal link between her husband's operational service and the medical cause of his death.
6. We find that the decision made by the VRB on 1 September 2010 was incorrect. We set aside that decision and in substitution determine that the death of Mr Chambers was war-caused as that expression is defined in the VE Act.

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| I certify that the preceding 113 (one hundred and thirteen) paragraphs are a true copy of the reasons for the decision herein of Mr Egon Fice, Senior MemberDr Kerry Breen, Member |

....[sgd]....................................................................

Dated 5 September 2012

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| Date of hearing | **7 June 2012** |
| Counsel for the Applicant | **Mr C Thomson** |
| Solicitors for the Applicant | **Williams Winter** |
| Counsel for the Respondent | **Mr G Purcell** |
| Solicitors for the Respondent | **Department of Veterans' Affairs** |