[2014] AATA 330

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| Division | **VETERANS' APPEALS DIVISION** |
| File Number | 2012/5514 |
| Re | Malcolm Dunn |
|  | APPLICANT |
| And | Repatriation Commission |
|  | RESPONDENT |

# Decision

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| Tribunal | **Dr M Denovan, Member** |
| Date | **28 May 2014** |
| Place | **Brisbane** |

The Tribunal affirms the decision under review.

.........................Sgd............................................

**Dr M Denovan, Member**

**CATCHWORDS**

VETERANS’ AFFAIRS – Benefits and entitlements – Eligibility for pension – Ulcerative proctitis – Operational service – Reasonable hypothesis connecting disease with veteran’s service – Whether condition aggravated or materially contributed to by service – Decision under review affirmed

**LEGISLATION**

Veterans’ Entitlements Act 1986 (Cth) ss 9, 120, 196B

**CASES**

Bushell v Repatriation Commission (1992) 175 CLR 408

Federal Broom Co Pty Ltd v Semlitch [1964] HCA 34; (1964) 110 CLR 626

Ford v Repatriation Commission [2001] AATA 602

Johnston v Commonwealth [1982] HCA 54; (1982) 150 CLR 331

Repatriation Commission v Bendy (1989) 18 ALD 144

Repatriation Commission v Deledio (1998) 83 FCR 82

Repatriation Commission v Law (1980) 31 ALR 140

Repatriation Commission v Milenz [2006] FCA 1436

Trigg and Repatriation Commission (1990) 20 ALD 194

**SECONDARY MATERIALS**

Statement of Principles concerning Inflammatory Bowel Disease No. 19 of 2012

# REASONS FOR DECISION

**Dr M Denovan, Member**

**28 May 2014**

1. The applicant in these proceedings is Mr Malcolm Dunn. Mr Dunn served as a member of the Australian Army (“the Army”) from 12 January 1987 to 12 October 1993.
Mr Dunn served as a peacekeeper in Cambodia from 9 June 1992 to 10 June 1993, and this constitutes operational service under the *Veterans’ Entitlements Act 1986* (Cth)
(“the Act”).
2. He has been diagnosed with ulcerative proctitis, which is a form of ulcerative colitis, which in turn is a type of inflammatory bowel disease. Mr Dunn was first diagnosed with this condition in 1998, approximately five years after he discharged.
3. Mr Dunn made a claim for pension and treatment of this condition, under the Act.
His hypothesis is that he first developed the condition whilst he was serving in Cambodia, and the Army failed to provide adequate clinical management of this condition whilst he was in Cambodia, and as a result the condition was materially contributed to or aggravated. He contends that appropriate clinical management would have resulted in his condition being diagnosed and treated during the time he was serving in Cambodia, and the failure to obtain that treatment has materially contributed to and/or aggravated his condition.
4. The question for me is whether there is, with reference to the relevant Statement of Principles (“SoP”), a connection between Mr Dunn’s ulcerative proctitis and his peacekeeping service.

**RELEVANT LEGISLATION**

1. Section 9 of the Act provides that where an injury or disease results from an occurrence that happened while the veteran was rendering operational service or where it arose out of, or was attributable to, that service, the injury or disease will be taken as being
war-caused. Causation questions such as these, where a veteran has rendered operational service, are addressed by applying the standard of proof in s 120(1) of the Act. That requires decision-makers to determine that an injury or disease is war-caused unless satisfied beyond reasonable doubt that there is no sufficient ground for making that determination.
2. The issue of whether the diagnosed condition was caused by operational service is to be decided by reference to the four-step process identified by the Federal Court in *Repatriation Commission v Deledio[[1]](#footnote-1)* (“*Deledio”*). In *Deledio,* the Court said there was a four-stage process involved in the determination of whether an injury, disease or death was war-caused. At the first stage, the decision maker has to consider whether the whole of the material points to a hypothesis connecting the death (or injury or disease) with the circumstances of the veteran’s service. If not, then the application fails. At the second stage, where the material raises such an hypothesis, the question is whether there is an SoP in force. At the third stage (where an SoP is in force), the Tribunal must decide whether the hypothesis is consistent with the ‘template’ in the SoP; that is, whether one or more of the minimum factors the SoP lists are present and whether one or more of them is related to the relevant service, which, in turn, involves the application of
s 196B(14) of the Act.[[2]](#footnote-2) Until this stage is complete, the Tribunal is not permitted to make findings regarding the facts necessary to make out the hypothesis. It is not to determine whether the material before it establishes the necessary facts, only if the material “points to some fact or facts (“the raised facts”) which support the hypothesis”,[[3]](#footnote-3) which in turn must be supported by the applicable SoP. If, in accordance with these principles, the material raises a reasonable hypothesis connecting the service and the injury, disease or death, the claim has to be dealt with in accordance with s 120(1): that is the fourth stage. It is only at the fourth stage that fact-finding is to occur.[[4]](#footnote-4)
3. The relevant SoP for the applicant’s condition and operational service, is the Statement of Principles concerning Inflammatory Bowel Disease No. 19 of 2012 (“the relevant SoP”). Mr Thompson, for the applicant, said Mr Dunn was relying on only one factor at cl 6(n) of the relevant SoP which reads:

(n) Inability to obtain appropriate clinical management for inflammatory bowel disease

This factor only applies to material contribution 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.[[5]](#footnote-5)

**BACKGROUND**

1. Mr Dunn gave evidence in person at the hearing, and his case is as follows. Prior to going to Cambodia he was a well man, and he had no gastrointestinal problems. Soon after he arrived in Cambodia he developed severe vomiting and diarrhoea. This was not unusual, and almost all of the members posted in Cambodia with Mr Dunn developed similar symptoms, however he considers his condition was more severe and more protracted.
2. Mr Dunn presented to the Regimental Aid Post (“RAP”) soon after his symptoms commenced, and recalls being confined to bed for some days. He said that at this point in time his presentation was not especially different to any of the other numerous sick members, all suffering from gastroenteritis, which was a consequence of eating the local food. There is a contemporaneous RAP report dated 17 June 1992, which states that
Mr Dunn presented complaining of diarrhoea for the past 6 days. The report indicates
Mr Dunn complained of nausea but no vomiting. No mention of blood or mucous per rectum (“PR”) is made. A diagnosis of gastroenteritis was made, and he was treated with buscopan, fluids and gastrolyte. He was deemed not fit for duty that day.
3. Mr Dunn told the Tribunal his vomiting remitted however he continued to suffer from diarrhoea during the entire time he was in Cambodia. He claims he was unable to present for treatment because he was often away from the base performing water-purifying duties for many weeks at a time. He said he attended the RAP some months later when the diarrhoea flared up again. There is a record of Mr Dunn attending the RAP on
10 November 1992. That report records Mr Dunn as complaining of diarrhoea for the past 3 days, approximately 12 times a day. It was noted he reported passing what appeared to be mucus. No mention of passing blood PR is made in this medical record. The report indicates that Mr Dunn had a history of having diarrhoea in June 1993
(all parties agree this is an error and should read 1992). There is no mention of Mr Dunn having suffered diarrhoea continuous from June 1992 in the contemporaneous notes.
Mr Dunn was placed on sedentary duties for one day.
4. When he returned to Australia, Mr Dunn said the diarrhoeas settled, however he claims he did not feel quite right. In retrospect he believes he was in denial. He discharged from the Defence Force soon after returning from Cambodia in 1993. A medical board examination record dated 31 August 1993 records Mr Dunn as having self-limiting diarrhoea while in Cambodia only.
5. Gastroenterologist Dr Cliona Maguire saw Mr Dunn in 2007. In her report dated
18 August 2009 she noted the history as follows: Mr Dunn reported having blood and mucus in his motions, which occurred as diarrhoea six times a day for a year whilst he was in Cambodia. His symptoms settled spontaneously however he had a recurrence of blood and mucus PR in 1998. A colonoscopy performed at that time showed ulcerative proctitis in the distal 8 cm. He was treated with Salazopyrin for one year. He remained reasonably well until October 2005 when he had a further flare up of his symptoms with blood and mucus in his stools. He had a colonoscopy done which again showed ulcerative colitis in the distal 8cm. He was treated with steroid enemas. In 2007 he had a further flare up of his symptoms and was seen and treated by Dr Maguire. He was treated with Mesalazine suppositories and Salazopyrin. Dr Maguire stated that presently
Mr Dunn has minimal symptoms. Mr Dunn reported that he occasionally has blood and mucus PR but does not have diarrhoea.
6. In 2010 a colonoscopy was said to have been normal.

**CONSIDERATION**

1. The respondent accepts that Mr Dunn has raised a hypothesis, but not a reasonable hypothesis. The respondent accepts that there is material which points to Mr Dunn having an inability to obtain appropriate clinical management for his condition, but argues that there is no material which points to Mr Dunn’s condition being aggravated or materially contributed to by his inability to obtain appropriate clinical management.
2. For the hypothesis to be reasonable there must be material that points to some facts that support the hypothesis. The hypothesis Mr Dunn has raised has the following salient points:

(1) his condition of ulcerative proctitis was suffered or contracted before or during (but not arising out of) his service in Cambodia;

(2) he was unable to obtain appropriate clinic management of that condition whilst in Cambodia; and

(3) there was a material contribution or aggravation of the condition as a result.[[6]](#footnote-6)

1. Although Mr Dunn was not diagnosed with ulcerative colitis until 1998, there is evidence which points to him first suffering the condition during his service in Cambodia. That is the opinion of Dr Maguire, who referred to the history given to her by Mr Dunn, and stated in her report:

it is likely that his inflammatory bowel disease commenced in 1993 whilst he was overseas in Cambodia as his symptoms of blood and mucous PR which lasted for one year are typical of this.

1. Gastroenterologist Dr Cohen concurs with Dr Maguire. Dr Cohen provided a report dated 27 April 2012 and also gave evidence by telephone at the hearing.
2. As stated, the respondent accepts that there is evidence which points to Mr Dunn having not received appropriate clinical management for the condition whilst he was in Cambodia. Dr Cohen referred to the history of the condition given to him by Mr Dunn and concluded that a definitive diagnosis (of ulcerative proctitis) should have been made by either sigmoidoscopy or colonoscopy at that time.
3. Mr Thompson for the applicant said that there was evidence which pointed to the condition worsening as a result of the failure of the condition to be diagnosed whilst
Mr Dunn was in Cambodia. He said that the length of affected bowel identified by colonoscopy had progressed over time from 8 cm to 12 cm. He contended that, due to the failure to obtain appropriate medical treatment, we have no way of knowing what length of bowel was affected when Mr Dunn was in Cambodia. He suggested that it was likely less that 8cm noted in 1996, and the progression of affected bowel from 8 cm to 12 cm was a consequence of Mr Dunn’s failure to obtain appropriate clinical management.
4. Before deciding if there is any material which points to a material contribution or aggravation of Mr Dunn’s ulcerative proctitis due to lack of ability to obtain appropriate clinical management of his condition, it is useful to consider what is meant by material contribution and aggravation.
5. In *Repatriation Commission v Bendy*[[7]](#footnote-7) (“*Bendy”*), Davies J noted in reference to *Repatriation Commission v Law[[8]](#footnote-8)* that it is sufficient if a veteran's war-service was one of a number of causes of a disease, providing it was a contributing cause. There must be a material contribution, which must also be of a causal nature. In the matter of *Bendy*, Davies J concluded that for something to be a material contribution, it must be "pertinent" or "likely to influence". The contributing factor need not be part of a "special character" or involving a special risk. Davies J also noted that “it would be wrong to consider solely factors of which it can be said that without them the disease would not have developed for that is not the test”. The issue of contributing cause should be approached in a "practical, commonsense way", Davies J concluded. In the matter of *Ford v Repatriation Commission*,[[9]](#footnote-9) the Tribunal noted this is the appropriate application both for issues of initial contribution or aggravation. What is required is that it added measure to the creation of a condition or its aggravation or acceleration. Thus, the contributing factor must be part of a cause.
6. The meaning of aggravation has been considered by many Tribunals and by the
Federal Court on many occasions. It is generally accepted that aggravation means
making worse, or increasing the gravity and seriousness of the condition. The meaning
of "aggravation" was considered by the High Court in *Federal Broom Co Pty Ltd
v Semlitch. [[10]](#footnote-10)* Windeyer J explained, at 637, that a condition was aggravated if the consequences of the sufferer’s affliction have become more serious. His Honour added, at 639, that the real question was:

whether the disease has been made worse in the sense of more grave, more grievous or more serious in its effects upon the patient.

1. In the matter of *Johnston v Commonwealth*,[[11]](#footnote-11) the High Court said that failure to diagnose and treat cancer lead to the worsening of the condition when compared with the course that, with timely treatment, it should have taken.
2. Mr Crowe referred me to the matter of *Trigg and Repatriation Commission*,[[12]](#footnote-12) which he said was authority for the principle that it is the condition, not symptoms of the condition that must be aggravated or materially contributed to. In the matter of *Repatriation Commission v Milenz*,[[13]](#footnote-13) Finn J said that whether a condition has worsened is a medical question requiring expert evidence, and when considering whether there was any worsening of a condition, reference should be made to the definition of the condition included in the relevant SoP. The SoP for inflammatory bowel disease reads as follows:

**Kind of injury, disease or death**

3. (a) …

(b) For the purposes of this Statement of Principles, "inflammatory bowel disease" means 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. This definition includes ulcerative colitis, Crohn's disease and inflammatory bowel disease of unspecified type, but excludes bowel inflammation secondary to vascular insufficiency, food allergy, radiation, infection or gastrointestinal toxins.

1. Ulcerative colitis is one of three different types of inflammatory bowel diseases referred to in the relevant SoP’s definition. According to Dr Cohen, ulcerative colitis is a type of inflammatory bowel disease characterised by ulcers in the gastrointestinal tract, and when considering Mr Thompson’s contention relating to the worsening of the condition, I took into account the description of the condition given by Dr Cohen, and did not limit my consideration only to the definition of the condition given in the SoP.
2. Dr Cohen said the length of gastrointestinal tract involved varies from person to person. In his oral evidence, Dr Cohen said that the disease is characterised by episodes of abdominal pain and diarrhoea, which if not treated are self-limiting. In between episodes a person with the condition is well, provided they do not develop any extraintestinal manifestations. Mr Dunn’s ulcerative colitis is relatively mild; he has never experienced any extraintestinal manifestations. According to Dr Cohen, the cause of the condition is unknown and it does not necessarily progress or get worse. He said there was no way of predicting the frequency or severity of attacks in any person.
3. There is no evidence before me which points to the amount of Mr Dunn’s bowel affected by ulcers having increased as Mr Thompson suggests. Both Dr Maguire and Dr Cohen refer to a colonoscopy performed in 1998 by Dr Sandford; Dr Maguire states the colonoscopy showed 8cm of affected bowel, and Dr Cohen recorded the colonoscopy as showing 12cm of affected bowel. This is clearly not evidence pointing to any progression of the disease; it is simply an error made in one of the reports. As Dr Maguire stated that a further colonoscopy performed in October 2005 showed ulcerative colitis in the distal 8cm, I think it is likely that the error is in Dr Cohen’s report.
4. Dr Cohen’s evidence did not point to there being any worsening of Mr Dunn’s condition at any time. Dr Cohen told the Tribunal that the measurement of the length of affected bowel by colonoscopy was not an accurate science, and that there can be many variables which affect the measurement, such as the type of preparation for colonoscopy used, and when this preparation is performed. He said even if there was evidence of progression from 8 cm to 12 cm, small changes in measurements of the affected bowel demonstrated by successive colonoscopies was not indicative of the condition worsening or progressing.
5. Mr Dunn also claims that he was generally unwell from the time he developed diarrhoeas in Cambodia, and although his diarrhoea remitted, his general unwellness did not.
Mr Dunn stated that he thinks the reason he did not seek medical attention prior to 1998 is because he was in denial. He contends that had he been treated appropriately whilst in Cambodia, he would have not been sick during this period. The definition of inflammatory bowel disease in the SoP includes extra gastrointestinal symptoms, but does not include general malaise or persistent symptoms of the nature described by
Mr Dunn. The evidence of Dr Cohen was that between episodes of diarrhoea, most persons with ulcerative colitis are symptom free. Mr Dunn has not contended he has suffered from any of the systemic symptoms included in the definition of inflammatory bowel disease in the SoP. There is no medical evidence which points to Mr Dunn having any symptoms attributable to inflammatory bowel disease after his discharge, until 1998.
6. The contemporaneous medical evidence points to Mr Dunn having diarrhoea in
June 1992 and again in November 1992. Whilst there is no contemporaneous evidence which points to Mr Dunn having continuous diarrhoea it is possible that the diarrhoea which he sustained in November 1992 did not remit and, due to the nature of his duties, he was unable to attend the RAP.
7. According to Dr Cohen, ulcerative colitis is an autoimmune disease of unknown cause, and the treatment of ulcerative colitis settles the symptoms experienced during the episode, but does not prevent future episodes or have any impact on the frequency or severity of future episodes. He said that whether an episode was treated or not had no impact on the progress of the condition. Dr Cohen explained that symptoms of ulcerative colitis are cyclical and intermittent. He said that had Mr Dunn’s diarrhoea in Cambodia been attributable to ulcerative colitis, and he had been treated for the condition whilst he was in Cambodia, his symptoms would have subsided earlier. However, there was no long-term effect on Mr Dunn’s condition that resulted from the fact that his condition was not diagnosed or appropriately medically treated whilst he was in Cambodia.
8. Whether a condition has worsened, aggravated or materially contributed to is a medical question. This case is very different to one such as cancer, where the absence of diagnosis and treatment results in the condition progressing in a manner that could have been prevented.
9. After reviewing all of the medical evidence I find that there is nothing which points to the possibility that Mr Dunn’s condition was aggravated or materially contributed to by an inability to obtain appropriate medical treatment during his service in Cambodia.
That being the case, the hypothesis raised is not reasonable.
10. Dr Maguire stated that Mr Dunn’s ulcerative colitis might have been precipitated by the gut infection he contracted whilst in Cambodia. There are no factors in the relevant SoP which raise gut infection as a possible cause connecting inflammatory bowel disease with service. Therefore, no reasonable hypothesis exists in relation to a causal link between the gut infection in Cambodia and ulcerative proctitis.
11. No fact finding was made in reaching my decision that the hypothesis raised was not reasonable. Had the hypothesis been reasonable, the inconsistencies between the history given in the contemporaneous medical notes and the history given to Dr Maguire and
Dr Cohen would need to have been considered when determining whether there was an inability to obtain appropriate clinical management whilst Mr Dunn was in Cambodia.

**DECISION**

1. The Tribunal affirms the decision under review.

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| I certify that the preceding 36 (thirty-six) paragraphs are a true copy of the reasons for the decision herein of Dr M Denovan, Member |

.........................Sgd............................................

Dated

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| Date of hearing | **2 April 2014** |
| Advocate for the Applicant | **Mr Rod Thompson, APPVA Advocate** |
| Solicitors for the Respondent | **Adrian Crowe, Department of Veterans' Affairs** |

1. (1998) 83 FCR 82. [↑](#footnote-ref-1)
2. Deledio at 97-98. [↑](#footnote-ref-2)
3. Bushell v Repatriation Commission (1992) 175 CLR 408 at 414 per Mason CJ, Deane and McHugh JJ. [↑](#footnote-ref-3)
4. Deledio at 97-98. [↑](#footnote-ref-4)
5. Clause 7 of the relevant SoP. [↑](#footnote-ref-5)
6. Although in the written statement of facts and contentions submitted by the applicant’s representative it is contended that the ulcerative colitis arises out of service, at the hearing Mr Dunn’s representative stated that only the factor at
cl 6(n) of the relevant SoP was relied upon for the hypothesis put forth. [↑](#footnote-ref-6)
7. (1989) 18 ALD 144. [↑](#footnote-ref-7)
8. (1980) 31 ALR 140. [↑](#footnote-ref-8)
9. [2001] AATA 602. [↑](#footnote-ref-9)
10. [1964] HCA 34; (1964) 110 CLR 626. [↑](#footnote-ref-10)
11. [1982] HCA 54; (1982) 150 CLR 331 at [14]. [↑](#footnote-ref-11)
12. (1990) 20 ALD 194. [↑](#footnote-ref-12)
13. [2006] FCA 1436 at [29]. [↑](#footnote-ref-13)