Veterans' Entitlements Appeal Board

[redacted]
War Pensions Number

VETERANS' ENTITLEMENTS APPEAL BOARD

Name: [redacted]

Service Number and Rank: [redacted] NZ Army, Rifleman, [redacted]

Address: [redacted]

Grounds of appeal: Appeal against the 10 August 2020 decision of the Review Officer to uphold the 9 September 2019 decision of the Decision Officer to decline to accept peripheral neuropathy as service-related under the Veterans' Support Act 2014.

Held: Commenced at Wellington on 30 July 2021, concluded 5 November 2021

Parties:
The Appellant, Mr [redacted] represented by Ms Janet Castell, RSA Support Manager and Mr Rob Todman, RNZRSA

The Respondent, Veterans' Affairs New Zealand, represented by Ms Anne-Marie Tribe, Manager Decisions and Entitlements, and Dr Mike O'Reilly, Principal Clinical Advisor

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Outcome:

The Appeal Board revokes the 10 August 2020 decision of the Review Officer, to decline to accept the condition of peripheral neuropathy as being service-related. The Appeal substitutes its decision for that of the Review Officer; namely that the Appellant has a condition of peripheral neuropathy which must be accepted as service-related.

Summary of reasons for decision:

The Appellant does not have a condition that is presumed to be service-related.

The Appellant does have a condition of peripheral neuropathy that is service-related because the factor prescribed in paragraph 6(u) of Statement of Principles (74/2014) Peripheral Neuropathy is met.

DECISION

This is an appeal by [redacted] against the 10 August 2020 decision of the Review Officer to uphold the 9 September 2019 decision of the Decision Officer to decline to accept peripheral neuropathy as service-related under the Veterans' Support Act 2014.

Background

Qualifying service

The Appellant served as a rifleman in the Royal New Zealand Infantry Regiment of the New Zealand Army between 25 June 1963 and 30 July 1970.

He has qualifying routine service during the period 25 June 1963 and 30 July 1970.

He has qualifying operational service in the Indonesian Confrontation and two tours in Vietnam; he served in the Indonesian Confrontation from 17 August 1964 to 11 August 1966 and in the Vietnam War from 13 May 1968 to 7 May 1969 and from 20 August 1969 to 13 November 1969.

The Appeal Board thanks the Appellant for his service.

Possible peripheral neuropathy diagnosis

The Appellant was first suspected of having peripheral neuropathy in a Vietnam Annual Medical Assessment dated 26 July 2018. General practitioner Paul Johnston considered the medical diagnosis to be " Increased unsteadiness on feet. ? peripheral neuropathy – not clear. High falls risk."

On 20 August 2018, Veterans' Affairs received the Appellant's application for a disablement pension for peripheral neuropathy on the basis that it was caused or contributed to by his exposure to Agent Orange during service.

Veterans' Affairs investigated the claim by obtaining medical evidence including from the Appellant's treating neurologist, Peter Wright.

Dr Wright's opinions on diagnosis

On 21 May 2019 Dr Wright saw the Appellant and wrote that he had "multiple system features and do not fit readily into a single unifying diagnosis". He considered possible diagnoses could be "a paraneoplastic, an Agent Orange-related, a primarily cerebellar pathology in combination with motor neuronopathy, and length dependent sensory polyneuropathy".

Dr Wright recorded the history of the Appellant's symptoms as follows:

- Mr and Mrs [redacted] first noted clawing of the Appellant's toes in about 1990. He did not have these symptoms as a youngster and he does not have a family history of the same.

- In about 2000, the Appellant first noted problems with him being wobbly on his feet, having foot pain and having a progressive decline in dexterity with a gradually worsening tendency to drop things.
- Bladder retention first occurred in 2010 and recurred in 2012. He began losing weight. He was 90 kg and is now 59 kg.
- In 2013, he began “furniture walking” – grasping for whatever support was available.
- Over the last five to six years, he has tended to choke a little on his food and has an "awful cough", which may be related to COPD or something else.
- Since 2015, he has been progressively dysarthric.
- Since 2018, his gait has been especially bad, with falls about once a month.
- Cognitive issues were first noticed about a year ago and his dysarthria has been much worse in the last three to six months.

On 27 August 2019 Dr Wright discussed the findings of investigations. He noted that the CT brain scan had “suggested some atrophy of the parietal>frontal lobes, but preserved mesial temporal structures.” Dr Wright reviewed the Appellant and gave his opinion that he had a "multisystem neurologic disorder as yet undiagnosed". His impression was that "it is unlikely to be related to Agent Orange".

Decision Officer's decision

On 9 September 2019, the Decision Officer declined to assess the condition of peripheral neuropathy as no confirmed diagnosis had been made despite a number of tests being done.

On 27 September 2019, Veterans’ Affairs advised the Appellant that his application for a Disablement Pension for Probable peripheral neuropathy had been declined as no diagnosis had been made.

Dr Wright

On 3 March 2020, Dr Wright commented on Dr Johnston's provision of information that the Appellant had contracted malaria when in Malaya in 1965, 1967 and 1968 and had been treated with Dapsone over a period of seven years. Dr Wright wrote:

> **Regarding Dapsone-related peripheral neuropathy**, although an uncommon side effect of oral treatment, is clinically significant due to its frequent subtle onset (especially with motor neuropathy) and the high potential for long-term persistence, including after cessation of dapsone intake. The onset of peripheral neuropathy after initiation of dapsone therapy is variable. The mechanism has not been proven; however, likely a direct neurotoxic effect due to the ability of dapsone to concentrate in neural tissue. This is a poor fit for [redacted]'s presentation.

Review filed

On 6 March 2020, the Appellant with the assistance of RNZRSA representative, Janet Castell, sought a review of the Decision Officer’s decision.

Ms Castell questioned Dr Wright's diagnosis of multisystem neurological disorder noting that he did not know the Appellant had been diagnosed with Falciparum Malaria in November 1968 and Vivax Malaria in February 1969 and was treated with Quinine, Dapsone, Daraprim and Chloroquine.

She noted that the Appellant's younger brother had been diagnosed with peripheral neuropathy in 2010. She queried whether the Appellant had an inherited condition because his younger brother had also served in the New Zealand Army and as a firefighter in the New Zealand Fire Service.

She noted that the Appellant accepted that he did not have a confirmed diagnosis for peripheral neuropathy but said Dr Wright had not taken all factors into account.

Dr Wright

On 23 July 2020, Dr Wright reported that the results of the complex EMG test taken on 14 July 2020 demonstrated "severe sensory axonal neuropathy, and mild mixed axonal / demyelinating motor neuropathic changes and as a consequence widespread denervation limbs > more proximally." His opinion was that the Appellant did not have motor neurone disease.

His concluded that the EMG, like that of the Appellant's brother, shows "profound loss of sensory axons, and in both sensory conductions were undetectable suggesting this is likely the same pathology in both". Dr Wright's opinion was that the test results showed the Appellant had a "more advanced process" than his brother. Dr Wright suggested further gene testing.

On 27 July 2020, Dr Wright advised that he could consider the Appellant's brother's gene tests results as they would be the same.

Review Officer's decision

On 10 August 2020 the Review Officer concluded that he could not establish a reasonable hypothesis of a relationship between Mr [redacted]'s service and the diagnosis of peripheral neuropathy, so the original decision to decline to accept peripheral neuropathy as service-related under the Veterans' Support Act 2014 (**the Act**) was correct.

The Review Officer stated that the relevant Statement of Principles (**SOP**) was 74/2014 Peripheral Neuropathy. He recorded that the Appellant had peripheral neuropathy but the cause was "familial rather than acquired given the symptomatic and diagnostic features shared between [the Appellant] and his brother." He stated that "[i]nherited neuropathies are specifically excluded from consideration within the SOP", so they cannot be considered service related. [1]

The Review Officer's decision was:

> I uphold the decision of 9 September 2019: and decline to accept Peripheral Neuropathy as service-related under the Veterans' Support Act 2014.

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[1] The Review Officer found there was a reasonable hypothesis that the Appellant's cognitive impairment was associated with his service. He decided that condition should be accepted as service-related under the Veterans' Support Act 2014 and a permanent pension of 14% awarded.

> I amend the decision of 9 September 2019 and accept Cognitive Impairment as service related under the Veterans' Support Act 2014 and award a permanent pension of 14%.

On 14 August 2020 Veterans' Affairs advised the Appellant of the Review Officer's decision.

Procedure

The hearing was adjourned part heard to enable the Appellant's wife to give further evidence, including whether she noticed any physical change in the Appellant on his return from Vietnam. The Respondent was also to identify any gaps in the medical evidence.

Mrs [redacted]'s evidence

She said that she had been with the Appellant since 1970, which was shortly after his return from the Vietnam War. They began their relationship when he was working as a bus driver. It was during this time that he would complain of numbness in his hands and fingers. This would occur while he was driving buses and also while performing everyday living tasks. He would also complain of cramps in his feet and toes. This continued through to the 1990's up until his retirement in the early 2000's. She recalled times when he would go running for exercise but at times would not be able to complete his run due to severe pains in his legs and feet.

She also gave evidence about the Appellant's current poor health.

Veterans' Affairs

The Respondent obtained general practice notes from the Clive Medical Centre dating back to 2013.

The Respondent then sought an opinion from Dr Wright in relation to the new evidence.

Opinion of Dr Wright

On 14 October 2021 Dr Wright provided a report for the Respondent, referring to his previous conclusions and discussing the evidence obtained from the Appellant and the Appellant's wife as well as his understanding of the Appellant's family and history. Dr Wright also referred to his examination notes and investigations and assessments by others, as well as the Appellant's brother's whole exome genetic study. He responded to the questions posed by the Respondent as follows:

1) Does Mr [redacted] have an "acute or subacute" peripheral neuropathy related to his service in Vietnam between 1968 and 1969?

   Reply: There is no evidence to support this. At best a presentation from the 1970s would represent a chronic neuropathy, but the evidence for such an early start to his symptoms is non-specific in its nature.

2) Does Mr [redacted] have a chronic peripheral neuropathy or another cause?

   Reply: Yes. It is probable that both he and his brother have inherited the same disorder, presenting with chronic progressive cerebellar syndrome as well as a predominantly sensory axonal neuropathy, that has a sensory and a motor component. Further investigations remain possible.

The Appellant's case

The Appellant made the following main points:

- The Appellant is a Vietnam veteran with peripheral neuropathy. Peripheral neuropathy appears on the presumptive list so should be accepted as service-related.
- Veterans' Affairs has not applied the principle of benevolence.
- Too much emphasis has been placed on the possibility that the Appellant's peripheral neuropathy is familial.
- The Appellant's peripheral neuropathy may be due to high doses of the Dapsone used to treat his malaria.
- The Appellant is a man who would rather not know what was wrong with him.
- Both parties to the appeal had agreed in principle that the Appellant has symptoms that would be consistent with a peripheral neuropathy as defined within the SOP.
- The definition of peripheral neuropathy within the SOP is consistent with a broadly accepted clinical definition encompassing all peripheral neuropathies, so Veterans' Affairs should have accepted the Appellant's peripheral neuropathy as service-related.
- The Memorandum of Understanding[2] requires the reverse onus of proof for veterans; a condition suffered by a veteran is deemed to be service-related unless there is proof to the contrary. Veterans' Affairs has no proof that the Appellant's peripheral neuropathy was not caused by his service in Vietnam.
- Peripheral neuropathy is presumptively related to exposure to Agent Orange or toxic herbicides and no proof of this relationship as a cause is required by the current law.
- In the 1960s, 70s and 80s the medical establishment did not have the clinical knowledge to diagnose, treat or recognise the symptoms of peripheral neuropathy. The symptoms were often misdiagnosed as symptoms of other medical issues, dismissed or ignored and not recorded. Little research was available regarding the effects of Agent Orange on veterans during their service.
- *Presumptive Service Connection and Disability Compensation*, Congressional Service Report 7- 5700 R41405 of 18 November 2014, shows the serious problems of historical fact relating to the "early onset" rule as applied under US Veterans Administration (VA) law, specifically for peripheral neuropathy. This is a "bogus" requirement that stands in the face of the facts, not the least of which is that the medical establishment, during the years of and following the Vietnam War, could not recognise the symptoms of peripheral neuropathy let alone at the 10% disabling level required by VA law since 2010.
- Dr Wright's opinion is not enough to satisfy the reverse onus of proof.
- Dr Wright is preoccupied with the idea that both the Appellant and his brother have familial peripheral neuropathy when there is no definitive evidence to support this. He even states

[2] On 6 December 2006 a Memorandum of Understanding was signed between the Crown and organisations representing Vietnam veterans (the Ex-Vietnam Veterans Services Association and the Royal New Zealand Returned and Services' Association) to guide New Zealand's treatment of veterans.

that the Appellant's brother's whole exome genetic study cannot meaningfully be used for diagnostic interpretation.

- Dr Wright was mistaken; the Appellant's brother did not serve in Vietnam. Both had taken Dapsone medication.

Veterans' Affairs case

The Respondent made the following main points:

- The decision not to apply section 21 of the Act was correct. The list of conclusively presumed conditions for Vietnam veterans associated with exposure to dioxin and chemical defoliants (Agent Orange)[3] includes acute or subacute peripheral neuropathy. It does not include all causes of peripheral neuropathy.
- It is regrettable that peripheral neuropathy is not further clarified with a definition within the Veteran's Support Regulations 2014 (**the Regulations**). The terms "acute" and "subacute" are well-defined medical terms. The *Oxford Concise Medical Dictionary* (Eighth Edition, 2010) defines these terms as follows:

  "acute" as "a disease of rapid onset, severe symptoms, and brief duration";

  "subacute" as "a disease that progresses more rapidly than a chronic condition but does not become acute"; and

  "chronic" as describing "a disease of long duration involving very slow changes. Such a disease is often of gradual onset".
- The onset of neurological symptoms related to exposure to Agent Orange is known to occur soon (within weeks to months) after the exposure to the chemicals and was initially thought to be of relatively short duration (less than two years).
- The Appellant's symptoms are first described three decades after the last potential exposure to Agent Orange and could not reasonably be thought to have an acute or subacute onset. The Appellant's late onset peripheral neuropathy cannot be considered a conclusively presumed condition.
- The decision to decline the claim under section 14 of the Act was correct. The Review Officer acknowledged the diagnosis of peripheral neuropathy and assumed there was a hypothesis of a potential relationship between the Appellant's peripheral neuropathy and his service. He also identified an appropriate SOP (SOP 74/2014 Peripheral Neuropathy). The Appellant's condition is thought by a clinical expert to be familial and therefore genetic in origin. That evidence includes the shared symptoms with the Appellant's brother, the similarities in the EMG findings between the Appellant and his brother, and the presence of a possible gene associated with abnormalities in myelination in the Appellant's brother's genetic screen.
- There was no evidence supporting the presence of any of the described factors within the associated SOP, specifically a relationship to treatment with Dapsone. The factor relating Dapsone to service requires the consumption of Dapsone at the time of clinical onset. The

[3] Veterans' Support Regulations 2014 reg 13.

Appellant's cessation of Dapsone predates the onset of symptoms by more than 20 years. Dapsone has been discounted as a causative agent by the specialist.

- In the absence of a service-related factor and with the possibility of hereditary or familial peripheral neuropathy, the Appellant's claim was declined in accordance with section 14.
- At the time of writing the written submissions, the Respondent did not dispute that the Appellant had peripheral neuropathy but noted the inclusion of only acute or subacute peripheral neuropathy in the list of conclusively presumed conditions.
- In keeping with the findings of Dr Wright the specialist neurologist, rather than suffering from a primary peripheral neuropathy, the Appellant is suffering from a complex neurological syndrome affecting both the central and peripheral nervous systems, characterised principally by a profound cerebellar ataxia, against which peripheral neuropathy should be considered a syndromic component rather than a unifying diagnosis itself. Further, given the clinical similarities with his brother's presentation, this would most likely represent a familial rather than an acquired condition.

Analysis

In considering this appeal, the Board has had specific regard to all the principles specified in section 10(b) of the Act, and the overarching benevolent intent of the Act.

Does the Appellant have a condition that is presumed to be service-related?

Section 21 of the Act provides that, in the context of particular prescribed operational service, certain prescribed injuries, illnesses and conditions are conclusively presumed to be service-related.

Regulation 13 of the Regulations contains a list of conclusively presumed conditions associated with exposure to chemical defoliants used during the Vietnam conflict. This list includes acute and subacute peripheral neuropathy.

Neither the Act nor the Regulations define acute or subacute peripheral neuropathy.

Any provision in an enactment must be interpreted in the light of its context and the purpose of the enactment as a whole.[4]

The Respondent provided the background to the list of conclusively presumed conditions for Vietnam service. It was created after the Vietnam Veterans' Memorandum of Understanding was signed in 2006 in order to ease the process for Agent Orange-related claims. The list was derived from an identical list created for that purpose by the US Veterans Administration (**VA**) in 1994. The VA list was created and maintained on the basis of reviews of the global literature by the US Institute of Medicine, first in 1994 and on a biennial basis thereafter. A second review published in 1996 determined that there was "some evidence to suggest that neuropathy of acute or subacute onset may be associated with herbicide exposure" and the VA list subsequently included "acute or subacute peripheral neuropathy", which it defined as a peripheral neuropathy occurring within 12 months of exposure to Agent Orange, resulting in at least 10% impairment and resolving within 24 months.

[4] Legislation Act 2019 s 10(1).

This definition remained in place until about 2012. After the 2010 update determined that there was some evidence to support the possibility that acute or subacute onset peripheral neuropathies could persist beyond two years, the VA presumptive list was altered to remove "acute or subacute" peripheral neuropathy and replace it with "early onset" peripheral neuropathy. The VA redefined it as a peripheral neuropathy occurring within 12 months of exposure to Agent Orange, resulting in at least 10% impairment.

Despite the evolution of the foundational list, the list of presumptive conditions used by Veterans' Affairs has never included a definition of the condition, nor has it been amended to reflect the subsequent research or changes in VA descriptors. Unfortunately, the list was subsequently translated into the Regulations in 2014, in the absence of any such definition or modification.

The Respondent points to the *Oxford Concise Medical Dictionary* (8th ed, 2010) for the medical definition of "acute" and "subacute". This points to a temporal relationship between exposure and onset of symptoms. The Appeal Board accepts the need for a temporal relationship.

The Appeal Board accepts that the Appellant was directly exposed to Agent Orange during his operational service. He gave a history of being sprayed with Agent Orange. The Appeal Board also accepts Mrs [redacted]'s evidence of the Appellant complaining of paraesthesia in his digits in the 1970s after returning from Vietnam.

The Appeal Board accepts that the Appellant has peripheral neuropathy. The medical evidence from Dr Wright, the treating Neurologist, is that the Appellant does not have an acute or subacute peripheral neuropathy, but has a chronic peripheral neuropathy. Dr Wright has also diagnosed a cerebellar ataxia (which the Appellant appears to share with his brother). Dr Wright is unclear whether the two are part of a syndrome or are co-existing conditions. Dr Wright is an experienced neurologist and reached his view on diagnosis after examining the Appellant, considering his medical history, understanding the onset of symptoms including evidence from both the Appellant and his wife, reviewing a CT scan and EMG test results as well as a genetic study of the Appellant's brother.

The Appeal Board accepts that Dr Wright's opinion is reliable in what is a complex area of medicine. The error he initially made in referring to the Appellant's brother serving in Vietnam is not material. Dr Wright has diagnosed the Appellant's condition. The Appellant's presentation has clinical similarities with that of his brother, which suggests a familial rather than an acquired condition.

The Appeal Board finds that Veterans' Affairs was correct not to provide cover under section 21. The Appellant has not been diagnosed with a condition on the presumptive list. The Appeal Board has sympathy for the argument that the law is out of date but must apply the law as it stands.

Does the Appellant have a condition that is service-related because a factor in an SOP is met?

Section 14 of the Act sets out the sequential steps to be taken in deciding whether to accept a claim for conditions that are not on the presumptive list. The first step is to consider all the available material that is relevant and decide whether the material is consistent with a hypothesis that the veteran's injury, illness, or death was service-related. If the material is

consistent with such a hypothesis, then the second step is to decide whether there is a SOP that applies. If there is no SOP that applies, then section 15 applies. If there is a SOP that applies, the third step is to decide whether the hypothesis is consistent with the SOP. If it is consistent with the SOP, the claim must be accepted unless there are reasonable grounds for believing that the veteran's injury, illness, or death was not service-related.

The Appellant has qualifying operational service under the Act.

The Respondent initially identified that the relevant SOP is SOP 74/2014 Peripheral Neuropathy.

The Respondent has submitted that, based on the further evidence from Dr Wright, the Appellant does not have peripheral neuropathy. The Appeal Board takes a more benevolent view of the medical evidence. That evidence does not exclude the possibility that the Appellant may have chronic peripheral neuropathy. In terms of section 14(2)(b) of the Act, it is consistent with a hypothesis that he does have that condition. In those circumstances, the principle of benevolence impels the Appeal Board to find that he does.

As a consequence of this finding, the Appeal Board has considered whether the Appellant's circumstances satisfy a factor in the SOP, such that it can be said there is a reasonable hypothesis that his peripheral neuropathy is service-related.

The Appeal Board finds that the only factor which potentially applies is the factor prescribed in paragraph 6(u) of the SOP. That paragraph prescribes that a reasonable hypothesis may be raised connecting peripheral neuropathy with the circumstances of a veteran's relevant service if, as a minimum, the veteran was being treated with a drug from Specified List 1, for a condition for which the drug could not be ceased or substituted, at the time of the clinical onset of peripheral neuropathy. Dapsone is one of the drugs on Specified List 1.

The Appeal Board accepts Dr Johnston's evidence that the Appellant was treated with dapsone over a seven-year period after contracting malaria when in Malaya in 1965, 1967 and 1968. There is evidence in the Appellant's medical file that confirms he was treated with dapsone on 31 October 1968. There are other references to chloroquine and quinine but no other references to dapsone. However, the Appeal Board notes that military medical files from the 1960s are notoriously incomplete, especially if they were being maintained in an operational theatre. As a consequence, applying the principle of benevolence, the Appeal Board accepts the evidence of Dr Johnston, which we note he obtained from Mrs [redacted] at a time when she could not have been aware of the significance of the information she was providing.

It follows from this that the Appeal Board cannot rule out the possibility that the Appellant was still taking dapsone at or around the time of his paraesthesia onset in the early 1970s in Christchurch. The Appeal Board accepts that these symptoms are consistent with the early onset of chronic peripheral neuropathy.

The medical evidence from Dr Wright is that dapsone-related peripheral neuropathy is a "poor fit for the Appellant's presentation". The Appeal Board understands that this is because his peripheral neuropathy is sensory whereas the subtle onset of a dapsone-related peripheral neuropathy is usually motor peripheral neuropathy. However, when section 14 of the Act is read together with regulation 15(2) of the Regulations, it is clear that the question for the Appeal Board in the case of a veteran with qualifying operational service is not whether it is

more likely than not that the veteran's condition is service-related,[5] but whether there is a reasonable hypothesis that it *might be*.

Applying this test to the evidence before it, and taking full account of the principle of benevolence, the Appeal Board finds that the factor prescribed by paragraph 6(u) of the SOP is satisfied and, accordingly, there is a reasonable hypothesis that the Appellant has a peripheral neuropathy which is service-related.

Under section 14, the claim must be accepted unless there are reasonable grounds for believing that the veteran's illness was not service-related. While the Appeal Board acknowledges the diagnosis is uncertain and the presentation not typical, the Appeal Board finds that does not amount to a reasonable ground to believe the Appellant's peripheral neuropathy was not service-related.

The Appeal Board revokes the Review Officer's decision

The Appeal Board revokes the 10 August 2020 decision of the Review Officer, to decline to accept the condition of peripheral neuropathy as being service-related. The Appeal substitutes its decision for that of the Review Officer; namely that the Appellant has a condition of peripheral neuropathy which must be accepted as service-related.

Ms Raewyn Anderson, Chairperson

Mr Christopher Griggs, Member

Dr Deborah Read, Member

Dr Chris Holdaway, Member

Date: 10 December 2021

[5] That is the balance of probabilities standard which applies to veterans with qualifying routine service: reg 15(3) of the Veterans' Support Regulations.