DEPARTMENT OF HOMELAND SECURITY
BOARD FOR CORRECTION OF MILITARY RECORDS

Application for Correction of
the Coast Guard Record of:

BCMR Docket No. 2017-220

[redacted]
RD2/E-5 (former)

FINAL DECISION

This proceeding was conducted under the provisions of s10 U.S.C. § 1552 and 14 U.S.C. § 425. After receiving the applicant's completed application, including her military and medical records, the Chair docketed the case on July 13, 2017, and prepared the decision for the Board as required by 33 C.F.R. § 52.61(c).

This final decision, dated March 8, 2019, is approved and signed by the three duly appointed members who were designated to serve as the Board in this case.

APPLICANT'S REQUEST AND ALLEGATIONS

The applicant is a former radioman, second class (RD2/E-5) who served on active duty in the Coast Guard from August 1984 to November 1994, when she was placed on the temporary disabled retired list (TDRL).[1] She asked the Board to correct her record to show that she was permanently medically retired[2] with at least a 70% disability rating when her time on the TDRL ended in 1999, instead of being medically discharged with a 20% rating and severance pay.[3]

The applicant stated that she understands that her Coast Guard disability rating is based on her condition at the time and that "any subsequent changes full under the auspices of the DVA [Department of Veterans Affairs]." However, her medical condition was extremely rare, and the members of her Coast Guard medical board "may not have rated such a case before." She explained that in October 1992,

> I was diagnosed with a malignant fibrous histiocytoma, soft tissue sarcoma tumor, under my left arm. I underwent chemotherapy, radiation, and finally resection in March of '94. Lymph nodes, a

[1] Active duty members may be temporarily retired and placed on the TDRL for up to five years due to a disability incurred in the line of duty that may be permanent but "is not determined to be of a permanent nature and stable." 10 U.S.C. §§ 1202, 1210.
[2] Active duty members may be permanently retired due to disability incurred in the line of duty if they have at least 20 years of service or if the disability is rated at least 30%. 10 U.S.C. § 1201.
[3] Active duty members may be separated with severance pay due to a disability incurred in the line of duty that is rated less than 30%. 10 U.S.C. § 1203.

> portion of main artery, and some muscle were removed. My latissimus dorsi and pectoralis major muscles were cut and reconfigured, nerves in my left arm were severed, and a 4" x 8" skin graft was taken from my leg and mended under my arm. The tumor was the size of a grapefruit and 1.5" of surrounding tissue was removed with the tumor. To this day, I have limited range of motion, nerve damage, and numbness or lack of feeling in and around my left arm.

The applicant stated that, after her cancer went into remission, she was medically discharged from the TDRL with severance pay and so has received no retired pay or benefits. She stated that she appealed this decision of the Central Physical Evaluation Board (CPEB) and appeared in person at a hearing before the Formal Physical Evaluation Board (FPEB) only to be told that she was denied retirement because her condition "did not fit into a category that deems retirement." But she has suffered "with lifetime tingling, swelling, and range of motion limitations of my left arm." She stated that she believes that the PEB's decision was based on a limited understanding of her condition and that she should have been retired with a disability rating similar to the one assigned by the DVA.

The applicant stated that she did not apply to the BCMR sooner because she was unaware of this avenue of appeal, and she asked the Board to reevaluate her entitlement to a medical retirement. To support her request, the applicant submitted copies of her records, which are included in the summary below.

SUMMARY OF THE RECORD

The applicant enlisted in the Coast Guard on August 13, 1984, and indicated on her pre-enlistment Report of Medical History that she was right-handed. After recruit training, she earned the radioman (RD) rating, and she advanced to RD2/E-5 in 1991.

On March 30, 1994, the applicant had a malignant tumor removed from her left axilla.[4] On May 6, 1994, the surgeon reported that the surgery—

> included en bloc mass resection with axillary lymph node dissection, resection of the latissimus dorsi muscle, lateral portion of the pectoralis major and minor muscles, complete resection of the serratus anterior, tares major, and subscapularis muscles. The axillary vein was adherent to the pseudocapsule and was sacrificed. A small margin of areolar tissue was present between the pseudocapsule of the tumor and the axillary artery and brachial plexus. The tumor was penetrating the serratus anterior muscle, but did not penetrate through this muscle and an adequate fascial plane was obtained between this and the lateral chest wall. … Postoperatively she did extremely well, the skin graft and myogenous flaps were 100% viable, and wound had healed without complications. She was begun on physical therapy and subsequently discharged to convalescent leave. … She has demonstrated a slow steady progression in the range of motion of the left shoulder, and the distal arm is neurologically intact. She has had significant lymphedema of the left arm, has required gradient compression stocking to control the lymphedema

On November 4, 1994, following evaluations by a Medical Board and Physical Evaluation Board, the applicant was placed on the TDRL with a 100% disability rating due to a "Stage IV-A

[4] The axilla is "the pyramidal region between the upper thoracic wall and the upper limb." DORLAND'S ILLUSTRATED MEDICAL DICTIONARY, 32nd Ed., p. 185.

Pleomorphic Malignant Fibrohistiocytoma of the Left Axilla – Rated Analogous to Lympho-granulomatous (Hodgkin's Disease)."[5]

At a periodic TDRL evaluation on November 26, 1996, an Air Force surgical oncologist reported that after her surgery the applicant—

> had limited range of motion in the left arm, with a significant left arm lymphedema [swelling]. She was placed in a compressive stocking and underwent an extensive course of rehabilitation. Her distal left upper extremity was neurovascularly intact. By September 1995, a fair portion of her disability had resolved. Her lymphedema had resolved, her range of motion had markedly increased, still being limited to complete extension overhead secondary to scar contracture. She had the expected weakness of latissimus and infraspinatus muscles….
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> PHYSICAL EXAMINATION: On original presentation she had an approximately 10 cm left axillary mass with fixation to skin and chest wall musculature, but without overt neurological deficit of the left upper extremity. The rest of her physical examination at the time was essentially within normal limits. … Demonstrated well healed surgical scars and skin graft with slight scar contracture in the left axilla. The left arm range of motion was limited to a full overhead extension by approximately 10 degrees. The distal arm was neurovascularly intact, the only noticeable disability is on posterior extension and adduction of the shoulder.
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> WORLD WIDE DUTY QUALIFICATIONS: The patient is fully independent and capable of performing normal daily activities. However, she does have significant weakness of extension of the left shoulder which would limit her ability to climb and she has some decreased range of motion. She has no lymphedema of that shoulder, but with strenuous exercise this could return to be a difficult problem for her. … She will require close follow-up … Given limitations and requirements for follow-up, I do not feel that this individual is world wide qualified.
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> CURRENT PROFILE: Unlimited profile except for no strenuous activity with the left upper extremity.
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> FINAL DIAGNOSIS/RECOMMENDATIONS: Stage IV-A (G3-T2-N1-M0) pleomorphic malignant fibrohistiocytoma of the left axilla, status post combined modality therapy, disease free at this point. The patient will require continuous follow-up as noted above, but requires no additional therapy at this point.

At a periodic TDRL evaluation on December 31, 1997, an Air Force hematologist and oncologist reported that the applicant's cancer was in "complete remission" but she had—

> residual numbness in the left axillary region. She has full function of her left upper extremity from the elbow down, but at the shoulder she has limited range of motion due to weakness secondary to surgical changes. The patient currently has an excellent performance status and works full time without limitation in her job as a UPS supervisor. … EXTREMITIES: … The left upper extremity at the axillary region and upper thorax demonstrates skin and soft tissue defect due to prior surgery. There are no suspicious nodules. All suture lines are well healed. … The highest risk of relapse is in the first two years after therapy. However, due to high risk features of her tumor, she should continue follow-up indefinitely … .

[5] VASRD Code 5329, at 38 C.F.R. § 4.74 (1999), states that a soft-tissue sarcoma of muscle, fat, or fibrous connective tissue receives a 100% rating for at least 6 months following surgery, after which "if there has been no local recurrence or metastases, the rating will be made on residuals."

At her final TDRL evaluation on March 10, 1999, the Air Force hematologist and oncologist reported that the applicant was—

> in complete remission with primary therapy and has been followed since March 1994 with no evidence of disease. The patient's last TDRL evaluation was in December 1997 and the patient has had no problems since. The patient does report residual numbness in the left axillary region. She has limited range of motion of the shoulder joint due to weakness due to surgical changes. While she enjoys an excellent performance status, she is unable to use her left arm to reach above her head. … EXTREMITIES: No edema [swelling]. The right upper extremity is normal. The left upper extremity demonstrates skin and soft tissue defect due to prior surgery. There is limited abduction of the arm greater than 135 degrees. There are no suspicious nodules. All suture lines are well healed. … Due to the irreversible loss of function of her left upper extremity, I do not believe that the patient will be able to return to full active duty.

On April 29, 1999, the Coast Guard convened a CPEB to review the records and assess the applicant's fitness for duty. The CPEB diagnosed her with "Sarcoma, soft tissue, residual impairment rated as muscle injuries; the left shoulder girdle and arm; Group I: Moderate," pursuant to codes 5329 and 5301 of the Veterans Affairs Schedule for Rating Disabilities (VASRD), and recommended that her left shoulder disability receive a 10% disability rating.[6]

On May 12, 1999, after consulting her assigned counsel, the applicant rejected the recommendation of the CPEB and demanded a hearing before an FPEB.

At a hearing on August 10, 1999, at which the applicant was present and represented by counsel, the FPEB diagnosed her with "Sarcoma, soft tissue, rated as Group I function: Non-dominant left shoulder girdle and arm; Moderately severe." The FPEB therefore recommended that she be discharged with a 20% disability rating and severance pay. Also on August 10, 1999, the applicant signed a statement indicating that she would not rebut the findings and recommendation of the FPEB. Commander, Personnel Command approved the FPEB's recommendation on August 23, 1999, and directed that the applicant be removed from the TDRL and discharged with severance pay. She was discharged from the TDRL with severance pay on September 2, 1999.

VIEWS OF THE COAST GUARD

On December 5, 2017, a judge advocate (JAG) submitted an advisory opinion recommending that the Board deny relief in this case. The JAG stated that unlike the DVA, the FPEB rates only "duty-disqualifying disabilities" and that not all service-connected disabilities are duty-disqualifying. The JAG stated that the 70% rating of the DVA "is not evidence that the 20% rating determined by the FPEB is in error as they are different evaluations." The JAG also submitted a memorandum on the case signed by Commander, Personnel Service Center (PSC).

PSC noted that the application was not timely filed. With respect to the merits, PSC stated that during the applicant's final TDRL examination, she was found to be in complete remission and so in accordance with regulations, she was rated on her residual disability. After the CPEB initially rated her residual muscle injury as moderate and assigned a 10% rating, the FPEB found

[6] VASRD Code 5329, at 38 C.F.R. § 4.74 (1999), states that a soft-tissue sarcoma of muscle, fat, or fibrous connective tissue receives a 100% rating for at least 6 months following surgery, after which "if there has been no local recurrence or metastases, the rating will be made on residuals."

that her muscle injury was moderately severe and assigned a 20% rating. Therefore, in accordance with 10 U.S.C. § 1203 she was discharged with severance pay.

PSC stated that the applicant received due process, including representation by counsel and a full and fair hearing before the FPEB, as provided by the Physical Disability Evaluation System (PDES). PSC concluded that she has not shown that the approved recommendation of the FPEB in 1999 was erroneous or unjust.

APPLICANT'S RESPONSE TO THE COAST GUARD'S VIEWS

On December 8, 2017, the Chair sent a copy of the Coast Guard's advisory opinion to the applicant and invited her to submit a written response within thirty days. The applicant was granted extensions of the time to respond and submitted significant new medical evidence:

- In a letter dated April 19, 2018, the surgical oncologist who resected the applicant's tumor in 1994 described the surgery and stated the following:

> The extent of her surgery and treatment would cause permanent changes to her shoulder function. This is much more extensive than a mastectomy. … I have not seen or treated her since her separation and was not involved with any of the subsequent disability boards. … [Her] left shoulder function will always be abnormal. Range of motion in all directions will have significant limitations, some severe. She will have proximal arm weakness and a winged scapula greatly affecting her ability to push, climb, and reach overhead. The distal arm and hand should function well, but lymphedema will always be a threat, and will vary depending on activity and other factors. … She worked hard in therapy to maximize her function after treatment, always had a positive outlook, and may have minimized her limitations during her evaluation for the FPEB. … I have no experience dealing with the FPEB or the specifications to determine percentage ratings. I do deal with these major oncological resections all the time, and in civilian life many people after a similar illness and treatment would be considered permanently disabled, not working, and receiving assistance. Hopefully we can support our service members in a similar fashion if they become ill or injured while sacrificing for our country.

- In a letter dated April 18, 2018, an FAA Aviation Medical Examiner who has "reviewed her medical history and evaluated her on several occasions" and has "presided over numerous Medical Boards" stated that the applicant—

> was rated correctly for loss of shoulder abduction for which she was found not fit for duty and separated from the USCG. … However, after a review of her medical records at her request, I believe that her functional limitation was more severe at the time of her separation than mere loss of abduction. The TDRL examination (1996) reported "Significant weakness of extension" which would limit her climbing ladders, a requirement for full duty, but which does not involve abduction. She was reported to have significant loss of internal rotation as well. She was also found not fit for duty due to lymphedema in her left arm, an inevitable consequence of her surgery which included removal of the large axillary vein.
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> I ask that your BCMR take a closer look at the massive debridement which resulted in her unfitness for duty (1) due to weakness and reduced range of motion in all planes, and also (2) due to "lymphedema of her left arms," (as noted in her narrative summary) in part due to excision of the axillary vein and significant axillary dissection.

> Please consider if her debridement might be more appropriately rated, via VASRD paragraph 4.20 Analagous Ratings, using the rating code 7626 for those massive debridements which occur secondary to mastectomy, surgery which removes those very muscles (pectoralis major and minor, and serratus anterior) listed in 7626. Consider that the narrative summary of her FPEB states that she is not fit for duty also due to the lymphedema subsequent to the massive axillary and chest wall dissection, which would be addressed under this code. …
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> [The applicant's] initial evaluation and subsequent separation may not have reflected the true nature of her limitation as it was *at the time of her separation*, so I ask the BCMR to look very closely again to ensure that we have done the right thing for this young servicewoman.

The applicant stated that the VASRD code used by the CPEB and FPEB, 5301 Group I, does not address her residual disabilities. She noted that the muscles that were cut during her surgery are not all listed under 5301 Group I. She stated that she should have received a 20% rating under VASRD code 5201,[7] which concerns ankyolosis and joint disabilities, and she submitted a photograph showing how her ability to raising her left arm differs significantly from her ability to raise her right arm. She stated that she also should have received ratings under codes 5302 and 5304 for muscles injuries of the shoulder girdle and arm because "most of the muscles that were resected are listed" under 5302, Group II, and the inward rotation of her arm "has been an issue since the surgery," which is addressed in 5304, Group IV. She stated that the surgery's impact on her muscles was similar to the impact of a radical mastectomy, which is rated under VASRD code 7626,[8] and she also has substantial scarring from her skin graft.

The applicant stated that the DVA "performed a full examination, including all ranges of motion and assigned a 70% disability" rating. She alleged that the doctor who conducted her TDRL examination did not address her range of motion or any other issues. At that time, she was cancer-free and felt good, but ever since then she has been dealing with—

> the loss of several ranges of motion, complete loss of major muscles, loss of an axillary vein, disfigurement, and complete loss of lymph nodes under my left arm. Because my arm continues to have lymphedema (swelling), I can no longer play sports comfortably such as softball, volleyball, surfing, jogging, etc. With the loss of my lymph nodes, I have to pay particular attention when I scratch or injure my arm to protect against infection.

APPLICABLE LAW AND POLICY

Coast Guard Medical Manual (COMDTINST M6000.1B)

The Medical Manual provides the physical standards that members must meet to be retained on active duty. Chapter 3-F-12(a)(2) and Exhibit 1 state that to be fit for duty, members needed to be able to raise their arms, straightened, 90 degrees (parallel to the floor) in front of them ("flexion") and 90 degrees to the side ("abduction").

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[7] VASRD code 5201, at 38 C.F.R. § 4.71, which concerns ankyolosis (joint deformity) and other joint disabilities. Under code 5201, ankyloses or another joint injury that limits the motion of the arm to shoulder level is rated at 20%.
[8] VASRD code 7626, at 38 C.F.R.§ 4.116, provides that the removal of the mammary glands of one side is rated as 30% disabling if there is no removal of the axillary glands; 40% disabling if the axillary glands are removed; and 50% disabling if there is extensive damage to the muscles and nerves.

VASRD

The VASRD in effect in 1999, at 38 C.F.R. § 4.10, "Functional Impairment," states that the "basis of disability evaluations is the ability of the body as a whole, or of the psyche, or of a system or organ of the body to function under the ordinary conditions of daily life including employment."

Pursuant to 38 C.F.R. § 4.14, evaluating the same disability under more than one diagnosis or VASRD code, known as "pyramiding," must be avoided. "Disability from injuries to the muscles, nerves, and joints of an extremity may overlap to a great extent. … the evaluation of the same manifestation under different diagnoses are to be avoided."

According to 38 C.F.R. § 4.40, "Functional loss," a disability of the musculoskeletal system "is primarily the inability, due to damage or infection in parts of the system, to perform the normal working movements of the body with normal excursion, strength, speed, coordination, and endurance. … the functional loss may be due to absence of part, or all, of the necessary bones, joints and muscles, or associated structures, or to deformity, adhesions, defective innervation, or other pathology, … Weakness is as important as limitation of motion."

Under 38 C.F.R. § 4.56, with regard to muscle injury disabilities,

- "slight" means "slight, if any, evidence of fascial defect or of atrophy or of impaired tonus. No significant impairment of function";
- "moderate" means "signs of moderate loss of deep fascia or muscle substance or impairment of muscle tonus, and of definite weakness or fatigue in comparative tests";
- "moderately severe" means "moderate loss of deep fascia, or moderate loss of muscle substance or moderate loss of normal firm resistance of muscles compared with sound side. Tests of strength and endurance of muscle groups involved (compared with sound side) give positive evidence of marked or moderately severe loss"; and
- "severe" means "moderate or extensive loss of deep fascia or of muscle substance. … Muscles do not swell and harden normally in contraction. Tests of strength or endurance compared with the sound side or of coordinated movements show positive evidence of severe impairment of function."

According to 38 C.F.R. § 4.55(g), "Muscle injury ratings will not be combined with peripheral nerve paralysis ratings for the same part, unless affecting entirely different functions."

Possible ratings for muscle injuries of the shoulder girdle and arm are listed at 38 C.F.R. § 4.73. The available ratings for these disabilities depend upon whether the shoulder of the dominant hand/arm or non-dominant hand/arm is injured. Because the applicant is right-handed and sustained injuries to the muscles in her left shoulder, only ratings for injuries to the non-dominant side are included here:

- **5301, Group I,** addresses the function of rotating the scapula upward and elevating the arm above shoulder level. The muscles listed as being involved in this motion are the

trapezius, levator scapulae, and serratus magnus. The authorized ratings for injuries to the muscles with this function on the non-dominant side are 0% for slight, 10% for moderate, 20% for moderately severe, and 30% for severe.

- **5302, Group II**, addresses the function of lowering ones arms from vertical to hanging at the side. The muscles listed as being involved in this motion are the pectoralis major II, latissimus dorsi and teres major, pectoralis minor, and rhomboid, as well as swinging the arms back and forth. The authorized ratings for injuries to the muscles with this function on the non-dominant side are 0% for slight, 20% for moderate, 20% for moderately severe, and 30% for severe.
- **5303, Group III**, addresses the function of elevating (to the front) and abducting (to the side) the arm to the level the shoulder (parallel to the ground), as well as swinging the arms back and forth. The muscles listed as being involved in this motion are the pectoralis major I and deltoid. The authorized ratings for injuries to the muscles with this function on the non-dominant side are 0% for slight, 10% for moderate, 20% for moderately severe, and 30% for severe.
- **5304, Group IV**, addresses the function of stabilizing the muscles of the shoulder against injury in strong movements, holding the head of the humerus in its socket, abduction, outward rotation, and inward rotation. The muscles listed as being involved in these functions are the supraspinatus, infraspinatus and teres minor, subscapularis, and coracobrachialis. The authorized ratings for injuries to the muscles with this function on the non-dominant side are 0% for slight, 10% for moderate, 20% for moderately severe, and 20% for severe.

FINDINGS AND CONCLUSIONS

The Board makes the following findings and conclusions on the basis of the applicant's military record and submissions, the Coast Guard's submissions, and applicable law:

1. The Board has jurisdiction concerning this matter pursuant to 10 U.S.C. § 1552.

2. An application to the Board must be filed within three years after the applicant discovers the alleged error or injustice.[9] The applicant knew she had been medically discharged with severance pay, instead of medically retired, in 1999. Therefore, the preponderance of the evidence shows that the applicant knew of the alleged error in her record in 1999, and her application is untimely.

3. The Board may excuse the untimeliness of an application if it is in the interest of justice to do so.[10] In *Allen v. Card*, 799 F. Supp. 158 (D.D.C. 1992), the court stated that the Board should not deny an application for untimeliness without "analyz[ing] both the reasons for the delay and the potential merits of the claim based on a cursory review"[11] to determine whether the interest of justice supports a waiver of the statute of limitations. The court noted that "the longer the delay

[9] 10 U.S.C. § 1552(b) and 33 C.F.R. § 52.22.
[10] *Id.*
[11] *Allen v. Card*, 799 F. Supp. 158, 164 (D.D.C. 1992).

has been and the weaker the reasons are for the delay, the more compelling the merits would need to be to justify a full review."[12] With respect to these issues, the Board finds as follows:

a. Reasons for Delay: The applicant stated that she was previously unaware of the BCMR. The Board finds that the applicant's explanation for her delay is not compelling because she failed to show that anything prevented her from complaining about the alleged error or injustice and learning about the Board more promptly.

b. Potential Merits of the Claim: The applicant's claims cannot prevail. Although she alleged that she should have received a rating under VASRD code 5201, which applies when the motion of the arm is limited due to a joint deformity or disease,[13] her limitations are due to muscle injuries—not a joint deformity or disease—and pyramiding (assigning more than one VASRD code to a functional disability) must be avoided.[14] Although she alleged that, based on the muscles that were cut and injured during her surgery, she should have received ratings under VASRD codes 5302 and 5304, as well as 5301, disability ratings are not based on the names of muscles damaged during surgery but on actual functional limitations[15] and pyramiding must be avoided.[16] The applicant alleged that her range of motion was not properly measured in 1999,[17] but during her final TDRL examination, the doctor found that she was "unable to use her left arm to reach above her head. … No edema [swelling]. There is limited abduction of the arm greater than 135 degrees." Therefore, her range of motion was clearly tested and measured in 1999 and appropriately rated under VASRD code 5301, which addresses elevation of the arm above the shoulder.[18] And finally, although the applicant and her doctors compared her condition to a radical mastectomy with axillary gland removal and muscle injuries, under VASRD code 7626, a mastectomy by itself—with no axillary gland removal or muscle injuries—receives a 30% rating, and the addition of axillary gland removal and extensive damage to muscles and nerves raises that rating by just 20% to 50%. Therefore, the ratings provided under VASRD code 7626 do not suggest that the applicant's 20% rating for muscle and nerve injuries and axillary gland removal is erroneous or unjust. Moreover, the applicant received all due process in 1999 and appeared before the FPEB, where she could present medical evidence and show and explain all of her functional limitations. The evidence of record does not overcome the presumption of regularity accorded her 20% disability rating[19] or substantiate her claims of error and injustice.

4. Because the applicant has not justified her long delay and her claims cannot prevail, the Board will not excuse the application's untimeliness or waive the statute of limitations. The applicant's request should be denied.

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[12] *Id*. at 164, 165; *see also Dickson v. Secretary of Defense*, 68 F.3d 1396 (D.C. Cir. 1995).
[13] 38 C.F.R. § 4.71 (1999).
[14] 38 C.F.R. § 4.14 (1999) ("Disability from injuries to the muscles, nerves, and joints of an extremity may overlap to a great extent. … the evaluation of the same manifestation under different diagnoses are to be avoided.").
[15] 38 C.F.R. §§ 4.10, 4.40 (1999).
[16] 38 C.F.R. § 4.14 (1999).
[17] The Board notes that applicant's final disability rating from the Coast Guard had to be based on the extent of her disability in 1999, not on previous or subsequent examinations.
[18] 38 C.F.R. § 4.73 (1999).
[19] 33 C.F.R. § 52.24(b); *see Arens v. United States*, 969 F.2d 1034, 1037 (Fed. Cir. 1992) (citing *Sanders v. United States*, 594 F.2d 804, 813 (Ct. Cl. 1979), for the required presumption, absent evidence to the contrary, that Government officials have carried out their duties "correctly, lawfully, and in good faith.").

ORDER

The application of former RD2 [redacted], USCG, for correction of her military record is denied.

March 8, 2019

[redacted]