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UNITED STATES AIR FORCE
BOARD FOR CORRECTION OF MILITARY RECORDS

RECORD OF PROCEEDINGS

IN THE MATTER OF: [redacted]

DOCKET NUMBER: BC-2023-01144

COUNSEL: NONE

HEARING REQUESTED: NO

APPLICANT'S REQUEST

1. His general (under honorable conditions) discharge be upgraded to honorable.

2. His narrative reason for separation of "Misconduct-Pattern Discreditable Involvement with Military or Civil Authorities" be changed.

3. His grade be restored to senior airman (E-4).

APPLICANT'S CONTENTIONS

He suffered a head injury and was told directly after it, he was fine. Eventually he was hospitalized and although the testing psychologist stated head trauma, now known as traumatic brain injury (TBI), the attending psychiatrist decided he was just chronically depressed. He was hospitalized for six months, was picked up by his unit from the hospital, discharged, and brought back to the hospital. Following the hospitalization, the local authority made charges against him involving a "check was dropped." The check problem occurred while he was suffering from the TBI and having a whole part of the day missing from his memory. In the last couple months, he has finally gotten a Department of Veterans Affairs (DVA) psychiatrist who is treating him for TBI, and the prescribed drugs have made him cognitive enough to pursue this correction.

In support of his request for a discharge upgrade, the applicant provides a personal statement, copies of his medical records, and his DD Form 214, *Certificate of Release or Discharge from Active Duty*.

The applicant's complete submission is at Exhibit A.

STATEMENT OF FACTS

The applicant is a former Air Force airman basic (E-1).

Dated 28 Aug 91, AF Form 910, *Enlisted Performance Report*, indicates the applicant's supervisor submitted a referred enlisted performance report describing the applicant's misconduct.

Dated 9 Sep 91, AF Form 3219, *Request for Authorization for Separation*, indicates the applicant's discharge was approved with a service characterization of general (under honorable conditions).

On 10 Sep 91, DD Form 214, provided by the applicant, reflects he received a general (under honorable conditions) discharge, and he was credited 2 years, 8 months, and 13 days of total active service. The narrative reason for separation is "Misconduct – Pattern Discreditable Involvement with Military or Civil Authorities."

For more information, see the excerpt of the applicant's record at Exhibit B and the advisory at Exhibit D.

POST-SERVICE INFORMATION

On 5 Feb 24, the Board sent the applicant a request for post-service information, including a standard criminal history report from the Federal Bureau of Investigation (FBI); however, he has not replied.

APPLICABLE AUTHORITY/GUIDANCE

On 3 Sep 14, the Secretary of Defense issued a memorandum providing guidance to the Military Department Boards for Correction of Military/Naval Records as they carefully consider each petition regarding discharge upgrade requests by veterans claiming PTSD. In addition, time limits to reconsider decisions will be liberally waived for applications covered by this guidance.

On 25 Aug 17, the Under Secretary of Defense for Personnel and Readiness issued clarifying guidance to Discharge Review Boards and Boards for Correction of Military/Naval Records considering requests by veterans for modification of their discharges due in whole or in part to mental health conditions [PTSD, Traumatic Brain Injury (TBI), sexual assault, or sexual harassment]. Liberal consideration will be given to veterans petitioning for discharge relief when the application for relief is based in whole or in part on the aforementioned conditions.

Under Consideration of Mitigating Factors, it is noted that PTSD is not a likely cause of premeditated misconduct. Correction Boards will exercise caution in weighing evidence of mitigation in all cases of misconduct by carefully considering the likely causal relationship of symptoms to the misconduct. Liberal consideration does not mandate an upgrade. Relief may be appropriate, however, for minor misconduct commonly associated with the aforementioned mental health conditions and some significant misconduct sufficiently justified or outweighed by the facts and circumstances.

Boards are directed to consider the following main questions when assessing requests due to mental health conditions including PTSD, TBI, sexual assault, or sexual harassment:

a. Did the veteran have a condition or experience that may excuse or mitigate the discharge?
b. Did that condition exist/experience occur during military service?
c. Does that condition or experience actually excuse or mitigate the discharge?
d. Does that condition or experience outweigh the discharge?

On 25 Jul 18, the Under Secretary of Defense for Personnel and Readiness issued supplemental guidance, known as the Wilkie Memo, to military corrections boards in determining whether relief is warranted based on equity, injustice, or clemency. These standards authorize the board to grant relief in order to ensure fundamental fairness. Clemency refers to relief specifically granted from a criminal sentence and is a part of the broad authority Boards have to ensure fundamental fairness. This guidance applies to more than clemency from sentencing in a court-martial; it also applies to any other corrections, including changes in a discharge, which may be warranted on equity or relief from injustice grounds. This guidance does not mandate relief, but rather provides standards and principles to guide Boards in application of their equitable relief authority. Each case will be assessed on its own merits. The relative weight of each principle and whether the principle supports relief in a particular case, are within the sound discretion of each Board. In determining whether to grant relief on the basis of equity, an injustice, or clemency grounds, the Board should refer to paragraphs 6 and 7 of the Wilkie Memo.

On 5 Feb 24, the Board staff provided the applicant a copy of the liberal consideration guidance (Exhibit C).

Department of the Air Force Instruction (DAFI) 36-3211, *Military Separations*, describes the authorized service characterizations.

Honorable. The quality of the airman's service generally has met Department of the Air Force standards of acceptable conduct and performance of duty or when a member's service is otherwise so meritorious that any other characterization would be inappropriate.

General (Under Honorable Conditions). If an airman's service has been honest and faithful, this characterization is warranted when significant negative aspects of the airman's conduct or performance of duty outweigh positive aspects of the member's military record.

AIR FORCE EVALUATION

The Air Force Review Boards Agency (AFRBA) Psychological Advisor completed a review of all available records and finds insufficient evidence to support the applicant's request for the desired changes to his record. The applicant's military records and his treatment records at the time of service find no report or evidence he sustained a TBI during service. The applicant was referred to a "full personality assessment" during his second inpatient psychiatric treatment at [redacted] Department of Veterans Affairs Medical Center (DVAMC). He was assessed over several days

from Jul to Aug 91. His testing evaluation report stated he was hospitalized because of inappropriate behaviors such as writing a no-account check for a camera he did not need or desire and disassembling the clock of a co-worker while the co-coworker was not in his office. He had only a vague recollection of these events. He attempted suicide following the camera incident. He was also reported to have experienced depression since Jan of that year following the divorce from his wife. His inappropriate behaviors were the reason for his testing referral. There was no report of any TBI causing his memory or behavioral problems or was the reason for his testing referral. The results of his neuropsychological test found there was evidence of cognitive impairment that was likely resulting from a left hemisphere lesion from his lowered verbal memory, concentration, and intelligence, language difficulties, and reading problems. These issues showed evidence of a learning disability as he displayed dyslexia and reading problems and comprehension. His difficulties or problems were not identified to be caused by a TBI. He was also given a diagnosis of Obsessive-Compulsive Personality Disorder with passive-aggressive traits from testing. He was referred to a full neurological examination to rule out the possible left hemisphere lesion and the result, documented in the report dated 6 Sep 91, found negative examination, negative computed tomography (CT) scan, and no symptoms definitely referable to the left hemisphere. In the same neurological consultation report, the neurologist reported, the applicant had no particular problems in the past with head injuries and he never lost consciousness. This report, near or around the time of his alleged TBI, supports the notion he did not have or ever sustained a TBI during service. The neurologist opined he had a final diagnosis of psychosis with no definite evidence of focal brain lesion. He claimed to his DVA provider he was diagnosed with a left hemisphere lesion during service however, this report is not accurate. He was never diagnosed with this condition and a CT scan and other physical examinations had ruled out this hypothesis.

The applicant reported to his providers at the DVA he had sustained a TBI in 1991, but his reports about his experience were somewhat inconsistent. He reported on 5 Apr 01 that in 1991, he fell face first seven to eight feet on concrete, was unconscious for several hours, and had periods of blackouts for the next month. He was informed by others he had been fixing something but had no memory of it. He informed the psychologist during this neurological testing on 15 May 01, he had a loss of consciousness (LOC) for two hours (not several hours) in 1991. Several years later on 6 Jul 22, he reported to a different provider/his current psychiatrist he had fallen seven feet from a bunk bed with his face planted on the floor and started having blackouts. He did not specify he fell from a bunk bed in 2001 and no reports he was fixing something in the bunk bed. There is no evidence or reports of any of these falls at the time of service. There is also no evidence or reports he was unconscious for several hours after falling and/or had experienced recurring blackouts after the fall in any of his military records or treatment records from the DVA during service. There are no records he received any medical or mental health treatment for his fall or head injury during service especially if he was allegedly unconscious for several hours. His reports to his DVA providers years and decades after service were disputed by the aforementioned neurological consult report completed in Sep 91 which stated he denied having any head injuries and never lost consciousness. His DVA providers accepted the applicant's report of sustaining a TBI during service but did not corroborate his report with any past medical records. The applicant had received numerous magnetic resonance imaging (MRIs), CT scans, and electroencephalogram (EEGs) for his complaints of memory problems and TBI over the years

from the DVA and all results were consistent finding no significant cognitive impairment or neurological changes. His MRIs had detected mild atrophy in bilateral parietal convexity with sulcal enlargement and subtle difficulties in the area of cognitive functioning were consistent with frontal lobe dysfunction. There was no report these irregularities were caused by a TBI. Moreover, his neurological examinations performed at the time of service, which was near the time of this alleged TBI, found no evidence of any abnormal examinations on an MRI, CT scan, or EEG. He was never given a diagnosis of a TBI, cognitive disorder, etc. by any of his medical providers, during and after service.

The applicant received neuropsychological testing at least three times after service by the DVA in 2001, 2017, and 2022. His neuropsychological testing in 2001 found he had moderate to severe impairment with auditory reaction time and his visuo-construction abilities were impaired due to his slowed response speed. However, the examiner opined these difficulties were caused by his personality functioning and his anxiety gives rise to increased preoccupation with physical problems and poor cognitive performance. His re-evaluation in 2017 found impairment in auditory attention, which was consistent with his previous test results in 2001. It is also noted; he was diagnosed and is currently treated for attention-deficit/hyperactivity disorder (ADHD) and this condition could cause his auditory attention problems. His detected difficulties identified by testing were not caused by his claimed TBI. More importantly, all his neuropsychological test results performed in 2001, 2017, and 2022 consistently find no evidence of any memory deficiencies, executive functioning dysfunction, or other cognitive impairment issues caused by a TBI. The physician performing his most recent TBI consult on 25 Jan 22 determined a TBI cognitive evaluation was needed and stated a mild TBI usually recovers within the first-year post-injury. This could explain why he had no significant cognitive impairment or deficiencies detected in his test results years after the original TBI if it had occurred. Nevertheless, it does not appear he had a mild TBI because of his reports. Mild TBIs typically include brief alterations of consciousness or LOC for less than 30 minutes and the applicant claimed to his DVA providers he experienced LOC for two hours or several hours, which is more than 30 minutes. The Cleveland Clinic also states, people who have mild TBI can experience confusion for about one day, which is different from difficulties with attention or memory. His memory problems may not be related to a TBI according to this description. Additionally, he contends he had whole parts of the day missing from his memory stemming from his TBI. If this report was true, it would not be considered a mild TBI but a serious one if he had this type of significant memory loss. Again, the applicant did receive neurological testing at least twice during service by the DVA and the results found no cognitive impairment or memory problems caused by a TBI.

The applicant made complaints of memory problems during and after service and was examined and assessed for these complaints accordingly. There were concerns he may have Dissociative Disorder, Dementia, and Schizophrenia causing his memory loss, disorganized thoughts, and unusual behaviors during service, but these conditions were never confirmed. He was given a diagnosis of Brief Reactive Psychosis (now known as Brief Psychotic Disorder) when he was referred to his first hospitalization. He reported hearing voices talking nonsensical things about two days prior to his first hospitalization, but he was also reported to have been stressed, unable to concentrate, and was afraid he was jeopardizing his work due to his financial problems from his

divorce. Being overly stressed and anxious could cause these hallucinations, disorganized thinking, and unusual behaviors. Brief Reactive Psychosis is not the same as Schizophrenia. He was given a diagnosis of Chronic Undifferentiated Schizophrenia by his DVA hospital provider after his military discharge in Nov 91. After this last hospital discharge, there are no records he was given a diagnosis of Schizophrenia. The Psychological Advisor finds it unlikely he had Schizophrenia for this reason. Schizophrenia is a serious mental health condition and if it is chronic as it was specified to be at the time of his last hospital discharge, this condition would not have resolved after his hospital discharge. He had reported he was taken off of antipsychotic medications when he was treated at the Gainesville DVA sometime after his military discharge and there were no reports or records he continued to have psychosis or psychotic symptoms since that time. He appeared to be functioning well and he is stable based on his recent DVA treatment records. His DVA treatment notes dated 29 Mar 17 reported he had been employed as a systems programmer for the Chemistry department at the University of Florida and had been working in the same field for the past 21 years and his most recent visit on 13 Dec 23 reported he is still in the same job. If he had chronic Schizophrenia, he would not be able to have this type of stable employment for this prolonged period of time. Again, when he heard voices, had disorganized thinking, and his behaviors were peculiar during service, he was overly stressed, anxious, and depressed at the time. Stress-induced psychosis may occur and this appeared to be the applicant's experience because he returned to a premorbid level of functioning after his stressors of the military, hospitalization treatment, etc. had dissipated. The applicant does presently carry a diagnosis of major depressive disorder (MDD) with psychotic features that is in remission per his recent treatment notes by his psychiatrist; however, this same psychiatrist reported in his treatment notes on 19 Dec 22 the reason for this diagnosis was he was given MAJ DEP W/PSYCHOTIC FEAT (10 percent service connected) and states psychosis was a result of side effects to medications given to him. This reporting is incorrect. The applicant was never diagnosed with MDD with psychotic features during any of his hospitalizations. He was given diagnoses of adjustment disorder with depressed mood and adjustment reaction with depressed mood during his time in service for depression caused by his divorce, and financial, occupational, and legal problems. These conditions are not the same as MDD with psychotic features. His neuropsychological testing performed by the DVA in Jun 91 while in service stated, test results give little evidence for major mood disorder or psychosis. This finding also supports he does not have MDD with psychotic features. As mentioned, he did display some odd behaviors such as not remembering issuing checks with insufficient funds, not remembering dissembling a coworker's clock, and attempting suicide by injecting air into his veins but these are not the typical psychotic features that would be experienced by an individual with MDD. His psychiatrist again documented his reports and did not corroborate his reports with his objective records. He claims his physician diagnosed him as chronically depressed during service instead of a TBI but there is no evidence to support his contention as discussed. He was also diagnosed with Schizoid and Schizotypal Personality Disorders during service which may explain his odd and eccentric behaviors and some traits of these conditions may resemble psychosis.

There is clear evidence the applicant had a mental health condition requiring at least three hospitalizations during his military service. There were, however, various opinions from different providers regarding the types of mental health conditions or mental disorders he had. The applicant

was noted to be inconsistent with his reporting, underreporting his symptoms, and admitted to one of the hospital providers he had not been forthright with his reporting. These types of reporting make it difficult to assess his true functioning and conditions. Nevertheless, the primary concern is whether his mental health condition could cause, excuse, or mitigate his discharge. The Psychological Advisor cannot determine with a degree of certainty whether his mental health condition could excuse or mitigate his discharge because his discharge paperwork is unavailable and not submitted by the applicant for review. His hospital progress notes stated he had received at least two Article 15s for being absent without leave (AWOL) and issuing a bad check and he had to be escorted to court for legal charges that may be considered felony offenses. He also received Letters of Reprimand for unknown reasons. The applicant claims he had whole parts of his day missing from his memory from the residual effects of a TBI at the time he had check problems. His hospital records stated he wrote a no-account check for a camera he was unable to remember. This is a highly unusual behavior with no actual evidence to support this incident or experience that had occurred. There is no evidence or records to substantiate he had a mental health condition or cognitive issues at the time of his misconduct. Even if he had a mental health condition at the time of his misconduct, his misconduct was serious enough he had to attend court and possibly be charged with a felony and would not mitigate this behavior and misconduct. The charges were eventually dropped but his behaviors were inappropriate, nonetheless. Having a mental health condition may explain his behavior but does not excuse or mitigate his behaviors. This is the only misconduct he addressed and from the available records, he may have had more. His hospital progress notes stated he was AWOL and his military records reflected he received a referral EPR because he failed to pay his debts, disobeyed direct orders from his superiors, and was careless with his social and personal behaviors. He never addressed any of these issues as well and they could be additional reasons for his discharge. He claims he does not remember engaging in his misconduct but not remembering the events does not excuse or mitigate his behaviors or discharge as well. There is no evidence his mental health condition caused any of these reported issues. It is observed from his service treatment records, the applicant had difficulties adjusting to situational stressors, i.e. divorce, financial, legal, and occupational problems causing him to feel depressed. There is ample documentation stating he began to feel depressed after his divorce and this divorce caused him to have significant legal problems including having his car repossessed and being unable to pay his debts. This could be a reason he was issuing bad checks and not because of an unsubstantiated experience of blacking out from a TBI. It was reported he attempted suicide by injecting air into his veins after the camera incident and the stressors or consequences from this incident may have caused his self-harming behaviors. His neuropsychological testing performed in 2001 found his anxiety would increase his poor cognitive performance. This information would support his cognitive and emotional functioning becoming impaired when he is stressed, anxious, or even depressed but again, would signify his emotional distress and cognitive problems were more likely than not caused or developed by the ramifications of his own misconduct. There were no records showing he had misconduct problems prior to these problems. He was diagnosed with Obsessive-Compulsive Personality Disorder during service and individuals with traits of these conditions tend to be preoccupied with perfectionism, organization, and control, and involve anxiety and fear. He continued to display traits of this condition after discharge as detected in his neuropsychological testing in 2001 which continues to cause him difficulties. Since his discharge paperwork is unavailable, the presumption

of regularity is applied and there is no evidence of an error or injustice with his discharge from a mental health perspective. The burden of proof is placed on the applicant to support his contention and request, and the Psychological Advisor finds his contentions and the available records not compelling or sufficient to support his request for the desired changes to his records.

Liberal consideration is applied to the applicant's request due to the contention of a mental health condition. The following are responses to the four questions in the policy based on the available records for review:

1. Did the veteran have a condition or experience that may excuse or mitigate the discharge?
The applicant contends he suffered from a head trauma or TBI and the check problem he had occurred while he was suffering from a TBI causing whole parts of the day missing from his memory. He claims his physician decided he was chronically depressed. He is unable to remember his hospitalization during service and unable to remember his misconduct and disciplinary actions.

2. Did the condition exist or experience occur during military service?
There is no evidence the applicant's TBI had existed or was experienced during his military service and in fact, the neurologic consultation performed during service reported he denied having any head injuries and never lost consciousness. Neurological examinations performed during service found no cognitive impairments or a legion in the left hemisphere of his brain; his CT scan was negative. Neuropsychological evaluations during service found he had a learning disability but no evidence or report his difficulties were caused by a TBI. The applicant was never diagnosed with a TBI by any of his past and present providers. He was evaluated numerous times for complaints he had from his TBI after service and the results found no significant cognitive or memory impairments or deficiencies. He was hospitalized a few times during service for depression, a suicide attempt, and inappropriate behaviors and was diagnosed with adjustment disorder with Depressed Mood, Adjustment Reaction with Depressed Mood, Obsessive-Compulsive Personality Disorder, Schizoid and Schizotypal Personality Disorder, and Brief Reactive Psychosis. There is no evidence he was diagnosed with chronic depression or other types of depressive disorders such as MDD during service.

3. Does the condition or experience excuse or mitigate the discharge?
The applicant's discharge paperwork is not available for review to determine whether his mental health condition may excuse or mitigate his discharge. The available records find no evidence his mental health condition or TBI caused his reported misconduct of writing bad checks, being unable to pay his debts, being AWOL, failing to obey orders, and being careless with his social and personal behaviors. It appeared he developed anxiety and depressed mood in response to his situational stressors of divorce, and financial, legal, and occupational problems, and there are no records he had mental health issues or a TBI prior to his misconduct problems. Since his discharge paperwork is unavailable for review, the presumption of regularity is applied and his mental health condition or TBI does not excuse or mitigate his discharge.

4. Does the condition or experience outweigh the discharge?

Since his mental health condition or TBI does not excuse or mitigate his discharge, his condition or TBI also does not outweigh his original discharge.

The complete advisory opinion is at Exhibit D.

APPLICANT'S REVIEW OF AIR FORCE EVALUATION

The Board sent a copy of the advisory opinion to the applicant on 1 Feb 24 for comment (Exhibit E) but has received no response.

FINDINGS AND CONCLUSION

1. The application was timely filed. Given the requirement for passage of time, all discharge upgrade requests under fundamental fairness or clemency are technically untimely. However, it would be illogical to deny a discharge upgrade application as untimely, since the Board typically looks for over 15 years of good conduct post-service. Therefore, the Board declines to assert the three-year limitation period established by 10 U.S.C. § 1552(b).

2. The applicant exhausted all available non-judicial relief before applying to the Board.

3. After reviewing all Exhibits, the Board concludes the applicant is not the victim of an error or injustice. Since the discharge paperwork is unavailable, the presumption of regularity was applied and the Board finds the discharge was consistent with the substantive requirements of the discharge regulation and was within the commander's discretion. Nor was the discharge or demotion actions unduly harsh or disproportionate to the offenses committed which were egregious in nature. Furthermore, the Board concurs with the rationale of the AFRBA Psychological Advisor and finds a preponderance of the evidence does not substantiate the applicant's contentions. Specifically, the Board finds no evidence he sustained a TBI during service. He was diagnosed with adjustment and personality disorders due to poor cognitive performance but being diagnosed with a mental health disorder does not excuse his behavior as the Board finds his misconduct egregious in nature. Liberal consideration was applied to the applicant's request due to the contention of a mental health condition; however, since there is no evidence his mental health condition had a direct impact on his behaviors and misconduct resulting with his discharge, his condition or experience does not excuse, mitigate, or outweigh his discharge. In the interest of justice, the Board considered upgrading the discharge based on fundamental fairness; however, given the evidence presented, and in the absence of post-service information and a criminal history report, the Board finds no basis to do so. Therefore, the Board recommends against correcting the applicant's records.

The applicant retains the right to request reconsideration of this decision. The applicant may provide post-service evidence depicting his current moral character, occupational, and social advances, in the consideration for an upgrade of discharge characterization due to clemency based on fundamental fairness.

RECOMMENDATION

The Board recommends informing the applicant the evidence did not demonstrate material error or injustice, and the Board will reconsider the application only upon receipt of relevant evidence not already presented.

CERTIFICATION

The following quorum of the Board, as defined in DAFI 36-2603, *Air Force Board for Correction of Military Records (AFBCMR)*, paragraph 2.1, considered Docket Number BC-2023-01144 in Executive Session on 18 Jun 24:

[redacted], Panel Chair
[redacted], Panel Member
[redacted], Panel Member

All members voted against correcting the record. The panel considered the following:

Exhibit A: Application, DD Form 149, w/atchs, dated 6 Apr 23.
Exhibit B: Documentary Evidence, including relevant excerpts from official records.
Exhibit C: Letter, SAF/MRBC, w/atchs (Post-Service Request and Liberal Consideration Guidance), dated 5 Feb 24.
Exhibit D: Advisory Opinion, AFRBA Psychological Advisor, dated, dated 30 Jan 24.
Exhibit E: Notification of Advisory, SAF/MRBC to Applicant, dated 1 Feb 24.

Taken together with all Exhibits, this document constitutes the true and complete Record of Proceedings, as required by DAFI 36-2603, paragraph 4.12.9.

4/18/2025

[redacted]

[redacted]
Board Operations Manager, AFBCMR
Signed by: USAF