ARMY BOARD FOR CORRECTION OF MILITARY RECORDS

RECORD OF PROCEEDINGS

IN THE CASE OF: [redacted]

BOARD DATE: 5 June 2024

DOCKET NUMBER: AR20230010898

APPLICANT REQUESTS: reversal of the denial decision by the Awards and Decorations Branch at the U.S. Army Human Resources Command to award him the Purple Heart (PH).

APPLICANT'S SUPPORTING DOCUMENT(S) CONSIDERED BY THE BOARD:

- DD Form 149 (Application for Correction of Military Record)
- 306-129, 1st Mobilization Brigade, 2 November 2005
- Standard Form (SF) 600 (Chronological Record of Medical Care), 17 June 2006
- 3-page Medical Record, 22 May 2019
- Officer Record Brief (ORB), 2 September 2020
- DD Form 214 (Certificate of Release or Discharge from Active Duty)
- Sworn Statement, MEH, 26 April 2021
- Sworn Statement, GWC, Undated
- Memorandum, U.S. Army Human Resources Command (AHRC), 21 June 2021
- Sworn Statement, Medical Officer JS, 8 July 2021
- Self-Authored Statement, 8 July 2021
- Self-Authored Statement, 21 August 2023
- Partial Department of Veterans Affairs (VA) Rating Decision, undated
- Portion of an Army Times Article, “Justice in Baghdad,” undated

FACTS:

1. The applicant states, in effect:

a. While conducting combat operations in Iraq during Operation Iraqi Freedom (OIF) IV an enemy Vehicle Borne Improvised Explosive Device (VBIED) was detonated on him, wounded him, and caused him permanent damage. He was treated on target and after exfil by a highly trained 18D Special Forces medic (medical professional per Army Regulation 600-8-22 (Military Awards)). The PH was created to recognize those wounded or killed in combat. He was wounded in combat. AHRC Awards and Decorations Branch rejection letter dated 21 June 2021 that is included in the award packet notes that AHRC determined the military medical documentation in the packed he submitted to them did not meet the statutory guidance outlined in Army Regulation

600-8-22, paragraph 2-8. Specifically, since he was treated by a medical professional and not a medical officer, his packet had to contain a letter from a medical officer with a statement that made clear the severity of the wound was such that it would have required treatment by a medical officer if one had been available to provide treatment. This omission has been corrected.

b. He was wounded by the enemy while engaged in combat operations in Iraq on 14 June 2006. He is seeking retroactive award of the PH. On this day during OIF IV, while serving as a Special Forces Assistant Detachment Commander, his unit was executing an emergency search and rescue mission alongside their Iraqi Special Operations Forces (ISOF) partners. They were trying to recover 3 captured American Soldiers IVO Baghdad/Yousafia Iraq. During this operation he was wounded by an enemy VBIED that was detonated on him while he was dismounted and approximately 3 feet from the VBIED. Instantly he was engulfed in a fireball and thrown by the blast wave through the air approximately 20-50 feet and he was peppered with shrapnel all over his body. The wounds he sustained included a traumatic brain injury (TBI) with loss of consciousness (LOC) and 2 lacerations to his right calf. He received initial treatment on target by his 18D Special Forces Medic (medical professional). The initial evaluation was quick and thorough as our element was in contact for a large part of the day. Eventually they had a pitched engagement with the enemy and eliminated the threat. He received follow-on evaluations and treatment from his 18D Special Forces Medic for about a week after they exfiled from the objective. The PH was created for service members that were wounded or killed in combat. He was wounded in combat.

c. Of the wounds he received, the TBI caused permanent damage to his cognitive abilities, he battled the effects of this for the remainder of his career and he will continue to deal with them for the remainder of his life. After overcoming the fear to speak up about what he was dealing with he received treatment and assessments for his TBI from military providers. That treatment culminated with him being a patient at the National Intrepid Center of Excellence (NICoE) at Walter Reed National Military Center. There he worked with specialists on the issues caused by his TBI. The witness statements in this packet and his medical records clearly show that he meets the requirement for being wounded by the enemy while conducting combat operations. His medical records and VA records also make it clear that the effects of his TBI with LOC were permanent and negative.

d. The issue at hand is that the PH packet he submitted did not contain a statement from a medical officer stating that he/she would have treated his wounds had they been on target that day. To address the question of whether a medical officer would have treated him had one been on target, he asks this. If someone were blown up by a car bomb, engulfed by a fireball, thrown through the air, tumbled to the ground unconsciousness and sustained a TBI and lacerations to the leg, do you believe a doctor (medical officer) would provide them with treatment at the point of injury if they

were able to do so? It is important to note that in 2006 there were no TBI protocols at the tactical level. At least none that they knew of or that they were being educated on. TBI's were not part of the vernacular at that time. This was simply referred to as "getting your bell rung" or "getting a concussion" and these issues were not feared or respected like they are today. Bottomline, while conducting combat operations an enemy VBIED was detonated on him, wounded him, and caused him permanent damage. He was treated on target and after exfil by a highly qualified 18D Special Forces medic (medical professional per Army Regulation 600-8-20. This all occurred while he was conducting combat operations in Iraq during OIF IV. The PH was created to recognize those wounded or killed in combat. He was wounded in combat.

2. The applicant retired honorably from the Regular Army in the rank/grade of lieutenant colonel (LTC)/O-5 on 30 September 2020. Evidence shows he served in Afghanistan from 5 March 2017 to 4 April 2017, 22 September 2017 to 21 October 2017, 22 June 2018 to 21 July 2018, 1 September 2018 to 1 December 2018, and 21 January 2019 to 20 April 2019. He also served in Syria from 17 January 2018 to 16 February 2018.

3. The applicant provides a/an:

a. 306-129, 1st Mobilization Brigade, Fort Carson, CO, 2 November 2005, reassigning and/or deploying the applicant in support of OIF effective 2 November 2005.

b. SF 600 dated 17 June 2006, stating the applicant complained of dizziness and disorientation x 3 days, accompanied with loss of sleep after a close proximity explosion during security operations in Baghdad, Iraq. Denies vision disturbance or vomiting, also has lacerations to right calf. Applicant is alert and oriented x 3, cranial nerves intact, tympanic membranes pearly white with cone of light visualized and good reaction under Valsalva, no blood fluid visualized. Pupils are equal, round, and reactive to light and accommodation, vision normal, no physical sign of trauma to head. 2 lacerations evident on right calf approximately 2 centimeters long, not past epidermis, no sign of penetration. Blast injury. Clean wounds, monitor for signs of infection or delayed healing. Monitor for vertigo, seek medical attention if worse or does not improve. Hearing exam, as soon as possible.

c. Medical record, 22 May 2019, consult for intermittent difficulty recalling commonly used words, needs to take copious notes, and tinnitus. History of multiple concussions. Applicant highlighted 1 VBIED while he was dismounted with brief LOC. Hundreds of close proximity indoor door breaches, airborne operations with subsequent head injury, etc. Provisional diagnosis of history of TBI, highest level of severity. Applicant further highlighted referral to TBI Speech Pathology Military Treatment Facility (MTF) (Routine) and TBI Neuro MTF BE (Routine) LOC 0-30 minutes.

d. Medical record, 17 July 2019, reason for appointment: Botox. Joints, back, mild headache. Migraine with aura, not intractable, without status migrainosus. Personal history of TBI, highest level of severity mild Glasgow Coma Scale 13-15, LOC 0-30 minutes, post-trauma amnesia 0–1-day, alteration of consciousness <24 hours. Obstructive sleep apnea. Released without limitations. Third follow-up headache evaluation in which he described a history of mTBI in 2006 (VBIED), who presented with a two-year history of bilateral retro-orbital/frontal headaches with associated scotoma and blurring of vision, prior brain MRI neuroimaging revealing bilateral temporal and parietal lobe atrophy, chronic anterior shin pain secondary to shin splints.

e. ORB dated 2 September 2020 and DD Form 214 with an ending dated of 30 September 2020.

f. Sworn statement from Sergeant First Class MEH (USA Retired), 26 April 2021, documenting injuries and heroism of the applicant during an emergency search and rescue mission of 3 missing/captured Soldiers from the 101st Airborne Division. He claims, in effect, during the mission the applicant was only 20 feet away from vehicles packed with explosives when an explosion injured the applicant. He received cuts from the explosion and was knocked down and unconscious for a few seconds, maybe 20 seconds or a little more. The applicant had an obvious TBI and concussion from the explosions with cuts and lacerations. Under intense direct enemy machine gun fire, the applicant was able to crawl out of ditch after being wounded in a post-concussive state and aimed at a 4-5 man enemy machine gun team and suspected spotter on a roof top and engaged them with his M-79 grenade launcher. Despite his own extremely critical physical condition, he was in the open while being exposed to a wall of enemy machine gun fire and mortar fire that was raining down on top of him and his position, he reloaded his M-79 grenade launcher and fired another round directly hitting the 4-5 man enemy element targeting American Soldiers with raking machine fire and grazing machine gun fire.

g. Undated witness statement from SFC GWC (USA Retired), who claims, in effect, he witnessed the applicant receive traumatic wounds from an explosion to include shrapnel and lacerations where he was bleeding. He also observed the applicant knocked out on the ground unconscious for about 10-30 seconds from the blast/explosion where he received a TBI. He always just assumed that the applicant received a PH for this operation and being wounded. He had no idea that he never received anything or a PH for being wounded on this operation while everyone else did trying to save 3 missing American Service members. He most certainly received a PH for these same combat injuries, and he believes and requests that entitlement to the PH also be given to applicant.

4. On 21 June 2021, the Deputy Chief, Awards and Decorations Branch, AHRC,

noted they were unable to take favorable action concerning his request for entitlement to the PH. Upon coordination with the AHRC Office of the Surgeon General, they determined the forwarded military medical documentation did not meet the statutory guidance outlined in Army Regulation 600-8-22 (Military Awards), paragraph 2-8. Therefore, they could not authorize award of the PH.

5. The applicant further provided a/an:

a. Statement from Major JS, a dual board-certified physician in both Critical Care and Emergency Medicine who claims, in effect:

(1) He has been the official medical reviewer for dozens of PH submission files and stood on both sides of concurrence and non-concurrence for cases regarding the entitlement of a PH. Upon reviewing the submission packet for the applicant, it is his professional medical opinion that the injuries he sustained in June of 2006 clearly warrant entitlement to the PH. The applicable regulation states that the wound must be documented in the member's medical health record and that an award may be made if the service member is treated by someone other than a medical professional if a medical officer includes a statement in the member's medical record that the severity of the wound was such that it would have required treatment by a medical officer if one had been available to provide treatment. As a doctor and a medical professional, it is clear and obvious that the TBI received by the applicant would have met the above qualifiers and that his injuries would have clearly required treatment by a medical officer and thereby warranted entitlement to the PH.

(2) The applicant's medical records contain SF 600 which clearly documents 3 days of concussion/TBI symptoms that were directly caused by an enemy placed IED. He had a LOC for up to 20 seconds after a close proximity blast and went on to have at least 72 hours of dizziness, disorientation, and loss of sleep as a direct result of this enemy placed IED. As a further testament to the close nature of this blast, he also sustained calf lacerations from shrapnel that required evaluation by a medical officer. The regulation clearly states the PH is entitled to service members who sustain concussions caused as a result of enemy-generated explosions that result in either LOC or restriction from full duty due to persistent signs, symptoms, or clinical finding, or impaired brain function for a period greater than 48 hours from the time of the concussive incident. In his professional opinion, it is obvious that the applicant's injuries clearly qualify him for the PH. LOC alone should warrant entitlement, but it is also clear that he was not fit for duty for at least 72 hours – if not longer – after the blast. He would have been pulled from duty and placed on direct medical observation given the above symptoms had he, or another medical doctor, been available to evaluate him at the time. He states this confidently with his vast experiences as a doctor seeing and treating IED blast related concussions/TBI both in a combat zone as well as upon redeployment.

(3) The medical facts of this case are the applicant had a close proximity IED blast, sustained a TBI with LOC of up to 20 seconds, and continued to have persistent TBI/concussion symptoms for at least 72 hours post incident. He should have been deemed not fit for duty at the time and been evaluated by a medical doctor – in particular, a neurologist – if one had been available at the time. As the medical professional reviewing this case, according to Army Regulation 600-8-22 Chapter 2-8, the applicant is clearly entitled to award of the PH based upon the evidence described above.

b. Applicant statement dated 21 August 2023, in which he provides background information of his previous submission through a Member of Congress to AHRC in July 2021. This application contains two additional statements missing from the previous packet.

c. Partial VA Rating Decision, undated, showing service connection for post-traumatic stress disorder and TBI at 70 percent effective 1 October 2020.

d. Partial Army Times article, “Justice in Baghdad,” undated.

6. Army Regulation 600-8-22 contains the regulatory guidance pertaining to entitlement to the PH and requires all elements of the award criteria to be met. There must be proof a wound was incurred as a result of enemy action, that the wound required treatment by medical personnel, and that the medical personnel made such treatment a matter of official record. Additionally, when based on a TBI, the regulation stipulates the TBI, or concussion must have been severe enough to cause a LOC; or restriction from full duty due to persistent signs, symptoms, or clinical findings; or impaired brain functions for a period greater than 48 hours from the time of the concussive incident.

BOARD DISCUSSION:

After reviewing the application, all supporting documents, and the evidence found within the military record, the Board found that relief was warranted. The applicant's contentions, the military record, and regulatory guidance were carefully considered. The applicant was involved in an enemy Vehicle Borne IED detonation. He was treated by an SF medic. He sustained TBI with loss of consciousness (LOC) and 2 lacerations to his right calf. To be awarded the Purple Heart, the regulatory guidance requires all elements of the award criteria to be met; there must be proof a wound was incurred as a result of enemy action, that the wound required treatment by medical personnel, and that the medical personnel made such treatment a matter of official record.

- The applicant was treated by a Special Forces Medic; however, he provides a statement from a board-certified physician who speaks of the severity of the applicant's injury was such that it would have required treatment by a medical officer if one had been available to provide treatment.
- The applicant provides a medical document that documents 3 days of concussion/TBI symptoms that were directly caused by an enemy placed IED and he also had LOC.
- The applicant would – and should - have been pulled from duty and placed on direct medical observation given the above symptoms had he, or another medical doctor, been available to evaluate him at the time.

Based on the preponderance of the evidence, the Board determined the criteria for award of the Purple Heart has been met.

BOARD VOTE:

Mbr 1	Mbr 2	Mbr 3	
[redacted]	[redacted]	[redacted]	GRANT FULL RELIEF
:	:	:	GRANT PARTIAL RELIEF
:	:	:	GRANT FORMAL HEARING
:	:	:	DENY APPLICATION

BOARD DETERMINATION/RECOMMENDATION:

The Board determined the evidence presented is sufficient to warrant a recommendation for relief. As a result, the Board recommends that all Department of the Army records of the individual concerned be corrected by awarding the applicant the Purple Heart for wounds received in action on 14 June 2006.

[redacted]

[redacted]

[redacted]

I certify that herein is recorded the true and complete record of the proceedings of the Army Board for Correction of Military Records in this case.

REFERENCES:

1. Army Regulation 600-8-22 prescribes Army policy, criteria, and administrative instructions concerning individual and unit military awards.

a. The PH is awarded for a wound sustained while in action against an enemy or as a result of hostile action. Substantiating evidence must be provided to verify that the wound was the result of hostile action, the wound must have required treatment by medical personnel, and the medical treatment must have been made a matter of official record.

b. A wound is defined as an injury to any part of the body from an outside force or agent sustained under one or more of the conditions listed above. A physical lesion is not required. However, the wound for which the award is made must have required treatment, not merely examination, by a medical officer. Additionally, treatment of the wound will be documented in the Service member's medical and/or health record. Award of the PH may be made for wounds treated by a medical professional other than a medical officer, provided a medical officer includes a statement in the Service member's medical record that the extent of the wounds was such that they would have required treatment by a medical officer if one had been available to treat them.

c. When contemplating an award of the PH, the key issue that commanders must take into consideration is the degree to which the enemy caused the injury. The fact that the proposed recipient was participating in direct or indirect combat operations is a necessary prerequisite but is not the sole justification for award.

d. Examples of enemy-related injuries that clearly justify award of the PH include concussion injuries caused as a result of enemy-generated explosions resulting in a mTBI or concussion severe enough to cause either LOC or restriction from full duty due to persistent signs, symptoms, or clinical finding, or impaired brain function for a period greater than 48 hours from the time of the concussive incident.

e. Examples of injuries or wounds that clearly do not justify award of the PH include post-traumatic stress disorders, hearing loss and tinnitus, mTBI or concussions that do not either result in LOC or restriction from full duty for a period greater than 48 hours due to persistent signs, symptoms, or physical finding of impaired brain function.

f. When recommending and considering award of the PH for a mTBI or concussion, the chain of command will ensure that both diagnostic and treatment factors are present and documented in the Soldier's medical record by a medical officer.

2. Army Directive 2011-07 (Awarding the PH), dated 18 March 2011, provides clarifying guidance to ensure the uniform application of advancements in medical knowledge and

treatment protocols when considering recommendations for award of the PH for concussions (including mTBI and concussive injuries that do not result in a LOC). The directive also revised Army Regulation 600-8-22 to reflect the clarifying guidance.

a. Approval of the PH requires the following factors among others outlined in Department of Defense Manual 1348.33 (Manual of Military Decorations and Awards), Volume 3, paragraph 5c: wound, injury or death must have been the result of an enemy or hostile act, international terrorist attack, or friendly fire; and the wound for which the award is made must have required treatment, not merely examination, by a medical officer. Additionally, treatment of the wound shall be documented in the Soldier's medical record.

b. Award of the PH may be made for wounds treated by a medical professional other than a medical officer provided a medical officer includes a statement in the Soldier's medical record that the extent of the wounds was such that they would have required treatment by a medical officer if one had been available to treat them.

c. A medical officer is defined as a physician with officer rank. The following are medical officers: an officer of the Medical Corps of the Army, an officer of the Medical Corps of the Navy, or an officer in the Air Force designated as a medical officer in accordance with Title 10, United States Code, Section 101.

d. A medical professional is defined as a civilian physician or a physician extender. Physician extenders include nurse practitioners, physician assistants and other medical professionals qualified to provide independent treatment (for example, independent duty corpsmen and Special Forces medics). Basic corpsmen and medics (such as combat medics) are not physician extenders.

e. When recommending and considering award of the PH for concussion injuries, the chain of command will ensure that the criteria are met and that both diagnostic and treatment factors are present and documented in the Soldier's medical record by a medical officer.

f. The following nonexclusive list provides examples of signs, symptoms or medical conditions documented by a medical officer or medical professional that meet the standard for award of the PH:

(1) Diagnosis of concussion or mTBI;

(2) Any period of loss or a decreased level of consciousness;

(3) Any loss of memory of events immediately before or after the injury;

(4) Neurological deficits (weakness, loss of balance, change in vision, praxis (that is, difficulty with coordinating movements), headaches, nausea, difficulty with understanding or expressing words, sensitivity to light, etc.) that may or may not be transient; and

(5) Intracranial lesion (positive computerized axial tomography (CT) or MRI scan.

g. The following nonexclusive list provides examples of medical treatment for concussion that meet the standard of treatment necessary for award of the PH:

(1) Limitation of duty following the incident (limited duty, quarters, etc.);

(2) Pain medication, such as acetaminophen, aspirin, ibuprofen, etc., to treat the injury;

(3) Referral to a neurologist or neuropsychologist to treat the injury; and

(4) Rehabilitation (such as occupational therapy, physical therapy, etc.) to treat the injury.

h. Combat theater and unit command policies mandating rest periods or downtime following incidents do not constitute qualifying treatment for concussion injuries. To qualify as medical treatment, a medical officer or medical professional must have directed the rest period for the individual after diagnosis of an injury.

3. Army Regulation 15-185 prescribes the policies and procedures for correction of military records by the Secretary of the Army, acting through the ABCMR. The ABCMR considers individual applications that are properly brought before it. The ABCMR will decide cases on the evidence of record. It is not an investigative body. The ABCMR begins its consideration of each case with the presumption of administrative regularity. The applicant has the burden of proving an error or injustice by a preponderance of the evidence.

//NOTHING FOLLOWS//