IN THE CASE OF: [redacted]

BOARD DATE: 19 September 2024

DOCKET NUMBER: AR20230011446

APPLICANT REQUESTS, through counsel: in effect to be retired due to disability or in the alternative a referral into the Legacy Disability Evaluation System for the following service-connected conditions:

- traumatic brain injury (TBI)
- headaches
- radiculopathy
- somatic symptom disorder
- tinnitus
- plantar fasciitis
- degenerative disc disease

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

- DD Form 149, Application for Correction of Military Record
- Power of Attorney
- Applicant’s Statement
- Legal Brief
- Military Records
- 4-Character References
- TBI Evaluation
- Neurology Evaluation
- Department of Veterans Affairs (VA) Rating Decision

FACTS:

1. The applicant did not file within the 3-year time frame provided in Title 10, U.S. Code, section 1552(b); however, the Army Board for Correction of Military Records (ABCMR) conducted a substantive review of this case and determined it is in the interest of justice to excuse the applicant's failure to timely file.

2. Counsel has incorporated the applicant's statement in his legal brief. Counsel states, in effect:

a. During basic training, a live grenade exploded next to the applicant at the live grenade range. He was also with another recruit who pulled the pin and dropped the grenade at their feet. The grenade exploded with shrapnel all around the bay. Luckily, the applicant did not sustain any physical injuries, but he did begin to develop post-traumatic stress disorder (PTSD) symptoms from the incident. In addition, he sustained a cut on his trigger finger that became infected in the nailbed of the finger, resulting in having to extract the fingernail.

b. The applicant was stationed at Fort Stewart, GA when he was hit by a car. He was walking down the road and he was struck by a drunk driver. The driver clipped him, which resulted in the mirror and trim on the side of the vehicle being torn off. The driver fled the scene and was never caught. This incident resulted in injuries to the applicant's left arm, left leg, and left side in general.

c. While stationed in Germany, the applicant sustained a TBI when he fell 6-8 feet off the top bunk on to the concrete floor slamming his head on the ground. While sleeping in the top bunk of a bunkbed, he fell out of the bed and hit his head and face on the concrete floor. The impact of his head to the ground caused him to be knocked unconscious and unresponsive for at least 30 minutes. The applicant was rushed to an urgent care center. This is when he suffered a severely deviated septum and developed sleep apnea. Some of the symptoms he began to suffer from were memory issues and a change in personality with behavioral issues.

d. The applicant was also suffering from back injuries. While doing maintenance on a HMMWV, he was pulling out batteries when his back went out. The first battery he pulled came right out, but after he put down the second battery his back went out and he could not stand up straight. He could not make it to medical on his own and needed another Soldier to assist him. When he arrived at medical, he was given only Motrin and 3-4 days of bed rest; his Command thought he was lying about the injury.

e. The applicant was medically separated from the Army for injuries sustained to his right foot. He is unsure how he initially injured his foot but after going to medical he was told he had chips in his foot that caused spurs. The spurs were caught on the muscles and tendons of his right leg. The doctors had him go through non-invasive treatments, but they were unsuccessful. The doctors then recommended he undergo surgery to correct the issue; however, he was never told the surgery was experimental and it had an extremely low success rate. Apparently, the bone spur was shaved off. Then, they shortened the tendons and muscles in his foot because they were too long due to the bone spurs. However, the doctors cut them too short, which caused more issues. Due

to this mistake, the applicant had a 3-4-inch gap between his foot and ground. He was required to walk with a cane, and he had a significant limp.

f. Due to the mistakes of the doctors, the applicant was referred to a medical evaluation board (MEB). The doctor, who was a colonel (COL)/O-6, recommended to the board that the applicant be medically separated and sent records to the Board. Soon after, the doctor deployed, and the applicant would not hear from him again. Additionally, the applicant did not hear anything again until he was medically separated from the Army. Prior to the MEB, his commander thought the applicant was lying about the medical issues and sought to give him an Article 15. The applicant was never told about a medical retirement, nor was he told he could be involved in the medical evaluation process. He had other medical issues going on during that time that should have been reviewed.

g. After completing his final medical examination, the applicant was ordered to participate in a field exercise and this is the field exercise when he was knocked unconscious by a two-hundred-pound steel beam and suffered a second TBI. The Soldiers were removing a final drive from an Armored Vehicle Launching Bridge using a swing arm to pull the drive out. The swing arm pivots to set the drive on the ground, and the applicant was guiding the swing arm off the final drive. The crane operator was supposed to keep tension in the line, but he made a mistake by putting slack in the line and the swing arm slammed into the final drive causing it to spin uncontrollably. The operator tried to move the swing arm away from the applicant, but it swung and hit him in head above his ear cracking the Kevlar. The applicant was knocked unconscious for a while due to the blow to his head. The Command sought to cover it up and the applicant was told to pack his bags and he was removed from the field. Everyone acted like nothing happened and the applicant was not allowed to go to medical, and the medic was not allowed to put anything in his records after being examined on site. After the incident happened, the applicant was fast tracked out of the Army.

h. The Soldiers who knew the applicant noticed he was suffering from the effects of TBI. He was suffering from persistent headaches, forgetfulness, memory issues, and his ability to process information greatly slowed down. It was also noticed that he began snoring in his sleep and losing his temper more easily.

i. The applicant was a high performer in the Army earning a Parachutist Badge, two Army Achievement Medals, and Good Conduct Medal. The applicant was honorably separated from the Army on 1 February 2001 with a disability. He also received a separation code of JFL and Reentry Eligibility code of 3.

j. The applicant was service connected by the VA to be 100% totally disabled for the following conditions:

- right lower extremity sciatic nerve radiculopathy at 20%
- tension headaches at 50%
- left lower extremity sciatic nerve radiculopathy at 20%
- right lower extremity femoral nerve radiculopathy at 20%
- left lower extremity femoral nerve radiculopathy at 20%
- somatic symptom disorder with predominant pain, persistent, severe at 70%
- tinnitus at 10%
- TBI at 70%
- plantar fasciitis at 20%
- degenerative disc disease, thoracolumbar spine at 40%

k. The applicant's spouse witnessed the issues related to the applicant's physical and mental injuries. She has seen him zone out for essentially the entire day. He also becomes unresponsive when in bed, on the toilet, on the computer, and other times. He will also forget to eat and sleep. He has outbursts of anger that are inappropriate for the situation. She also has seen the negative impact of the severe headaches he suffers from 2-3 times per week, and sometimes daily. These headaches force him to lay down for at least an hour. Based on the headaches alone, the applicant has issues finding any gainful employment. Moreover, he is unable to perform many basic tasks, such as dressing, bathing, preparing his meals, eating his meals, cleaning up after himself, paying bills, etc. without his wife's assistance.

l. On 13 April 2021 and 14 April 2021, Dr. [redacted] reviewed the applicant for TBI. Dr. [redacted] noted that the applicant continued to suffer from residuals of TBI at Level 3 impairment for memory, attention, concentration, and executive functions. The applicant's judgment was also noted to be at Level 3 impairment noting moderately severely impaired judgment for even routine and familiar decisions. He is also unable to understand the consequences of his choices. The applicant frequently acts inappropriately in social settings. The Doctor noted the applicant is Level 1 impairment for his motor activity with diminished balance. He continues to suffer from recurring headaches, tinnitus, tremors, and dizziness. It is important to note Dr. [redacted] stated the applicant's residuals of TBI are attributable to his inability to work.

(1) The applicant was noted as an exceptional student in high school in the gifted program with a 3.0 Grade Point Average (GPA). He then went to college with a 3.5 GPA while receiving an associate degree. This demonstrates his intellectually ability prior to joining the service. Based upon his TBI's he was noted to have the following:

- impaired concentration and attention
- speeded visual tracking and motor output

- average working memory
- impaired measures of general memory and memory recognition
- moderately impaired verbal memory testing
- moderately to severely impaired immediate recall
- several impaired to low average immediate recall/recognition
- average to moderately impaired mental flexibility and response inhibition
- severe level of depression
- moderate level of anxiety
- symptoms of PTSD

(2) The results of cognitive testing occasionally placed him in impaired range that is suggestive of an underlying organic impact, also known as TBI. It was noted that based on his fall onto the concrete and being struck in the head with the reports of loss of consciousness on two occasions within two years of each other are suggestive of TBI.

m. The applicant's discharge from active duty was both an error and injustice. A review of the relevant instructions and publications on point - namely, Department of Defense Instruction (DODI) 1332.18 - reveals that his case was not properly handled. The numerous procedural errors, in a legal, administrative, and medical sense, amounted to a severe injustice where a service member was separated with a severance rather than retirement. A careful review of the record demonstrates that had the command properly referred the applicant to the DES, many of these errors would not have occurred. This action becomes even more shocking when it is apparent that his immediate command sought to sweep his full scope of injuries under the rug, seek administrative actions against him, and ultimately treat him without the respect of a fellow Soldier.

n. DODI 1332.18 Enclosure 3, Chapter 2(E)(4) discusses impartial medical reviews as follows: Consistent with section 1612 of Public Law 110-181 the Secretary of the Military Department concerned will, upon request of the Service member, assign an impartial physician or other appropriate health care professional who is independent of the MEB to:

(1) Serve as an independent source of review of the MEB findings and recommendations.

(2) Advise and counsel the Service member regarding the findings and recommendations of the MEB.

(3) Advise the Service member on whether the MEB findings adequately reflect the complete spectrum of the Service member's injuries and illnesses.

o. In the present matter, the applicant was never provided information about his MEB to make an informed decision. He did not know that he could or how he could appeal the MEB's initial decision. Further, he did not know how to go back to the MEB after his Command sent him to the field after he was already determined to be unfit to continue to serve. If the applicant had someone counseling him during the medical review, he would have been able to discuss the extent of his injuries and the impact they had on his ability to serve.

p. DODI 1332.18 Enclosure 3, Chapter 2 under subsection f discusses the content of a MEB as follows:

(1) Medical information used in the DES must be sufficiently recent to substantiate the existence or severity of potentially unfitting conditions. The Secretaries of the Military Departments will not perform additional medical exams or diagnostic tests if more current information would not substantially affect identification of the existence or severity of potentially unfitting conditions.

(2) MEBs will confirm the medical diagnosis for and document the full clinical information, including history, treatment status, and potential for recovery of the Service member's medical conditions that, individually or collectively or through combined effect, will prevent the Service member from performing the duties of his office, grade, rank, or rating and state whether each condition is cause for referral to a PEB.

q. In the present matter, looking at the extent of injuries and impact at the time he was still in the Army, it would reveal the applicant was severely injured for numerous conditions and unfit to continue to serve. Furthermore, his Command somehow came to the decision to send him to the field despite already pending a medical separation. It was during this field exercise that he was struck in the head again suffering from yet another TBI. However, the Command sought to sweep this severe injury under the rug due to what the Command must have known would be a severe violation. This second TBI would have significantly changed the outcome of the first MEB. The enclosures clearly demonstrate second TBI that was never reviewed by the MEB and would have materially affected the medical separation of the applicant. The full scope of documentation and information is available to review and determine he was improperly rated for his medical conditions.

r. DODI 1332.18 Appendix to Enclosure 3, Chapter 2 discusses the general criteria for making unfitness determinations as follows:

(1) A Service member will be considered unfit when the evidence establishes that the member, due to disability, is unable to reasonably perform duties of his or her office, grade, rank, or rating, including those during a remaining period of Reserve obligation.

(2) A Service member may also be considered unfit when the evidence establishes that:

(a) The Service member's disability represents a decided medical risk to the health of the member or to the welfare or safety of other members; or

(b) The Service member's disability imposes unreasonable requirements on the military to maintain or protect the Service member.

s. In the present matter, the applicant's medical conditions rose to a level of being unable to perform any of his duties as a Soldier. Looking at the TBI condition, his symptoms were so severe that he would be a danger to himself and others around him.

t. It was noted by other Soldiers who knew the applicant that he was suffering from persistent headaches, forgetfulness, memory issues, his ability to process information greatly slowed down, began snoring in his sleep, and losing his temper more easily. Reviewing his back injuries, his being unable to stand up on at least one occasion demonstrates not only an initial injury but one that would cause long lasting effects that continue to cause pain throughout his time in service.

u. When making a determination for the fitness of a servicemember, the Military Department concerned will determine fitness or unfitness for military service on the basis of the preponderance of the objective evidence in the record. (See DODI 1332.18 Appendix to Enclosure 3, 6(b)). In the present matter, it is clear there is a preponderance of evidence that at the time of his separation, the applicant was not properly reviewed for his conditions nor all the injuries he suffered from. At the time of his separation in 2001, the Military and American society did not fully understand TBI and the impact it has on a person's ability to function. Given the information we know today, if the applicant were to go through a MEB today, he would undoubtedly be medically retired from the service due to extent of his symptoms.

v. The applicant was committed to his service in the Army. His career started promisingly but was unfortunately derailed by a series of severe injuries that were not properly reviewed or reviewed at all. He was injured and due to the discriminatory practices against injured Soldiers, did not report his initial injury. He was finally referred to a disability evaluation that his Command believed he was lying about the entire time, despite medical statements to state the opposite. Once he was prepared to be separated from the Army, his Command forced him to the field where he suffered a second TBI. The Command sought to hide this severe injury and swept it under the rug; thus, his condition was never properly reviewed by a MEB. The applicant should be granted a medical disability retirement or referred into the Legacy DES for his numerous medical injuries, including his TBI. In the alternative, his discharge should be upgraded to an honorable discharge and the narrative reason for separation be changed.

3. The applicant's record shows he enlisted in the Regular Army on 3 April 1995, and he was awarded military occupational specialty (MOS) 12B, combat engineer.

4. His record contains a DD Form 3349, Physical Profile, which shows the applicant received a permanent physical profile on 29 August 2000 for “heel pain.” The profiling officer recommended the applicant’s condition be reviewed by a MEB.

5. An MEB Narrative Summary, 11 October 2000, shows the applicant’s chief complaint was continued right inferior heel pain with post-static dyskinesis and dysfunction with altered gait to right foot. The examining medical provider stated, in effect:

a. The applicant presented with pain to right heel, worse in the morning after long periods of rest, accompanied with continued symptoms of throbbing, aching and pulsating sensation with prolonged activities for six months. He was managed with protective weight bearing and limited activities and was referred to Podiatry in June 1999. The applicant was managed for one year with heel cups, profile, non-steroidal anti-inflammatories, three injection treatments and guarded weigh bearing with no improvement. Surgical treatment was rendered in June 2000 with a partial plantar fascial release and resection of heel spur to the right calcaneus. Postoperative healing was uneventful, however the applicant continued to offer history of post static dyskinesis and dysfunction with altered gait to the right foot requiring use of multiple pain management regimens, a walking cane, and a permanent “P4” profile.

b. The impact of this is that he cannot perform essential aspects of his 12B MOS, which requires prolonged weight bearing. The applicant was also unable to run, march or bike. He was unable to participate in field related duties and prolonged standing in formation. A P4 profile was issued on 29 Aug 2000 with the following limitations, no running, no jumping, no PT, no APFT, and no marching.

c. It appeared that the applicant’s foot symptoms would continue with the stresses incurred for his occupation or recreational activities. With the cessation of the demands of his MOS, eventual resolution of this pathology was certain.

d. On 16 October 2000, the applicant’s commander called Podiatry and reported that the applicant was observed dancing (1) without use of walking cane and (2) without any gait disturbance while dancing at a night club. According to this objective evidence, this patient’s prognosis is considered good to return to full active duty.

e. In accordance with Army Regulation (AR) 40-501, Medical Services-Standards of Medical Fitness, chapter 3, paragraph e, it appeared that the applicant was unfit for continuation on active duty at the time. He was clearly unable to meet the demands of his MOS and to fulfill some basic Solder duties. Accordingly, his case was referred to the Physical Evaluation Board (PEB) for final adjudication.

6. A DA Form 3947, MEB Proceedings, shows the applicant's medical condition of right inferior calcaneal pain was referred to the PEB. The applicant made the following elections:

- he did not desire to continue on active duty
- he agreed with the MEB findings and recommendations on 1 November 2000

7. On 15 November 2000, a PEB, Washington, DC, reviewed the applicant's condition of right inferior calcaneal pain post plantar fascial release. The PEB found the applicant's condition was unfitting and recommended a combined rating of 0%. The Board recommended the applicant be separated with severance pay if otherwise qualified. On 21 November 2000, the applicant concurred with the findings and recommendation, and he waived his right to a formal hearing.

8. During his disability processing the applicant submitted an undated handwritten letter wherein he stated, in effect, that he had his cane with him at the night club but because it was considered a weapon, he was not allowed to bring it in the night club. Further, he had discussed participating in recreational activities with his doctor and was told that because he would be in pain the rest of his life, it was up to him how much pain he could tolerate in order to do the things he wanted to do. He did not violate his physical profile because he was not running or jumping.

9. On 1 February 2001, the applicant was discharged due to disability with severance pay. He completed 5 years, 9 months, and 19 days of net active service. He received an honorable characterization of service.

10. The applicant provides:

a. Four witness statements, two from his spouse and two from his fellow Soldiers. The Soldiers reported seeing the applicant suffer from various conditions to include having trouble processing information after falling off the top bunk and hitting his head on a concrete floor and having severe headaches after getting hit in the head with a beam while working in the motor pool. His spouse reported witnessing the applicant have severe headaches 2 to 3 times a week and having to lay down for at least an hour when the headaches came on. His spouse further noted that the applicant suffered from numerous other conditions which included dizziness, weakness in his hands, vertigo, difficulty sleeping, inability to concentrate, severe fatigue, loss of balance, bladder incontinence, anxiety, depression, nightmares, impaired judgement, and indecisiveness.

b. A neuropsychological evaluation, 21 January 2019. This document shows the applicant was referred for this evaluation to clarify any residual cognitive or mood-related impairment secondary to his history of concussions/TBIs. This provider stated, in effect, it appeared that a combination of factors could be playing a role in the applicant's

presentation, including chronic pain (which appeared, at the very least, to act as a significant distraction for him and likely leads to increased mood-related issues) and his profoundly elevated mood (with symptoms of depression, anxiety, and post-traumatic. stress). Additionally, reports made of symptoms (e.g., increased difficulties with attentional focus, short-term memory, irritability, and Interpersonal Interactions) following physical injuries (e.g., fall onto concrete and being struck in the head by the arm of a crane) in combined with reports of a loss of consciousness on two occasions within approximately two years of each other, would be suggestive of TBI. It was likely that, given reports of pre-existing mood and behavioral issues (from childhood/adolescence), his mood and behavior worsened with such injuries and the addition of chronic pain. Based on reported and observed symptoms, the applicant met the criteria for several disorders, such as major depressive disorder, recurrent, severe (ICD-10 F33.2), panic disorder (ICD-10 F41.0), somatic symptom disorder (with predominant pain (ICD-10 F45.1), and an unspecified neurocognitlve disorder (ICD-10 R41.9). It was difficult to tease apart the specific continued or residual Impact from the applicant's reported TBI's from ongoing somatic and cognitive concerns that could also be associated with significantly elevated depression and anxiety.

c. A review of the applicant's TBI rating conducted by a licensed clinical psychologist, Dr. [redacted] on 13 April 2021. This behavioral health provider reviewed the applicant neuropsychological testing and TBI Disability Benefits Questionnaire (TBI DBQ) and determined his symptoms and impairments fit the 70% rating and Level 3 impairments. The applicant also fit the VA criteria for Special Monthly Compensation(t).

d. An Evaluation of Residuals of TBI-DBQ, 14 April 2021. This document shows:

- the applicant has or had a diagnosis of TBI
- his hearing loss/and or tinnitus, gait, coordination, balance, headaches, and migraine headaches were attributed to his TBI
- his TBI impacted his ability to work

e. His VA Disability Rating document which shows the applicant has a combined disability rating of 100%, of which his TBI has been assigned a 70% rating.

11. Regulatory guidance states the mere presence of an impairment does not, of itself, justify a finding of unfitness because of physical disability. In each case, it is necessary to compare the nature and degree of physical disability present with the requirements of the duties the Soldier reasonably may be expected to perform because of their office, grade, rank, or rating.

12. Title 10, U.S. Code, section 1201, provides for the physical disability retirement of a member who has at least 20 years of service or a disability rating of at least 30 percent.

13. MEDICAL REVIEW:

a. The Army Review Boards Agency (ARBA) Medical Advisor reviewed the supporting documents, the Record of Proceedings (ROP), and the applicant's available records in the Interactive Personnel Electronic Records Management System (iPERMS), and the VA's Joint Legacy Viewer (JLV). The applicant through counsel, requests medical disability retirement. He indicated that PTSD and TBI conditions were related to his request. He was medically separated from service for a right foot condition and requests to be medically retired for TBI, headaches, radiculopathy, somatic symptom disorder, tinnitus, plantar fasciitis, and degenerative disc disease. Alternatively, he requests referral into the Legacy Disability Evaluation System.

b. The ABCMR ROP summarized the applicant's record and circumstances surrounding the case. Of note, the applicant enlisted in the Regular Army 13Apr1995. He completed airborne training 25Aug1995. He was stationed in Germany 19970311 to 19990310. His primary MOS was 12B10 Combat Engineer. He was discharged 01Feb2001 under provisions of AR 635-40 para 4-24B(3) . He was authorized disability severance pay.

c. Background

(1) The applicant's 05Dec1994 entrance exam showed history of depression and having undergone family counseling; he was overweight, his blood pressure was elevated and there was glucose in his urine. In the 12Sep2000 Report of Medical Exam for the Medical Board he endorsed being in 'fair' health. The document showed a P4 physical profile and that the applicant was qualified for a MEB.

(2) The 29Aug2000 permanent L4 physical profile for Heel Pain prohibited running, jumping, PT, APFT and marching.

(3) 11Oct2000 MEB NARSUM (narrative summary). The applicant was undergoing a MEB for continued right inferior heel pain with post-static dyskinesis and dysfunction with altered gait with regard to the right foot. Conservative management by podiatry services included heel cups, profile, NSAIDs, 3 injections. Ultimately, the condition required surgical intervention. In June 2000, he underwent a partial plantar fascial release and resection of heel spur to the right calcaneus. The MEB determined that the applicant's Right Inferior Calcaneal Pain did not meet medical retention standards of AR 40-501 chapter 3-14e. The applicant concurred with MEB findings.

(4) 15Nov2000 PEB Proceedings (DA Form 199). The PEB found Right Inferior Calcaneal Pain unfitting for continued service. The PEB rated the condition at 0% under code 5099 5003 based on his use of pain medication intermittently; the exam revealed mild plantar tenderness; and x-ray findings showed absence of right heel spur

and no other changes. The recommended disposition was separation with severance pay at 0%. He concurred with PEB findings and waived a formal hearing of his case.

d. Summary of pertinent medical record (and related documents) are below. Special attention was given to service treatment records (STRs) and records within 2 years of discharge. Of note, the applicant underwent a C&P exam in February 2003.

(1) Headaches. The VA service-connected Migraine Headaches at 50%, the effective date was not specified. In the 12Sep2000 Report of Medical History (for the MEB), the applicant denied frequent or severe headaches. It should be noted, review of records did not find report of headaches until 2016 (25May2016 Neuropsychological Assessment VAMC). No further details were recorded. The applicant's wife's statement concerning his headaches was noted.

(2) Lumbar Degenerative Disc Disease and Radiculopathy. The applicant was service-connected by the VA for Degenerative Disc Disease, Thoracolumbar Spine at 40% with the effective date not specified. The Right Lower Extremity Femoral Nerve Radiculopathy at 20% and the Left Lower Extremity Femoral Nerve Radiculopathy at 20% were service connected by the VA effective 12Jun2021. The applicant was service-connected by the VA for Right and Left Lower Extremity Sciatic Nerve Radiculopathy at 20% each, with effective date not specified. In his ABCMR application, the applicant reported he sustained back injury while attempting to remove a battery from an HMMWV. The back pain was reportedly treated with Motrin and 3-4 days of rest. In the 12Sep2000 Report of Medical History (for the MEB), the applicant endorsed recurrent (low) back pain; however, the spine exam did not show any abnormalities. The 11Oct2000 MEB exam (SF 502) revealed normal neurologic and motor nerve function bilaterally. The 10Feb2003 lumbar spine series did not show abnormalities. During the 10Feb2003 VA C&P Exam, the applicant reported back pain onset in 1998 or 1999. He did not report that back pain radiated to any other area. He denied history of back surgery or injections. The back exam revealed no tenderness or muscle spasm. There was forward flexion of 0-95 degrees (normal is 0-90 degrees), extension backward was a striking 0-40 degrees (normal is 0-30 degrees). Muscle mass and muscle strength in the lower extremities were documented as 'excellent'.

(3) Tinnitus. This condition was service-connected by the VA at 10%, effective 10Jun2015. In the 12Sep2000 Report of Medical History, he denied hearing loss. The were no questions regarding tinnitus and the applicant did not report tinnitus.

(4) Plantar Fasciitis. The applicant was not service-connected by the VA for Left Foot Plantar Fasciitis. He was service-connected by the VA at 20% for Plantar Fasciitis with Spur, Status Post Excision, Right Foot with the effective date not specified. In the 12Sep2000 Report of Medical History, he endorsed foot trouble. He also reported right heel spur surgery in June 2000. The 11Oct2000 MEB exam (SF 502) showed the

subtalar ankle and mid tarsal joint ROMs were within normal limits bilaterally. Heel to toe gait was normal on the left, heel to toe gait on the right showed dysfunction. The 10Feb2003 bilateral foot films showed left heel spur and no right-side right foot film abnormalities. In the 10Feb2003 C&P Exam, the applicant reported daily pain in the heels. He denied the use of inserts but endorsed that he had used heel cups in the past, but never used special shoes. Examination of the base of the feet showed no significant excess in callus formation and there was no tenderness during the exam.

e. In April 2008, seven years after discharge from the military, the applicant sought to rejoin the military (21Apr2008 Internal Medicine Clinic Note VAMC). At the time, it was divulged he had been discharged due to right foot bone spur requiring surgery. During the visit, he denied pain; he had full ROM; he was able to run/stand/walk without pain. He had reportedly been previously medically cleared to rejoin in 2003; however, the paperwork was lost. He had been working as a security guard since 2004 and had experienced no difficulty performing his duties as such. Obesity was noted, however, there was 23% body fat which met standards, so in 2008, he was cleared to reenter service. Nine months later, he was seen by podiatry reporting left heel pain (28Jan2009 Podiatry VAMC). There were no right-side symptoms. His diagnosis was Left Plantar Fasciitis, secondary to Pes Planus Deformity, Bilateral. He was given a trial of over-the-counter inserts the efficacy of which would be used to evaluate whether a custom orthotic would be of benefit. He ultimately did receive custom insoles (16Aug2010).

f. TBI. He was service connected by the VA at 70% for TBI with the effective date not specified, but likely sometime after the 14Apr2021 Residuals of TBI DBQ.

(1) In the 12Sep2000 Report of Medical History (for the MEB), the applicant endorsed having sustained a head injury. He denied frequent or severe headaches; loss of memory or amnesia; periods of consciousness; dizziness or fainting spells; and seizures. During the Mini-Mental Status Exam of the 11Feb2003 VA C&P Initial Psychiatric Examination, his short-term memory was intact. He registered 3 of 3 objects and recalled 3 of 3 in five minutes. Concentration for serial subtraction of 7 from 100 was also good and he performed the task without error. He was able to spell the word ‘world’ correctly forward and backward. His thought processes were goal-directed. He was able to duplicate a design and write a coherent and legible sentence. His abstraction ability was within normal limits. Cognitive impairment was not diagnosed.

(2) 15 years after discharge from service, neuropsychiatric testing was completed (24May 2016 and 25May2016 Neuropsychological Assessment VAMC). The applicant reported while in the military, he suffered 2 head injuries with loss of consciousness for unknown period and amnesia for a short period immediately after the events: He fell from the top bunkbed and hit his head on the concrete floor; and in 1999, he was hit in the head by a steel beam. After the military, he completed an A.A. degree in internet technology computer networking systems. He had worked as a lead web architect,

electrician apprentice, security guard, bouncer, and as a desktop engineer. He was currently unemployed at the time of the exam. Results of tests: The examiner assessed that overall, the applicant's memory was the only noted cognitive function that was low. Since the applicant noted its onset was in 2003, with worsening over the past 8 to 13 years, it was the examiner's opinion that the memory difficulties were likely related to the noted psychiatric conditions. The test results were considered an underestimate of his capabilities due to the presence of depression and anxiety.

(3) 20Apr2018 Mental Disorders C&P DBQ VAMC. The BH examiner reviewed a February 1999 STR which indicated the applicant was treated for a fall from his bunkbed while on pass to Amsterdam. He denied loss of consciousness at the time. He was treated for laceration on his forehead and otherwise demonstrated a normal mental status. The BH examiner questioned the reliability of the applicant's self-report due to inconsistency in reporting during the exam.

(4) Approximately 18 years after discharge from service, the applicant was referred and received an outside neuropsychological evaluation to clarify any TBI residuals or mood-related impairment secondary to his history of TBIs (21Jan2019 NeuroResources Neuropsychological Services). The applicant's reported symptoms were numerous, varied, and crossed multiple domains including cognitive, judgment and emotion. The specialist did conclude he met criteria for an Unspecified Neurocognitive Disorder. They stated that "it was difficult to tease apart the specific continued or residual impact from his reported TBIs, from ongoing somatic and cognitive concerns that could be associated with significantly elevated depression and anxiety". Concerning validity, the examiner wrote "several validity scales were consistent with expectations, one suggested the possibility of exaggeration of symptoms and another suggested that the test taker may not have been honest in his reporting." It was suggested that results of testing should be interpreted with caution.

(5) 20 years after discharge from service in April 2021, the applicant underwent another TBI evaluation (14Apr2021 Evaluation of TBI DBQ). The examiner assessed that due to his TBI, there was objective evidence on testing of moderate impairment of memory, attention, concentration, or executive functions resulting in moderate functional impairment; there was moderately severe impairment in judgement; his motor activity was mildly slowed at times; and there were three or more subjective symptoms mildly interfere with work, instrumental activities of daily living or relationships. The examiner identified the following as TBI residuals: Hearing loss and or tinnitus; gait, coordination, and balance issues; and headaches, including migraines. The examiner endorsed that the applicant's TBI rating should be increased from 10% rating at the time to 70%.
7. Somatic Symptom Disorder. This condition was service connected by the VA at 70% with effective date 08Aug2016.

(6) In the 12Sep2000 Report of Medical History (for the MEB), the applicant

endorsed depression. He denied nervous trouble, frequent trouble sleeping, and suicide attempt or plans. The examiner noted a past medical history of Dysthymia, Oppositional Defiant Disorder and Avoidant Personality Disorder. During the 11Feb2003 VA C&P Initial Psychiatric Examination. He reported that he had two separate premilitary psychiatric inpatient stays (in [redacted]) at the age of 13 for behavioral difficulties in the setting of adjusting to going back and forth between his divorced parents. Diagnoses at the time of hospitalization as a youth was called Adjustment Disorder with Mixed Disturbance of Emotions and Conduct. He did not report any treatment since age 13 prior to joining the military at age 20. At the time of the 2003 exam, the applicant was in school working on his masters in computers and programming. He denied overwhelming feelings of depression. He denied anxiety, phobias, thoughts of suicide or homicide. He also denied auditory or visual hallucinations. There were no substance abuse issues. At the time of the exam, he was not undergoing mental health care. He was not taking medication. The BH examiner assessed that the applicant did not currently have symptoms of a mood or anxiety disorder. His diagnosis in youth was most likely adjustment disorder, which had resolved. He was not given a BH diagnosis. GAF (global assessment functioning) in general was 90 which was consistent with good functioning in all areas.

(7) The PTSD and Depression screens were negative during 22May2009, 15Jul2010, 07Oct2011, 30Jul2013 VAMC primary care appointments. There had been no contact with BH services. The applicant initially sought care for BH services via social work in 2016 in relation to vocational services and housing needs. He had been unemployed since September 2015 when he returned to the United States from [redacted] where he had been working (since June 2014).

(8) 28Apr2016 Mental Health Note VAMC. The applicant was working in [redacted] on a work visa and got into an altercation at work. His work contract was not renewed so he started having visa issues. He reported the altercation was related to his anxiety and PTSD.

(9) 11May2016 Psychology Assessment VAMC. The visit was for testing for the purpose of diagnostic clarification. He reported after military service, he earned an associate degree in Internet Technology Computer Networking Systems. He also stated that he completed 11 of 12 quarters of a degree program at the Art Institute in [redacted] at or near the top of his class. He reportedly had worked various jobs as a lead web architect, an electrician's apprentice, a security guard, and a bouncer, with his most recent employment as a desktop engineer in [redacted] in 2015. He was unemployed since then seeking disability. Military stressors: He reported engaging in approximately six fights per month with fellow U.S. soldiers over the course of several years in Germany during which the other U.S. soldiers would try to “crush [his] throat” and “gouge [his] eyes out”. He also reported guns and knives were pulled on him by fellow soldiers. He further stated that he would frequently engage in large, 20-on-20

group fights (e.g., his unit versus the base's military police). And finally, he reported that a grenade exploded near him during a training exercise. He endorsed significant bodily pain and was observed multiple times to be wincing in pain during assessment. DSM-5 Diagnoses: Unspecified Anxiety Disorder, with Severe Depressive Features; and Somatic Symptom Disorder, with Predominant Pain, Persistent, Severe. It was not possible to differentiate what symptom(s) were attributable to each diagnosis and the contribution of traumatic brain injury could not be ruled out.

(10) 22Feb2017 Mental Disorders DBQ VAMC. The applicant estimated that he held about one or two jobs prior to his military service which included working as a cook and dishwasher and doing farm work. Of importance, this note chronicled the available service treatment records: A note from 10Jun1999 described his childhood history of mental health problems; that he was currently experiencing problems with his unit; and that he requested a mental health consult. No subsequent consult was noted. A diagnosis of alcohol abuse was also noted in June 1999. Problems related to depression/excessive worry as well as complaints regarding his drinking were noted on his separation evaluation. He filed a claim for dysthymia in 2001, and this was rejected as the evaluator reportedly found no evidence of mental health problems at that time. The applicant reported that he next received treatment after returning from [redacted] The VAMC BH examiner diagnosed Major Depressive Disorder (MDD) and Somatic Symptom Disorder. Although the majority of symptoms were thought to be associated with his mental health diagnoses, the possibility of TBI contributing to his symptoms could not be ruled out.

(11) 20Apr2018 Mental Disorders DBQ VAMC. Problems with truancy from school and fighting led to his mother taking him for psychiatric treatment in his youth. This note indicated there was documentation in service treatment records that he was diagnosed with Personality Disorder, Not Otherwise Specified in the context of continued problematic drinking (10-15 shots per night). He did not undergo any counseling, nor was he prescribed any medication. Conflicts with others caused him to move his family 4 times in 6 months in 2017. The examiner assessed that the applicant had one diagnosis: MDD, Recurrent. He opined the condition existed prior to service (depression, suicide ideation) and was worsened beyond natural progression by his service-connected illness/injury (back pain) and residuals of foot injury (foot pain). They further assessed that in addition, the applicant possessed maladaptive personality traits that were longstanding but did not meet the threshold to diagnose a personality disorder. This was based on the history of oppositional behavior in adolescence; and the applicant’s current description of his limited empathy for others, feeling misunderstood and use of those beliefs to continue to justify his avoidant behavior.

(12) 21Jan2019 NeuroResources Neuropsychological Services (Non VAMC, Non DoD report). The BH examiner concluded the applicant met criteria for the following disorders: MDD, Recurrent, Severe; Panic Disorder; Somatic Symptom Disorder (with predominant pain); and an Unspecified Neurocognitive Disorder. They stated that “it

was difficult to tease apart the specific continued or residual impact from his reported TBIs from ongoing somatic and cognitive concerns that could be associated with significantly elevated depression and anxiety".

g. Based on records available for review, in the ARBA Medical Reviewer's opinion, with the exception of the right foot condition, there was insufficient evidence to support that the applicant had another condition which failed medical retentions standards of AR 40-501 chapter 3 at the time of discharge: The applicant's permanent profile noted only functional activity limitations due to heel pain, and the MEB further clarified his source of pain as the right heel status post surgery. Evidence did not support that he failed medical retention standards for mental health condition(s) at the time of discharge based on the BH condition did not require prolonged absence from duty, modification of the work schedule, profiling, or hospitalization while on active duty. Also of import, global assessment functioning score was 90 in 2003, with negative subsequent screenings for PTSD and Depression until approximately 16 years after he was discharged from service. Evidence also did not support that he failed medical retention standards for TBI given his perfect performance on cognitive measures during the Mini-Mental Status Exam of the 11Feb2003 VA C&P Initial Psychiatric Examination. This was also consistent with his report of post military academic achievement (performing near the top of his class and college GPA 3.5). Despite his demonstrated performance of cognitive functioning at the level of moderate impairment in the April 2021 TBI DBQ, this was not consistent with the level of his performance demonstrated at or near the time of discharge from service. It was also noted that the applicant reported having been cleared for reentry into service in 2003; however, records were lost. Medical records were available which supported his clearance for reentry in 2008. Based on records available for review, referral for further medical discharge processing for the TBI, headaches, radiculopathy, somatic symptom disorder (or other BH condition), tinnitus, plantar fasciitis and degenerative disc disease conditions is not warranted.

BOARD DISCUSSION:

1. After reviewing the application, all supporting documents, and the evidence found within the military record, the Board found relief is not warranted.

2. The Board concurred with the conclusion of the ARBA Medical Advisor that available evidence confirms that prior to his discharge, the applicant only had one unfitting condition that prevented satisfactory performance of duty in his grade and primary specialty. The fact that he later received service-connected disability ratings from the VA for additional conditions is not a basis for concluding that those conditions had become unfitting prior to his discharge. Based on a preponderance of the evidence, the Board determined the applicant's discharge for disability with severance pay was not in error or unjust.

BOARD VOTE:

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

BOARD DETERMINATION/RECOMMENDATION:

The evidence presented does not demonstrate the existence of a probable error or injustice. Therefore, the Board determined the overall merits of this case are insufficient as a basis for correction of the records of the individual concerned.

3/6/2025

X [redacted]

CHAIRPERSON

[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. Title 10, U.S. Code, section 1552(b), provides that applications for correction of military records must be filed within 3 years after discovery of the alleged error or injustice. This provision of law also allows the ABCMR to excuse an applicant's failure to timely file within the 3-year statute of limitations if the ABCMR determines it would be in the interest of justice to do so.

2. Department of Defense Instruction 1332.18, 5 August 2014, establishes policy, assigns responsibilities, and provides procedures for referral evaluation, return to duty, separation, or retirement of Service members for disability in accordance with applicable Title 10, U.S. Code, and related determinations. Enclosure 3 provides the operational standards for the Disability Evaluation System.

a. A Service member will be considered unfit when the evidence establishes that the member, due to disability, is unable to reasonably perform duties of his or her office, grade, rank, or rating, including those during a remaining period of Reserve obligation. A Service member may also be considered unfit when the evidence establishes that:

(1) The Service member's disability represents a decided medical risk to the health of the member or to the welfare or safety of other members; or

(2) The Service member's disability imposes unreasonable requirements on the military to maintain or protect the Service member
.

b. Neither referral into the DES nor a finding of unfitness constitutes entitlement to disability benefits.

3. Army Regulation (AR) 635-40, Physical Evaluation for Retention, Retirement, or Separation, in effect at the time, established the Physical Disability Evaluation System (PDES) and sets forth the policies, responsibilities, and procedures that apply in determining whether a Soldier is unfit because of physical disability to reasonably perform the duties of his or her office, grade, rank, or rating.

a. It states commanders of medical treatment facilities (MTFs) who are treating Soldiers may initiate action to evaluate the Soldier's physical ability to perform the duties of his or her office, grade, rank, or rating. If the unfitness is of such a degree that a Soldier is unable to perform the duties of his office, grade, rank, or rating in such a way as to reasonably fulfill the purposes of his employment on active duty the commander will advise the Soldier's commanding officer of the results of the evaluation and the proposed disposition. If it appears the Soldier is not medically qualified to perform duty, the MTF commander will refer the Soldier to an MEB.

b. MEBs are convened to document a Soldier's medical status and duty limitations insofar as duty is affected by the Soldier's status. A decision is made as to the Soldier's medical qualification for retention based on the criteria in AR 40-501, Medical Services-Standards of Medical Fitness, chapter 3.

c. Only the unfitting conditions or defects and those which contribute to unfitness will be considered in arriving at the rated degree of incapacity warranting retirement or separation for disability.

d. Disability compensation is not an entitlement acquired by reason of service-incurred illness or injury; rather, it is provided to Soldiers whose service is interrupted and who can no longer continue to reasonably perform because of a physical disability incurred or aggravated in military service.

e. The mere presence of an impairment does not, of itself, justify a finding of unfitness because of physical disability. In each case, it is necessary to compare the nature and degree of physical disability present with the requirements of the duties the Soldier reasonably may be expected to perform because of their office, grade, rank, or rating.

4. AR 635-40, Personnel Separations-Disability Evaluation for Retention, Retirement, or Separation, 21 December 2017, establishes the Disability Evaluation System (DES) and sets forth policies, responsibilities, and procedures that apply in determining whether a Soldier is unfit because of physical disability to reasonably perform the duties of his or her office, grade, rank, or rating. It states there is no legal requirement in arriving at the rated degree of incapacity to rate a physical condition which is not in itself considered disqualifying for military service when a Soldier is found unfit because of another condition that is disqualifying. Only the unfitting conditions or defects and those which contribute to unfitness will be considered in arriving at the rated degree of incapacity warranting retirement or separation for disability. The DES consists of the three systems listed below.

a. Legacy Disability Evaluation System. Under the legacy system, for cases referred under the duty-related process, the PEB determines fitness and determines the disability rating percentages using the Veteran's Administration Schedule for Rating Disabilities (VASRD). The legacy process also includes the Reserve Component non-duty related referral process. No disability ratings are assigned for non-duty related cases. The Secretary of the Army or designee approves requests for legacy on a case-by-case basis. The VA Form 21–0819 will not be used, to include cases referred by the Army Board for Correction of Military Records when the applicant does not have an active status. The VA will not conduct the examination upon which the MEB findings are based. Instead, the MEB convening authority will assign a physician or physicians to conduct the required examination(s). The examination(s) will meet the minimum criteria of the VA medical examination(s). Conditions evaluated during the DES will consist solely of those conditions for which a P3/P4 profile was approved and any other conditions which the physician conducting the MEB finds individually or in combination are not likely to meet medical retention standards. Cases referred by the Army Board for Correction of Military Records address conditions in the context of their status at the time of the Veteran's separation.

b. Integrated Disability Evaluation System (IDES). The IDES features (1) A single set of disability medical examinations that may assist the DES in identifying conditions that may render the Soldier unfit. (2) A single set of disability ratings provided by VA for use by both departments. The DES applies these ratings to the conditions it determines to be unfitting and compensable. The Soldier receives preliminary ratings for their VA compensation before the Soldier is separated or retired for disability.

c. Expedited Disability Evaluation System. A voluntary process for Soldiers unfit for catastrophic injuries or diseases y permanently retire the Soldier for disability without referral to the PEB based on the MTF's medical narrative summary (NARSUM).

d. The DES assessment process involves two distinct evaluations, the Medical Evaluation Board (MEB) and the Physical Evaluation Board (PEB). The purpose of the MEB is to determine whether the service member's injury or illness is severe enough to compromise his or her ability to return to full duty based on the job specialty designation of the branch of service.

e. A PEB is an administrative body possessing the authority to determine whether a service member is fit for duty. A designation of "unfit for duty" is required before an individual can be separated from the military because of an injury or medical condition. Service members who are determined to be unfit for duty due to disability are either separated from the military or permanently retired, depending on the severity of the disability and length of military service. The overall effect of all disabilities present in an individual whose physical fitness is under evaluation must be considered both from the standpoint of how the disabilities affect the individual's performance, and requirements which may be imposed on the Army to maintain and protect him or her during future duty assignments.

5. Directive-type Memorandum (DTM) 11-015 explains the Integrated Disability Evaluation System (IDES). It states:

a. The IDES is the joint Department of Defense (DOD)-Department of Veterans Affairs (VA) process by which DOD determines whether wounded, ill, or injured Service members are fit for continued military service and by which DOD and the VA determine appropriate benefits for Service members who are separated or retired for a service-connected disability. The IDES features a single set of disability medical examinations appropriate for fitness determination by the Military Departments and a single set of disability ratings provided by the VA for appropriate use by both departments. Although the IDES includes medical examinations, IDES processes are administrative in nature and are independent of clinical care and treatment.

b. Unless otherwise stated in this DTM, DOD will follow the existing policies and procedures promulgated in DOD Directive 1332.18 and the Under Secretary of Defense for Personnel and Readiness Memoranda. All newly initiated, duty-related physical disability cases from the Departments of the Army, Air Force, and Navy at operating IDES sites will be processed in accordance with this DTM and follow the process described in this DTM unless the Military Department concerned approves the exclusion of the Service member due to special circumstances. Service members whose cases were initiated under the legacy DES process will not enter the IDES.

c. IDES medical examinations will include a general medical examination and any other applicable medical examinations performed to VA C&P standards. Collectively, the examinations will be sufficient to assess the member's referred and claimed condition(s) and assist the VA in ratings determinations and assist military departments with unfit determinations.

d. Upon separation from military service for medical disability and consistent with Board for Corrections of Military Records (BCMR) procedures of the Military Department concerned, the former Service member (or his or her designated representative) may request correction of his or her military records through his or her respective Military Department BCMR if new information regarding his or her service or condition during service is made available that may result in a different disposition. For example, a veteran appeals the VA's disability rating of an unfitting condition based on a portion of his or her service treatment record that was missing during the IDES process. If the VA changes the disability rating for the unfitting condition based on a portion of his or her service treatment record that was missing during the IDES process and the change to the disability rating may result in a different disposition, the Service member may request correction of his or her military records through his or her respective Military Department BCMR.

e. If, after separation from service and attaining veteran status, the former Service member (or his or her designated representative) desires to appeal a determination from the rating decision, the veteran (or his or her designated representative) has 1 year from the date of mailing of notice of the VA decision to submit a written notice of disagreement with the decision to the VA regional office of jurisdiction.

6. Title 10, U.S. Code, section 1201, provides for the physical disability retirement of a member who has at least 20 years of service or a disability rating of at least 30 percent. Title 10, U.S. Code, section 1203, provides for the physical disability separation of a member who has less than 20 years of service and a disability rating of less than 30 percent.

7. Title 38, U.S. Code section 1110, General - Basic Entitlement: For disability resulting from personal injury suffered or disease contracted in line of duty, or for aggravation of a preexisting injury suffered or disease contracted in line of duty, in the active military, naval, or air service, during a period of war, the United States will pay to any veteran thus disabled and who was discharged or released under conditions other than dishonorable from the period of service in which said injury or disease was incurred, or preexisting injury or disease was aggravated, compensation as provided in this subchapter, but no compensation shall be paid if the disability is a result of the veteran's own willful misconduct or abuse of alcohol or drugs.

8. Title 38, U.S. Code, section 1131, Peacetime Disability Compensation - Basic Entitlement: For disability resulting from personal injury suffered or disease contracted in line of duty, or for aggravation of a preexisting injury suffered or disease contracted in line of duty, in the active military, naval, or air service, during other than a period of war, the United States will pay to any veteran thus disabled and who was discharged or released under conditions other than dishonorable from the period of service in which said injury or disease was incurred, or preexisting injury or disease was aggravated, compensation as provided in this subchapter, but no compensation shall be paid if the disability is a result of the veteran's own willful misconduct or abuse of alcohol or drugs.

9. The Under Secretary of Defense for Personnel and Readiness issued guidance to Military Discharge Review Boards and Boards for Correction of Military/Naval Records on 25 July 2018, regarding equity, injustice, or clemency determinations. Clemency generally refers to relief specifically granted from a criminal sentence. Boards for Correction of Military/Naval Records may grant clemency regardless of the court-martial forum. However, the guidance applies to more than clemency from a 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.

a. This guidance does not mandate relief, but rather provides standards and principles to guide Boards in application of their equitable relief authority. In determining whether to grant relief on the basis of equity, injustice, or clemency grounds, Boards shall consider the prospect for rehabilitation, external evidence, sworn testimony, policy changes, relative severity of misconduct, mental and behavioral health conditions, official governmental acknowledgement that a relevant error or injustice was committed, and uniformity of punishment.

b. Changes to the narrative reason for discharge and/or an upgraded character of service granted solely on equity, injustice, or clemency grounds normally should not result in separation pay, retroactive promotions, and payment of past medical expenses or similar benefits that might have been received if the original discharge had been for the revised reason or had the upgraded service characterization.

10. Title 10, U.S. Code, section 1556, requires the Secretary of the Army to ensure that an applicant seeking corrective action by the Army Review Boards Agency (ARBA) be provided with a copy of any correspondence and communications (including summaries of verbal communications) to or from the Agency with anyone outside the Agency that directly pertains to or has material effect on the applicant's case, except as authorized by statute. ARBA medical advisory opinions and reviews are authored by ARBA civilian and military medical and behavioral health professionals and are therefore internal agency work product. Accordingly, ARBA does not routinely provide copies of ARBA Medical Office recommendations, opinions (including advisory opinions), and reviews to

Army Board for Correction of Military Records applicants (and/or their counsel) prior to adjudication.

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

//NOTHING FOLLOWS//