IN THE CASE OF: [redacted]

BOARD DATE: 22 August 2024

DOCKET NUMBER: AR20230013153

APPLICANT REQUESTS: find the deceased servicemember's (SM) death in the line of duty (LOD)

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

- DD Form 149 (Application for Correction of Military Record)
- Memorandum Rebuttal to Administrative Investigation and LOD Investigation into the Facts and circumstances Surrounding the Death of the SM
- Order 094-006 Promotion to sergeant
- Permanent Orders 301-032 Award of Drivers Badge - Track
- DA Forms 4980-14 (Army Commendation Medal (ARCOM) Certificate)
- DA Forms 1059 (Service School Academic Evaluation Report)
- DA Forms 4980-18 (Army Achievement Medal (AAM) Certificate)
- Certificate of Marriage
- DA Forms 2166-9-2 (Noncommissioned Officer Evaluation Report (NCOER))
- Adult Echocardiogram Report
- Polysomnography Report
- Polysomnography Technical Report
- Outpatient Active Medications List
- Pre-sleep Questionnaire
- Post-sleep Questionnaire
- Certificate of Death
- Agent's Investigation Reports
- Report of Investigation by Medical Examiner
- Toxicology Report
- DA Form 1569 (Transcript of Military Record)
- Letter from Casualty and Mortuary Affairs Branch
- DD Form 1300 (Report of Casualty)
- Report of Investigation - Final
- DD Form 261 (Report of Investigation LOD and Misconduct Status)
- DA Form 2173 (Statement of Medical Examination and Duty Status)
- Administrative Investigation and LOD
- Letter from Casualty and Mortuary Affairs Branch

- Memorandum to U.S Army Crime Record Center
- Letter from Criminal Investigation Division (CID)
- Ewens Toxicology Consulting Letter of Opinion
- Letter of Authorization
- Character References
- Medical Records
- Text Messages

FACTS:

1. The applicant, the wife of the SM, states she is requesting the LOD from the SM's death be corrected to in the LOD based on the documentation she provided. Medical records clearly state the SM had post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), and substance abuse due to his time in the service. He attempted recovery twice for his alcohol abuse and once for addiction. His demons won in the end. She believes the investigation did not take into account the SM's medical conditions and focused on the scene when his body was discovered. Upon viewing the documentation provided, the SM was not responsible for his actions. He was struggling with substance abuse, TBI, PTSD, heart issues, and having his military career coming to an unexpected end.

2. The applicant provides the following documents:

a. Memorandum Rebuttal to the Administrative Investigation and LOD Investigation into the Facts and Circumstances Surrounding the Death of the SM, states:

(1) Bottom Line up Front: On 5 December 2022, the LOD Investigating Officer (IO) determined the SM's death was not in the LOD and was instead an accident determined to be a result of "willful negligence." The IO recommended a finding of "Not in LOD - due to Own Misconduct." She rebuts the IO's findings and recommendation on the grounds that the IO failed to establish by the requisite burden of proof all three elements necessary for a determination of willful misconduct, in the event of a death by a drug overdose, if the SM's death was indeed the result of a drug overdose. In addition, the IO failed to establish by the requisite burden of proof that the SM's death was not an intentional suicide, thereby invoking the presumption that his death was, in fact, in the LOD.

(2) Statement of Facts: The SM started his military career in 2008, when he enlisted at [redacted] against his own family's surprise and doubt. He believed it was the best decision he could have made for himself. While that was true for finding his calling, sadly it did not come without gruesome consequences towards the end of his life.

(3) The applicant did not have the privilege to know the SM during the very first years of his career. They met after he joined the Civil Affairs community a few years into his service. Undeniably, what caught her attention was his infectious personality, charisma, and eloquence. But what really drew her in was his vulnerable side, which he was willing to show only to the lucky few. His heart was huge and full of compassion, always wanting to help out anyone and everyone. Sadly, he was forgetting to show the same amount of love and care to himself. He wore his heart on his sleeve around the ones he could trust but bottled up deeply rooted emotions, which he thought would show a sign of weakness - almost as if it was shameful to show personal struggles. She learned about those very first years in the Army, through the SM's scarce stories, whatever he was willing to share. He was not very keen about reminiscing about his time in active combat. She could not fully understand but suspected why.

(4) His first deployment was to Iraq from 1 February 2009 to 1 February 2010 as part of his artillery unit, during Operation Iraqi Freedom, for which he received the ARCOM. He had a second deployment to Iraq from 7 July 2011 to 31 December 2011 for which he received the AAM, which was then followed by a deployment to Kuwait from 1 January 2012 to 19 June 2012. Once he advanced to the Civil Affairs community, his missions changed their character of deployment, but continued to be demanding and taxing in a different way. It started with a deployment to Poland from October 2015 to January 2016, followed by Germany-Poland-Hungary-Poland-Slovakia from July 2016 to October 2016, Ukraine from January 2018 to June 2018 and finally Lithuania from July 2019 to December 2019.

(5) He always gave his all to any mission at hand. When overseas and speaking on the phone to him, he would appear tense and very focused on the tasks at hand. He really made the job his priority. The applicant is aware that each deployment came with risks he could not share but he did make her aware of some stressful moments - such as the bombing of a school in Ukraine where the team managed to barely escape, or in Lithuania where he was on constant alert being continuously followed. Those experiences of course do not even compare to the stressors he lived through, during active combat. The short breaks in between deployments did not provide enough personal time to regroup and take care of himself.

(6) He eventually elected to pursue the Civil Affairs route, as he believed more good could be achieved through channels of diplomacy without causing unnecessary casualties. In his mind, he wanted to undo the damage he had done, in the past. He sure chose the right path for himself as his experience, drive, passion, and interpersonal skills were being noticed by many. His drive and talent were quickly recognized, admired, and acknowledged by all those who were lucky to work with him. The ratings speak for themselves and were collected throughout the years in his many successful NCOERs. He always went above the required standards and excelled in ratings which often put him in the top five percent.

(7) The applicant stood on the sidelines and cheered him on throughout those deployments. Those were the best years of her life; she knows that now. She lives through those times and reminisces on each and every mission, because there is always some great memory in their personal life associated with each one. To advance even further and open options for his career in Europe, he initiated the process to pursue Officer Candidate School, to which he got accepted in 2020. His plan was to enroll in the school after returning from Germany in June 2021. Unfortunately, he never had the opportunity to do so, after the unfortunate sequence of events in Germany, which led to his relief for cause.

(8) Deployment to Germany in 2020-2021: The months leading up to that deployment were deep into the pandemic. Like everyone else, they were restricted as to where they could go and they spent most of their time at home. The SM shared how being constricted to one space made him feel claustrophobic and anxious. Many nights he would wake up in the middle of the night with cold sweats from what appeared to have been a bad dream. Sometimes he would talk or scream out some irrational phrases and then wake up. When confronted with questions of what was bothering him, he would reply that everything was okay.

(9) During the pandemic time, which also led to less time at work, the applicant noticed the SM drinking a beer or two frequently late in the mornings. Another day, she noticed something off about his eyes and when confronted, he responded he took a muscle relaxer given to him by his medic. He would always put her concerns to sleep and gave her no reason to really worry. After all, he portrayed a very strong persona able to handle any situation very well. In retrospect, she knows he was just too proud to ask for help, as many special operations servicemembers are.

(10) In the Germany deployment, the SM saw hope in throwing himself back into the busy schedule of the mission, wanting to feel useful and relevant, and essentially do what made him thrive. She had high hopes that he would be back to his old self, once back on the mission. The moment he landed in Germany, however, he was met with very strict COVID rules. He sounded very anxious each time they spoke. He also shared with her that he experienced some personal issues with the team and incompatibility with the team leader with whom he shared living quarters. What was alarming to the applicant, was that like never before, the SM would complain about feeling claustrophobic there and not knowing how to relax. He was constantly on edge. She did all she could to console him over the phone every day, but was really worried about him.

(11) She truly believes his driving under the influence (DUI) in Germany was the result of all those factors combined. She remembers that day vividly as their dog had passed away. She tried calming the SM down on the phone and kept reminding him to

stay humble and lay low. That night, after German police arrested him, he called her on the way to the precinct being extremely apologetic. He said, "I am sorry, I f-ed up; I don't know what happened to me." After that, he went on a downward spiral mentally. He was left with no psychological support other than the applicant and the Chaplain from Fort Liberty with whom he spoke every day. He sounded as if his world collapsed. She felt so helpless not being with him physically. He was not well, and the worst was still ahead of him back in [redacted].

(12) The SM's spiral into drug addiction: The applicant was very worried about the SM's mental wellbeing from then on. After having been sent back to Fort Liberty to face the consequences of his actions, he had become very vulnerable and depressed like never before. The unit pushed him away from any meaningful duties, cut off his time in the office, took away identification access to the building, and made him wait outside the door for someone to let him in. He was completely deflated and felt useless. His behavior changed drastically, and he would get home from work with what seemed like worse and worse news every day. His top secret clearance was suspended, he was assigned some insignificant duties at the office, and he felt pushed away by the colleagues working there.

(13) Physically he looked awful, and mentally he was inconsolable. That is when his drinking really picked up, and she would often find him with a half empty bottle of Jameson. She did not know back then about any drug use; he hid it very well. He finally had no choice but to admit his depression to her. The overall signs were so obvious, he could not camouflage that from her anymore.

(14) On 6 April 2021, the SM called the applicant before going home from work. He said he needed to go to the emergency room because he was feeling shaky and weak. She met him at the [redacted] which was just five minutes from their house. He was given electrolytes through an IV and diagnosed with severe anxiety and depression. That day their journey with antidepressant medication began. He was put on Klonopin and Lexapro and diagnosed with major depressive disorder.

(15) He tried many different types of medication for his depressive disorder. She literally had to dispense them to him because he would want to take multiple doses at once. Weeks went by and she believed he was getting on the right path. To her surprise, however, he revealed one evening that he had been struggling with cocaine use because the antidepressant pills were just not enough, and he needed some serious help. They stayed up very late that night talking and the following morning on 30 April 2021, she took him to check into the Behavioral Health Clinic. On his intake sheet, he admitted to having suicidal ideations with a plan for the previous three months and was admitted to the psychiatry ward.

(16) He was at his lowest low with the inability to have "everything under control" and finally officially admitted he had a big problem and was desperately in need of help. His cover up no longer worked. It was humbling and scary at the same time. That is how his journey with a rehabilitation program began.

(17) Rehabilitation efforts: It was a long and challenging journey, but the SM gave his all to recover. Aside from the Addictions Medicine Intensive Outpatient Program (AMIOP), he started attending weekly Alcoholics Anonymous meetings along with Bible study on Saturdays. He was fully committed and showed genuine effort in wanting a better life. Simultaneously, he had to face the ongoing and future consequences of the Germany incident, which he was very anxious about. He did have high hopes for being allowed to receive the reprimand, learn from it, and move on with his military career. After all, he had only six years left and had committed his adult life to the Army.

(18) After he completed the AMIOP program in late October 2021, the applicant believed there was a bright future ahead. The SM had a positive outlook and was ready to tackle his possible transition out of the Army. They had a plan in place. She was proud of him and felt that she got her husband back. They were also working on their personal goal of trying to have a baby. They experienced many failed attempts throughout the years, and they ultimately chose to pursue assistive reproductive medicine at its full potential. That was an exciting goal for both of them, something positive to look forward to.

(19) The SM's passing: In January 2022, the SM learned he would have to separate from the Army. He was not even allowed to join the Reserves, which had been a lingering glimmer of hope for him. He tried to play along with that verdict. The applicant knew, though, that he felt the opposite on the inside. He again started to have sleepless nights, and she would often find him sitting in the dark living room in the middle of the night. He threw himself into a rigorous workout routine. Yet he continued to assure her he was doing fine.

(20) In the meantime, he started to work on his Department of Veterans Affairs (VA) disability claim and had a long line of doctor appointments. He continued his assignments at the unit but was away from the office many days due to appointments. Despite his unit being aware of his addiction problem and that he had just recently completed a drug rehabilitation program, his only method of accountability was a daily text to his first sergeant. The applicant picked up on his irritability and constantly raised voice. He was drowning on the inside yet assured the applicant he was fine. She did believe him and believed they would get over this difficult phase. They were working on their future together, and she was under the impression they would smoothly get to their next chapter. But on the inside, the SM was dying. She knows now, when it is too late to

rescue him. He was hurting that after almost fourteen years of devoted and accomplished service, he was being ostracized and rejected. He felt betrayed.

(21) That day he was found deceased was the worst day of her life. She was in complete shock and disbelief. Her world ended. She was not at the scene when the authorities showed up at their house on 27 January 2022. She had to make a trip back from Europe. She learned over the phone from the detective that it "looked like a drug overdose." Once she finally got to the house on 29 January 2022, she was horrified. It looked more like a crime scene, with a huge puddle of blood on the carpet where the SM had been found lying. She will never forget that traumatizing scene.

(22) Since his death, she has been on and will continue to be on the quest for more answers. She still does not feel closure regarding his death. It is still too early, but she dreads the day when their daughter asks what happened to her daddy. The applicant will want her to learn about how loving, caring, and funny the SM was, and how much he would love to do all the things with her that a parent does - the normal, everyday mundane moments we take for granted. After all, he was putting a lot of effort forward to have her in his life. The applicant will want her to know how her daddy always saw the glass half full, completely opposite of her. He would always say "do you want to hug it out?" or "let's make today a better day." The applicant will want her to know how she would give anything in this world to hear that again.

(23) Their daughter will learn about the SM's military career and how much it had transformed him. She will know how proud he was to serve this country and how embedded he was in the Army and then when she asks what happened to him, the applicant wants to be able to share the emotional struggles he went through to get where he was. The applicant will tell her how he had to pay a high price for neglecting his own mental health and wellbeing to push forward, and how the applicant would give anything in this world to still have him here. She will know how much the applicant wishes he could be present in her life.

(24) Legal Standards: In every LOD investigation, an injury, illness, or death is presumed to be in the LOD, unless refuted by substantial evidence gleaned from the investigation. (Army Regulation (AR) 600-8-4, (Line of Duty Policy, Procedures, and Investigations) paragraph 2-6(b)). The purpose of the LOD investigation is to find whether there is evidence of intentional misconduct or willful negligence that is "substantial and of a greater weight than the presumption of 'in LOD'". (AR 600-8-4, Appendix B.) "LOD determinations must be supported by substantial evidence and by a greater weight of evidence than supports any different conclusion. The evidence contained in the investigation must establish a degree of certainty so that a reasonable person is convinced of the truth or falseness of a fact." Considering both direct and indirect evidence. (AR 500-8-4 paragraph 2-6 (c). If the presumption of "in LOD" is not

rebutted by such substantial evidence, the investigation must conclude that an injury occurred in the LOD.

(25) In defining "willful negligence" the regulation states that it is "[a] conscious and intentional omission of the proper degree of care that a reasonably careful person would exercise under the same or similar circumstances... Willful negligence is a degree of carelessness greater than simple negligence. Willfulness may be expressed by direct evidence of a member's conduct and will be presented when the member's conduct demonstrates a gross, reckless, wanton, or deliberate disregard for the foreseeable consequences of an act or failure to act." (AR 600-8-4, Glossary)

(26) For "intoxication and drug use" to qualify as willful misconduct, there are three pivotal considerations that must each be met. (AR 600-8-4, paragraph 4-10(a)). For intoxication to qualify as willful misconduct, it must show that: (1) the Soldier's physical or mental faculties were impaired due to intoxication, at the time of injury; (2) the the impairment was voluntary; and (3) that the impairment was the proximate cause of the injury.

(27) Should a Soldier's death result from suicide, a Soldier may be considered to have died in the LOD. (AR 600-8-4, paragraph 4-12(a)). When a Soldier is not mentally sound, it is assumed that the Soldier is incapable of forming intent, which is an essential element of intentional misconduct.

(28) LOD investigation determinations are subject to review and appeal. Where a Soldier incurs an injury, illness, or disease, while serving on active duty, a not in the LOD determination may be appealed. Final LOD determinations may be reopened where the competent authority either made a mistake of law or failed to consider pertinent new evidence, at the time of the original determination. In addition, "Qualified" survivors of a deceased Soldier who passes away, while serving on active duty, before becoming eligible to receive retirement pay, may on behalf of the Soldier and for the same basis for which a Soldier could appeal not in the LOD determination in a death case under the provisions of paragraph 4-17.

(29) Application of Legal Standards: The SM's death cannot be considered as willful misconduct, and thus should be considered in the LOD. First, even if the SM's death was a result of an unintentional drug overdose, the IO failed to meet the burden of proof required for all three pivotal considerations in establishing willful misconduct in drug intoxication as outlined in AR 600-8-4, paragraph 4-10(a). Second, the IO failed to meet the burden of proof that even if the SM's death was a result of a drug overdose, he did not intentionally commit suicide by drug ingestion.

(30) The SM's mental faculties were impaired due to military service derived mental health issues. The SM's faculties, at the time of death, were impaired by his

mental health issues derived from his time as a military servicemember. AR 600-8-4, paragraph 4-10(a) states that in order to demonstrate willful misconduct in cases of drug overdose, it must be shown that a Soldier's mental faculties were impaired by the intoxicant, at the time of injury. However, this standard is not met where the Soldier's mental faculties are previously impaired by mental health issues. The SM's faculties were impaired by his military service derived mental health issues long before his mental faculties were impaired by any intoxicant.

(31) The SM served his country for fourteen years, completing two deployments to Iraq and one to Kuwait, while in an artillery unit. He told the applicant how he experienced multiple hits on the head, during these deployments, despite wearing protective gear and how the blast of explosions made him feel as if his head was banging against a metal surface. Multiple times when going through his gear at home, handling the helmet he wore in Iraq, would make him freeze. He did share that touching it would instantly take him back to relive the moments of explosions. The applicant knows he did not like that memory but seeing his reaction took her by surprise. She has never seen him allow himself to open up that much before. Even after so many years gone by, the memory felt very real to him.

(32) It is no secret the SM struggled with mental health issues that were a direct result of his military service. The applicant knows he had seen things he did not want to relive again by sharing with her. His recounts of his military service were brief and limited. She did learn about the multiple explosions when operating artillery in Iraq, the assessment of the damage once it was over, and the casualties which often times involved babies and children. There were also episodes of the SM waking up startled from sleep, with a very distant gaze in his eyes. He would need to take a minute to assess his surroundings, and to realize he was in his own bed. When asked what was happening, he would respond that he felt he was back at his post, trying to sleep, and keep guard at the same time. She was lucky to have learnt even that much about his past. Most times he would just dismiss her requests.

(33) Following his return from Germany in 2021, he was diagnosed with major depressive disorder, in large part due to the structural changes to his brain and the trauma he experienced during his deployments. In his subsequent multiple doctors' appoints for his VA disability claim, he was diagnosed with PTSD and nine TBIs (serving in an artillery unit during combat deployment as well as taking falls during his parachute jumps contributed to this). The National Institute of Health's (NIH) National Library of Medicine had identified the most common chronic psychiatric consequences of TBIs. According to NIH, the chronic symptoms include:

- Cognitive deficits: "impairment in efficiency and speed of information processing, attention, and vigilance are seen in most cases. Alertness is

impaired in severe TBI. The patient may be withdrawn, dull, and apathetic."
- Memory: "Newly acquired knowledge is forgotten."
- Perception and Language
- Intelligence: "Both performance and verbal IQ are reduced..."
- Personality Change: "Personality change may result from neurochemical changes or from psychological reaction to TBI. Common changes include excessive tiredness, indifference, concentration and attention disorders, inflexibility, perseveration, inability to anticipate, behavioral disinhibition, irritability, change in quality of relationships with shallowness and obsessive-compulsive symptoms. "
- Aggression: "Physical/verbal aggression and impulsiveness are particularly difficult for family members to manage...This can be managed with anticonvulsants, antidepressants, lithium, calcium channel blockers, beta blocker, antipsychotic, benzodiazepines, and psychostimulants."
- Sexuality
- Alcohol abuse: "Alcohol abuse in the previously head injured can result in pathological intoxication."
- Post Concessional Syndrome, the symptoms of which include:
  - Mood disorders: "Almost 50 percent of post-traumatic...patients have abnormal EEG. Suicide is considerably increased after TBI and accounted for 14 percent of all deaths in an 18 year follow up of those with war brain injuries."
  - Psychoses
  - Neuroses: "Neuroses are among the commonest psychiatric sequelae of TBI. Anxiety may coexist with depression or present alone. Phobias, obsessive-compulsive disorders and PTSD may emerge. Dissociative (Conversion) symptoms including fits, fugue, amnesia, Ganser states, paralysis, anesthesia, and disturbance of speech, sight, or hearing are not uncommon. A neurasthenic reaction may incapacitate the patient for months or even years.

(34) The SM's military service led to impairment of his mental faculties long before they were impaired by any drug ingestion, on the date of his death. The IO failed to establish by the requisite burden of proof that the intoxicant was the cause of the impairment.

(35) The impairment of the SM's mental faculties was not voluntary. AR 600-8-4, paragraph 4-10(a) states that to establish willful misconduct in the case of drug overdose, a Soldier's impairment must be voluntary. To state that the SM's substance abuse history was voluntary fails to consider that addiction is a disease. If someone becomes so dependent upon a substance, their relationship stops being voluntary. The abuser ceases to be autonomous in choosing when and how they use. In the void

comes a dependency relationship, one in which the user seemingly cannot live without the substance. The SM had a history of substance abuse, and such a past should reflect an involuntary relationship. Despite treatment, he was addicted, and was unable to stop himself from continuing to use.

(36) There is strong evidence that suggest the SM's addiction was a direct result of his military service related to his PTSD and TBI diagnoses. He never had issues with substance abuse, prior to his deployments. Looking back, she realizes now that there were signs of PTSD and mental health issues resulting from TBIs. However, it was not until COVID hit and he lost his coping strategies that he turned to alcohol and, unbeknownst to her, cocaine to cope with his service related mental health issues.

(37) As the Article *Epidemiology and Prevention of Substance Abuse Use Disorders in the Military* explains, "[g"iven the increased military operations and frequency of deployments, there is little wonder that medical professionals at military health care and VA health care facilities are seeing an increasing number of servicemembers requesting care for substance use and psychological health disorders. Research has shown that any type of exposure to combat increases the risk of substance use disorders (SUD), PTSD, major depression, increased use of health care, cigarette use, and functional impairment in the workplace. Research also shows that high levels of combat exposure was predictive of cigarette use, heavy drinking, PTSD, and suicidal ideation...Hoge et al studied the impact of combat exposure on rates of alcohol use with co-occurring psychological health disorders and found that the prevalence rates for alcohol use, major depression, or PTSD were significantly higher for servicemembers after their deployment."

(38) According to the American Addiction Centers, "[p]eople seeking treatment for PTSD are 14 times more likely to also be diagnosed with a SUD." It is believed that individuals with PTSD may misuse substances as an attempt to self-medicate. As the American Addiction Centers explains, "[t]he thought is that by using substances, a person with PTSD, will null or avoid PTSD symptoms...Research indicates that servicemembers and Veterans, who have heavy drinking tendencies, are more likely to have PTSD and depression." To provide further emphasis, the VA National Center for PTSD notes the following statistics:

- More than 2 of 10 Veterans with PTSD also have SUD
- Almost 1 out of every 3 Veterans seeking treatment for SUD also have PTSD
- The number of Veterans who smoke (nicotine) is almost double for those with PTSD (about 6 of 10) versus those without a PTSD diagnosis (3 of 10)
- In wars in Iraq and Afghanistan, about 1 in 10 returning Veterans seen in the VA have a problem with alcohol or other drugs

- War Veterans with PTSD and alcohol problems tend to binge drink; binge drinking is when a person drinks a lot of alcohol (4-5 drinks or more) in a short period of time (1-2 hours)

(39) The applicant wishes she could provide a more comprehensive timeline between the SM's deployments, onset of PTSD and TBI symptoms, and substance abuse, but he was so good at convincing her that his mental health issues were nothing to be concerned about and hiding his substance abuse from her. He was able to conceal everything very well, not revealing his problems too much. He was able to perform at work with great success, hide his mental problems, and most likely used only behind closed doors whenever it felt necessary. It is only now in hindsight that she is able to connect the dots. She did notice he would lose touch when drinking socially and it would turn out to a black out often. But again, he would just respond to her "we were having fun and he was exaggerating." She tried to be vigilant to any signs and watched him closely, but because he hated her reaction and close inspections, he would make sure he was not using when she was around. One time, when she was really concerned for his health and sent him to the hospital (while she was away), he said he did not share any health scares with her because her reactions were over the top. He just simply did not want to get caught. She believes this is another indication of how involuntary his substance abuse was. He was suffering from a disease, which directly correlates with his military service incurred mental health issues - the impairment of his mental faculties was not voluntary.

(40) The IO failed to meet the burden of proof that the SM's drug intoxication was, in fact, the proximate cause of his death. AR 600-8-4, paragraph 4-10(a) states that to establish willful misconduct in the case of drug overdose, a Soldier's impairment must be the proximate cause of the injury as noted above, "LOD determinations must be supported by substantial evidence and by a greater weight of evidence than supports any different conclusion. The evidence contained in the investigation must establish a degree of certainty so that a reasonable person is convinced of the truth or falseness of a fact" in light of all evidence.

(41) The SM suffered from many military service-related physical ailments. In preparation for his VA disability claim, he had multiple doctors' appointments, which reveled numerous health problems he was experiencing. In addition to the major depressive disorder, PTSD, and nine TBIs, he was diagnosed with fibromyalgia, obstructive sleep apnea, hypertension, high cholesterol, concussion without loss of consciousness, exophoria, rheumatoid arthritis, infertility, and heart arrythmia. In the months leading up to his death, he frequently complained of headaches and black vision upon standing up. Whenever getting up, he would say he was feeling like he was about to faint. Those symptoms were increasing and worried the applicant tremendously, and, prior to his death, he was planning to be examined by a neurologist. Additionally, he was diagnosed with COVID on 6 December 2021 and subsequently

was admitted to the emergency room. COVID left a possibility of complications - such as blood clots, myocarditis, and thrombosis - which are mostly predominant in young males his age.

(42) A number of the physical ailments and diagnoses he had could have caused his death, and there remains insufficient evidence to determine that narcotics were the definite source of the SM's death. When she received a call from [redacted] Medical Examiner, she asked if an autopsy had been performed to which she received a negative response. When she continued to inquire about a possibility of one, she was told it was the medical examiner's discretion. No autopsy was ever performed regarding the SM's death, on the assumption that the presence of a powdered substance and paraphernalia was sufficient to determine an overdose. To assume an overdose fails to consider the litany of health issues faced by the SM that very well could have been the cause for his death.

(43) The IO took at face value the SM's death was the direct result of a drug overdose and failed to consider any possibility of other causes. The IO had a responsibility and burden to show the SM's cause of death determination is supported by substantial evidence and by a greater weight of evidence than supports any different conclusion. In light of the IO's failure to even so much as mention any other possible cause of death, the IO failed to establish the SM's cause of death with a degree of certainty so that a reasonable person is convinced of the truth. Therefore, the IO failed to meet the requisite burden of proof that the SM's death was even the result of a drug overdose.

(44) The IO failed to meet the burden of proof that, even if the SM's death was a result of a drug overdose, he did not intentionally commit suicide by drug ingestion. The Report of Investigation by Medical Examiner and Toxicology Report, referenced in the administrative investigation report, notes that the amount of cocaine identified within the SM's blood was low: 0/16 mg/L, which is much lower than the average lethal dose of 6.2 MG/L. While it is easy to make assumptions on arriving at the scene and viewing the SM in the state he was in, the toxicology test revealed amounts far lower than the lethal average.

(45) The applicant obtained an independent toxicology report from [redacted] PHD, Diplomate of the American Board of Toxicology who owns [redacted] Dr. [redacted] agreed that "[t]he toxicology test results of the [SM's} femoral blood shows that the combined amounts of cocaine and its active metabolite cocaethylene, were not at a high enough concentration to have caused death and likely weren't even high enough to cause significant intoxication either. Cocaine was found at a concentration that is 100 times less than the main metabolite benzoylecgonine. This is suggestive of [the SM] having consumed cocaine and remaining alive for quite some time. In addition, the metabolite cocaethylene is only produced when ethanol (alcohol) is

also consumed, indicating that it was present at the time [the SM] was consuming cocaine. However, his blood did not contain any ethanol. This again indicates that [the SM] had consumed cocaine and ethanol and remained alive long enough to have metabolized all the ethanol he drank."

(46) However, Dr. [redacted] notes that, "[b]ased on my education, training, experience, and review of the above documents and references, it is my opinion that [the SM] most likely died from fentanyl toxicity, with cocaine not contributing significantly to his death. It is possible that [the SM] had intentionally consumed a lethal dose of fentanyl." Dr. [redacted] explains that "fentanyl was detected at a concentration known to cause death, but its metabolite norfentanyl was not detected. This means that the concentration of fentanyl in [the SM's] blood increased to a lethal concentration and did not have time to peak and then start to decrease. Therefore, [the SM] died very quickly after the fentanyl got into his blood. The rapid death after a high dose of fentanyl is consistent with how a person who was intentionally trying to die would most likely have consumed fentanyl."

(47) The IO determined the SM's death was not a suicide because he did not leave a note. Lots of people do not leave notes when committing suicide. In addition, the applicant does not believe, as the IO suggests, that the SM took a "bad batch" of cocaine that, unbeknownst to him, was laced with enough fentanyl to kill him. There is strong evidence to suggest that the SM instead consumed the cocaine and fentanyl at different points in time and intentionally consumed a lethal dose of fentanyl. Sadly, it is well known that individuals often use illicit drugs to attempt suicide. According to the NIH, "[s]ubstance use often precedes suicidal behavior in the military. About 30 percent of Army suicides and over 45 percent of suicide attempts since 2003 involved alcohol or drug use."

(48) It is well documented that the SM had previously struggled with suicidal ideation, which started, during the pandemic. It was not brought to the applicant's attention until later, but on Thanksgiving 2020, they visited their good friends [redacted]. It was then the SM shared with [redacted] (a very close friend of his from childhood years) that something very bad was happening with him and he "was afraid of his own thoughts." A few months after this confess, the SM took the applicant by surprise when he blurted out of nowhere that he knew he was alive because of her. He would not elaborate on the topic despite her pleas.

(49) Things took a turn for the worse after he returned from Germany following his arrest. Every day when he would go back home, he was completely defeated, depressed, and lacked his usual charisma which made her concerned for his own safety. He would not believe her assurances that it would be okay, even if he had to face the harshest punishment. He completely shut down. After all, he was downgraded from being a desired and productive team member to a useless number. His identity had been taken away from him, and he was being ostracized by the unit. Over and over,

he expressed to her that he felt his life was over. He once told her "the only reason he did not shoot himself yet is because he wouldn't want her to find him on the floor." After hearing that, she immediately asked him to get rid of the guns in the house. Luckily, he complied with this request. The applicant thinks he started to become scared of his own thoughts.

(50) When she took the SM to behavioral health on 30 April 2021, after he admitted to her that he was struggling with cocaine addiction, they completed an intake assessment for him. During the intake assessment, he admitted to having had suicidal ideation with a plan for the previous three months.

(51) The days leading up to signing his separation papers from the Army, he was a wreck. He could not find a place for himself, was very brief with the applicant, isolated himself, and looked completely deflated. She continued to assure him there would be a life after this. She is not sure if he believed her. Seeing him in that state, she was doubtful too. On 7 January 2022, the SM shared with her that he would not be even allowed to serve in the Reserves, something he had high hopes for. From then on, he became a shadow of himself.

(52) The SM passed away on 26 January 2022 - the same day his terminal leave started. She was under the impression that his leave would not start until 13 February 2022, and has often wondered if this timing was not a coincidence. In addition, when she returned home, she found an open desk drawer in the SM's office. On the desk were codes pulled out from the small portable safe, which provided access to his digital wallet. He would often make sure she was aware of those codes and knew their whereabouts. She froze at this sight because it made her mind go to the darkest and scariest thought that his death was an intentional suicide.

(53) As noted, should a Soldier's death result from a suicide, a Soldier may be considered to have died in the LOD. Where a Soldier is not mentally sound, it is assumed that the Soldier is incapable of forming intent, which is an essential element of intentional misconduct. She still often wonders if his death was an intentional suicide. The IO certainly failed to meet the requisite burden of proof for ruling out his death as a suicide. If the SM was so mentally impaired by suicidal ideation, it would have been impossible for him to form the requisite element of intent necessary for showing of intentional misconduct.

(54) For the foregoing reasons, the SM's overdose should not be characterized as "not in line of duty - due to his own misconduct." Due to an insufficient factual record and an improper analysis of the facts present, it should be concluded the SM did not commit willful negligence or misconduct. She respectfully requests the Board enter a finding that his death was in the LOD.

b. Documents showing his promotion to sergeant, awards, and service schools he attended which are available for the Board's review.

c. The marriage certificate of the SM and applicant, which shows they were married on 20 April 2020.

d. NCOERs which show he was consistently rated as among the best, exceeded standards, or far exceeded standards. The NCOERs are available for the Board's review.

e. An Adult Echocardiogram Report, 8 December 2020, which shows he was being evaluated for a myocardial injury.

f. A polysomnography report and technical report, 8 September 2021, shows he was seen for testing following snoring, witnessed apneas, waking up gasping/chocking, fragmented sleep, nonrestorative sleep, nightmares, and excessive daytime sleepiness.

g. Agent's Investigation Reports, 28 January 2022, which are regarding the SM's death. An autopsy would not be performed, however, a drug screen/toxicology would be conducted.

h. Report of Investigation by Medical Examiner, 7 February 2022, shows the SM died on 27 January 2022. The probable cause of death was pending he had cocaine and fentanyl toxicity and the manner of death was accident. He had no known medical history. The SM's wife was out of the country and asked her dog sitter to check on the SM when she could not reach him. The dog sitter entered the secure residence using a key and found the SM unresponsive on the floor. White powder, a syringe, and cotton were on the kitchen counter. Law enforcement had no concerns for foul play.

i. A Transcript of Military Record, 27 June 2022, shows the SM had foreign service in Lithuania, Ukraine, Slovakia, Poland, Hungary, Germany, Kuwait and was in Iraq on two occasions. He died on active duty.

j. CID Report of Investigation - Final, 3 November 2022, shows an accidental death. The toxicology report indicated there was presence of cocaine metabolite, opiates/opioids, and fentanyl. The death certificate indicated the cause of death as cocaine and fentanyl toxicity and manner of death as accident.

k. Memorandum Administrative Investigation and LOD Investigation into the Facts and Circumstances Surrounding the Death of the SM, 5 December 2022, states in pertinent part, the IO found the SM had a history of substance abuse and mental health issues. On 26 January 2022, he died as a result of an overdose of illicit drugs. The SM's death was a result of his own intentional misconduct. His death was not as a result of

suicide. He did not leave a suicide note and no communication indicating he was planning on committing suicide. Additionally, the medical examiner's report indicates the overdose was accidental. The IO recommended the SM's death be found to have resulted due to his own intentional misconduct or gross negligence (not in LOD - due to own misconduct).

l. Letter from [redacted] 12 September 2023, states in pertinent part based on the Dr.'s education, training, experience and review of the report of investigation by medical examiner and toxicology testing report, it is his opinion that the SM most likely died from fentanyl toxicity, with cocaine not contributing significantly to his death. It is possible that the SM had intentionally consumed a lethal dose of fentanyl. The basis of the Dr.'s opinion is available for the Board's review.

m. Character References state:

(1) From A- T- 31 August 2023, he believed the systems in place to assist Soldiers, during their most stressful times failed to recognize the sings with the SM, a Soldier who proudly serviced his country and put the needs of the country above his and his family. The years of volunteering to deploy in support of his country, countless training events, and being separated from the military should have been recognized as major life stressors by the institutions which are supposed to support Soldiers. [redacted] first met the SM in 2013. Without the SM, [redacted] would have failed the Civil Affairs Qualification Course. [redacted] knew and worked with the SM for eight years. The SM was one of the best Soldiers with which [redacted] ever had the opportunity to serve with. He was the type of leader [redacted] would follow anywhere and constantly inspired others.

(2) From Major (MAJ) [redacted] during the years the MAJ worked with the SM there was no indication he had issues with alcohol or drugs. In the Special Operations Civil Affairs community, issues like that are noticed, as they work in small teams and deploy for long periods of time in a small team. The MAJ was shocked when he learned the SM received a DUI, wile deployed for a fifth time in as many years to Germany. Following the event, the SM reached out to the MAJ and they talked regularly throughout the disciplinary process. The MAJ believes that years of extremely rigorous training and operational tempo, coupled with the stress that the COVID-19 pandemic caused him while deployed, resulted in a spiral of depression that led to a terrible choice. The last time the MAJ spoke to the SM, the SM seemed optimistic about his future, even though his military career was coming to an end. He expressed remorse for the decision that he made that ruined his career and fought to try to save his career in the military to the very end. Having lost the fight, the MAJ now knows that his optimism for the future was a facade put up by a person that was broken. The MAJ believes the SM was a victim of PTSD and that was a result of years of combat and operational deployments in high stress environments. The SM the MAJ knew was a high performing NCO, selected by the military to serve further as a commissioned officer.

(3) From MAJ [redacted] , 31 August 2023, who served with the SM from August 2017 to January 2020. The MAJ quickly came to understand the SM as a senior enlisted Soldier who prioritized his mission, men, and family. The SM had a magnetic personality and nature that people from all cultures and backgrounds gravitated to. The SM embodied the character and abilities that every Civil Affairs NCO strives to be and every senior leader wishes to have amongst their ranks. The SM made a mistake that ultimately cost him his career and started a chain of events that the MAJ believes ultimately led him to make the decision that ended his life. Following the evaluation that led to his separation from the Army, the SM's demeanor noticeably changed. He began to isolate himself from his friends and family and voluntarily entered the SUD Clinical Care to address suicidal ideation and struggles with mental health. Service to his nation and the Army was the SM's identity and something that he truly cared for and loved. Looking back at their conversations leading up to his separation from the Army, the MAJ believes the SM began abusing substances as a coping mechanism to deal with his inability to understand or come to terms with this truly life-shattering event.

(4) From Command Sergeant Major (CSM) [redacted] 1 September 2023, the CSM was writing as he is still deeply affected by the SM's passing and saddened that the many years of combat and deployment related stress stemming from many years of honorable conventional and Special Operation service, went undiagnosed and untreated. The CSM and SM deployed to Ukraine together in 2018. The SM was responsible for the security and wellbeing of a four-person Civil Affairs team in some of the most politically strategic, and challenging locations in Europe. The SM was a charming, motivated and extremely likeable individual, and beloved member of their team who was extremely goal oriented and very competitive, which brought out the best in his teammates. During the CSM's tenure on the team, the SM never showed any indication of any drug or alcohol abuse. When the CSM got word the SM had gotten in trouble for DUI, he was shocked. This was completely out of character for the SM and the CSM believes that it was the multiple deployments and the associated stressors of being a high performing teammate that contributed to this issue. Additionally, during both of the SM's Special Operation Forces deployments he experienced death in his family first with his brother's suicide, while he was deployed to Poland, and his mothers passing of natural cause during his deployment to Ukraine. To then redeploy to home station and be affected by the COVID-19 pandemic must have put terrible strain on his mental and emotional health leading to a terrible mistake, which unfortunately ended his military career. The SM struggled in silence, while he tried to start his next chapter, post-military service. He sounded extremely optimistic when they spoke and was determined to fight to the very end to remain in the service. Unfortunately, he lost that fight, which the CSM can only assume worsened his depression and already massive stress. The SM was one of the very best Soldiers the CSM ever had the pleasure to lead and serve alongside. The CSM is still deeply saddened by his untimely passing.

(5) From MAJ [redacted] 24 September 2023, who would like to make a comment in support of the SM and ruling that his death was not service related. The SM suffered from a complex of mental health issues, some stemming from childhood trauma and some stemming from his service in the Army. His company and battalion leadership exacerbated these mental health issues by creating an environment where seeking mental health was known to have detrimental effects on your career in spite of Army policy. The MAJ saw firsthand the effect the constant deployments to stressful locations had on the SM. The MAJ saw the effect that toxic leadership environments had on him. The SM did make some bad choices. However, the unit leadership that should have supported him in his struggles cut off support to him, so he turned to the only thing he knew. The SM's identify was intimately tied to his service as an NCO and as a Civil Affairs operator. When his Civil Affairs community rejected him, he had no life left. This is unfortunately a common experience in the Civil Affairs community. The SM was a highly competent NCO and was widely recognized as such. He was well loved as a person as well. He made their community a better place. The MAJ hoped the Board would consider his life, service, family, and positive impact as a whole and not merely the immediate cause of his death in determining death benefits to his wife and children.

(6) From MAJ [redacted] 27 September 2023, who worked with the SM in a Civil Affairs Team. The SM was the exceptionally knowledgeable advisor the MAJ would rely on for planning and the innovative trainer that ensured the team's deployment readiness and its competitive edge. During their two plus years working together, the MAJ witnessed the SM's trustworthiness, integrity, loyalty, competence, and professionalism. The MAJ saw the SM struggles with the deaths of his broth and mother and the challenges he faced after receiving a DUI. Even then, he took responsibility and followed through with the Army Substance Abuse Program. Unfortunately, this was not enough to change his professional outcome. The SM's identity was hinged on being a Soldier, and in the MAJ's assessment, his addiction was a byproduct of the successive loses he had endured. Despite his ultimate outcome, the SM the MAJ knew was an outstanding NCO with profound potential. The MAJ asks the Board to support his wife and child in their time of grief and need.

n. The SM's medical records are available for the Board's review.

3. The SM's service record contains the following documents:

a. DD Form 4 (Enlistment/Reenlistment Document Armed Forces of the United States) shows he enlisted in the Regular Army and entered active duty on 29 January 2008. He remained in the Regular Army through immediate reenlistments.

b. His Enlisted Record Brief shows his overseas deployment and combat duty, his military education, and that he was promoted to sergeant first class (SFC) effective 1 May 2019.

c. Order Number 109-23, published by U.S. Army Human Resources Command (AHRC), 19 April 2019 shows he was promoted to SFC effective 1 May 2019.

d. A General Officer Memorandum of Reprimand (GOMOR), 3 March 2021, shows he was reprimanded for operating a vehicle while under the influence of alcohol. The SM rebutted the GOMOR, 5 March 2021, stating:

(1) He requested consideration be given to his statement and that the GOMOR be filed at the local level and not in his official military personnel file (OMPF).

(2) On 30 January 2021, while under the influence of alcohol, he made a poor decision, unbecoming a senior NCO and drove a vehicle. Prior to approaching the access control point, he turned into and hit a light post which deployed the airbag safety system. He remained at the scene of the accident and awaited authorities to arrive. When the U.S. Military Police (MP) and German police arrived, he was given a breathalyzer, which he failed and was escorted to the German police station unattended by the MPs. There, the German authorities took a blood sample. They then escorted him to a local ATM to pay 2,000 Euros for a deposit on the damage to the light post and then he was driven to his apartment.

(3) He had no excuse for his actions, he exercised extremely bad judgement by driving a vehicle after drinking alcohol. His actions were reckless and careless with disregard to the safety of himself and, more importantly, others. While not an excuse, this short-notice deployment, coupled with a high-tempo work environment and COVID-19 restrictions caused him to have anxiety and depression. During the week before this incident, he received news that his wife was being laid off from her job and that their dog died. On the day he made the decision to drive while intoxicated, the desire to meet with colleagues socially and escape the stressors of his life overrode rationality.

(4) Following the incident, he sought counseling from the Military and Family Life Counselor Program to help him cope with his anxiety and other stressors, which he continued to seek. He also enrolled in the Prime-For-Life course, which would provide him with support and guidance on how to avoid making high-risk choices. He regularly sought counseling from the battalion chaplain.

(5) He had served honorably for 13 years with two 12-month combat tours to Iraq as a 13B (Cannon Crewmember). While serving in the Artillery, he quickly rose through the ranks and was given responsibilities above his pay grade. Since his transition from Artillery to Civil Affairs, in 2015, he maintained a consistent 2:1 deployment operational tempo deploying five times totaling 35 months deployed with rigorous pre-mission training and training exercises at home and abroad in between. He led his teams as a team sergeant in Germany, Poland, Slovakia, Hungary, Ukraine, and

Lithuania. Until this incident, he maintained an unblemished career. He had a long list of service and achievement awards, outstanding evaluations, and letters of support in a separate binder to assist with a decision.

(6) Since 2019, his family had been challenged in several ways. Due to the pandemic, layoffs and furloughs from COVID-19, he was the sole provider for his family. A permanently filed GOMOR would undoubtedly jeopardize his military career and place his family in financial risk if he were separated from service.

(7) He took complete responsibility for his actions. He was sincerely sorry that his actions reflected poorly on the organization, his family, and himself. He woke up every morning wishing he could turn back the clock and make the responsible decision, but he hoped that his contribution, past record, and dedication to service would allow him to continue to serve in the military and Special Operations.

The SM included NCOERs and letters of recommendation with his rebuttal to the GOMOR, which are available for the Board's review. The issuing authority ordered the GOMOR filed in his OMPF.

e. DD Form 261 (Report of Investigation LOD and Misconduct Status), 23 November 2022, shows there was intentional misconduct or neglect, which was the proximate cause of the SM's death and the SM was mentally sound. His death was an accidental overdose. He died as a result of cocaine and fentanyl toxicity on or about 27 January 2022. His use of drugs resulting in his death was due to his own misconduct and was not in the LOD - due to own misconduct.

f. DA Form 2173 (Statement of Medical Examination and Duty Status), 23 November 2022, states the SM was dead on arrival. He was under the use of drugs cocaine and fentanyl toxicity. Alcohol was not detected.

g. Letter from AHRC, 7 February 2023, LOD determination, states AHRC made a LOD determination that the SM, who died in [redacted] on 27 January 2022 as the result of drug toxicity was not in LOD - due to own misconduct, at the time of his death.

h. Letter from Casualty and Mortuary Affairs, AHRC, to the applicant, 7 February 2023, who regretted to inform her that, after careful review of the LOD investigation, a final determination was made that the SM's death was not in line of duty. Evidence contained in the investigation indicated he used illicit substances that led to his death.

4. On 2 May 2024, the Chief, Casualty and Mortuary Affairs Operations Division, AHRC, provided an advisory opinion, which states:

a. The SM passed in [redacted] on 27 January 2022 as the result of cocaine and fentanyl toxicity. According to the investigation, he self-admitted to the [redacted] for shortness of breath. While there, he was given a drug screening and tested positive for cocaine. He was transferred to Womack Army Medical Center (WAMC) and treated for aspiration pneumonia.

b. In February 2021, he received a DUI in Germany and was referred to SUD Clinical Care. In April 2021, he self-admitted to WAMC for suicidal ideations where he tested positive for cocaine and opiates.

c. He was not retained by the Qualitative Management Program (QMP) and requested a voluntary release discharge. He was not scheduled to sign out of his unit until 4 February 2022. On 26 January 2022, the applicant was unable to reach him and asked their dog sitter to check on him. The dog sitter found the SM unresponsive on the floor with apparent drugs and drug paraphernalia. AR 600-8-4, Appendix D, Rule 3a states incapacitation because of the use of alcohol or other drugs that results in injury, illness, disease, or death is due to misconduct and is not in the LOD.

d. There is no supporting evidence to suggest that behavioral health conditions caused the SM to self-medicate with cocaine and fentanyl.

5. On 8 May 2024, the advisory opinion was provided to the applicant to allow her the opportunity to respond. On 18 June 2024, the applicant responded, stating:

a. The advisory opinion was lacking chronological order of events, and lacking any signature of a person who actually wrote it.

b. The SM has dealt with depression, anxiety, and PTSD for many years prior to the incident in Germany in January of 2021. That is clearly stated in his multiple records, one of them is the visit from 25 October 2021 at WAMC Neuro-Rehab OCC Therapy. The multiple problems include TBI, sleep apnea, anxiety and adjustment disorder, alcohol dependence, and cocaine-induced disorder.

c. The SM was being prescribed multiple anti-anxiety, depression, and pain killer medications which are listed in his medical records and include Rizatriptan, Codeine, Oxycodone, Ambien, and Klonopin. She knows it for a fact since she had to dispense those to the SM as he wanted to take a handful at a time and wash it down with whiskey or beer. That behavior intensified after the accident in Germany in 2021.

d. The SM was diagnosed with multiple concussions and that is documented during his occupational therapy visit on 29 November 2021. The concussions are as follows:

- 2009-2010, 2011-2012, during combat operations, manning guns had close proximity to heavy weapons fire, felt vibrations of weapons in Iraq
- 2008-2012, recalls episodes of hitting his head on weapons getting in and out of vehicle, stateside and Iraq
- 2012-2014, 2016-present, hard airborne landings; reports over 30 jumps, recalls at least two episodes of being dragged across drop zone, Fort Bragg
- 2008-2014, combatives recalls episodes at Fort Hood and Fort Bragg
- 2016, Survival, Evasion, Resistance, and Escape training recalls being hit in the fact, Fort Rucker
- January 2021, vehicle crash, Germany

e. The SM self-admitted to [redacted] Hospital. Yes, he did and the applicant was there. The letter is missing a date and it was in December 2020. He was struggling in silence for many years, and the incident in Germany only exacerbated his problem. The way he was treated afterwards, expelled by the unit and shamed was no help to his issue.

f. He self-admitted to WAMC in April for suicidal ideations and cocaine use. Again, she was there with him, and took him there. He admitted to her he was contemplating suicide and the only reason he had not done it yet was because he did not want her to find him on the floor. After that revelation, they decided to sell his guns he had at the house.

g. He was not to sign out until 4 February 2022 and on the day of his death, he was still a full-time Soldier. He checked in with his first sergeant on 26 January 2022, for the last time over a text message. The fact he was losing the entire identity which the Army gave him completely destroyed him.

h. What happened after the QMP decision completely crushed his self worth and ego. He was never the same after, upbeat and positive. The applicant could not recognize him and tried her best to keep his spirit up. Last time she heard from him was over the phone on 26 January 2022. She was away in Poland back then, he checked in with her and said he loved her very very much and never to forget that. That sounded odd to her but he always knew how to clam her suspicions.

i. He only knew how to help his medical conditions through numbing himself with prescribed medications in excessive amounts, or when those would not suffice, he would reach out for cocaine and alcohol. That is not an honorable way of coping, and frowned upon hence he would chose to do it behind her back. And he is only one of many Soldiers with the same problem who choose not to reach out for help.

j. His toxicology revealed no active cocaine in his system. His blood contained big amounts of fentanyl, which was not his choice of a drug. She has provided an

independent toxicologist's opinion, with her application. H described clearly was the SM's blood contained and that was based on the basic Medical Examiner's toxicology. Further testing, which she had done on her own, even showed that additionally, there was morphine in his system. She will have that document for further review. However, fentanyl and morphine is a lethal mix which stops the heart and breathing.

k. She was never offered an autopsy being performed, which could have a supportive value to this case. The SM was complaining about blacking out upon standing and headaches, which were the result of his multiple TBIs. Along with that, after having gone through COVID, there might have been an injury to his heart and multiple aneurysms, which would only deteriorate his health further.

l. When she entered the house, after her arrival from Poland, the first striking sight was unlocked and left codes on the desk to his crypto assets. He would always put enormous emphasis on those and her being aware where they were. To her it was a scary sight because it was conclusive to him committing suicide.

m. While in Germany in February 2021, he was in touch with a chaplain. Their conversation showed how much of a distress the SM was in. He was battling serious anxiety. The conversation thread was attached in the packet.

n. There is enough supporting evidence to show the SM's distress and how mentally unsound he was. She respectfully asks the Board take this into consideration, along with all the supporting documentation her packet contained. The SM's death should not be characterized as not in the LOD - due to own misconduct. Due to an insufficient record and an improper analysis of the facts present, it should be concluded that the SM did not commit willful negligence or misconduct.

6. MEDICAL REVIEW:

a. The Army Review Boards Agency (ARBA) Medical Advisor was asked to review this case. Documentation reviewed included the applicant’s ABCMR application and accompanying documentation, the military electronic medical record (EMR – AHLTA and/or MHS Genesis), the VA electronic medical record (JLV), the electronic Physical Evaluation Board (ePEB), the Medical Electronic Data Care History and Readiness Tracking (MEDCHART) application, the Army Aeromedical Resource Office (AERO), and the Interactive Personnel Electronic Records Management System (iPERMS). The ARBA Medical Advisor made the following findings and recommendations:

b. The SM’s widow is applying to the ABCMR requesting a reversal the United States Army Human Resources Command’s determinations that her husband’s death was not in of line of duty. She states:

"Requesting the Linc of Duty from my husband's death be corrected to in the Line of Duty based on documentation provided. Medical records clearly state my husband had PTSD, TBI, and substance abuse due to his time in the service. He attempted recovery twice for his alcohol abuse and once for addiction. His demons won in the end. I believe the investigation did not take in to account my husband's medical conditions and focused on the scene when his body was discovered.

Upon viewing the documentation provided, my husband was not responsible for his actions. He was struggling with substance abuse, TBI, PTSD, heart issues, and having his military career coming to an unexpected end."

c. The Record of Proceedings details the SM's military service and the circumstances of the case.

d. The behavioral health aspects of this case will be addressed in a separate behavioral health advisory. This advisory will address the assertion a heart condition was related to his death.

e. The SM's death certificate shows his immediate cause of death was "Cocaine and fentanyl toxicity." Part II of block 23, "Other significant conditions contributing to death but nor resulting in the underlying cause" is blank.

f. A Report of Investigation Line of Duty and Misconduct Status (DD Form 261) shows a formal investigation ruled his death was "Not in Line of Duty – Due to Own Misconduct.

g. From appendix D in Army Regulation 600–8–4, Line of Duty Policy, Procedures, and Investigations (8 March 2019):

"D–3. Rule 3

a. Incapacitation because of the abuse of alcohol or other drugs (see glossary; drugs is a broad term that includes such intoxicants as Difluoroethane Toxicity and synthetic marijuana) that results in injury, illness, disease, or death is due to misconduct and is NLD. This rule applies to the effect of the drug on the Soldier's conduct, as well as to the physical effect on the Soldier's body. Any actions that are induced by voluntary ingestion of alcohol or drugs that cause injury, illness, disease, or death are misconduct and are NLD.

That the Soldier may have had a pre-existing physical condition that caused increased susceptibility to the effects of the drug does not excuse the misconduct.

Abuse of alcohol or drugs must be proven as the proximate cause for the injury, illness, aggravation, or death. While merely drinking alcoholic beverages is not misconduct, one who voluntarily becomes intoxicated is held to the same standard of conduct as one who is sober. Intoxication does not excuse misconduct.

b. In accordance with medical command regulations, prescribed medications have a 6-month expiration date. Voluntarily ingesting prescription medication that has expired is misconduct."

h. The finding on the DD 261 was appealed to The Adjutant General of the Army. The Adjutant General to the Army (TAG) oversees and manages the Army's line of duty processes as directed by the Deputy Chief of Staff, G-1. Paragraph 1-7c1 of AR 600-8-4, Line of Duty Policy, Procedures, and Investigations (15 March 2019):

"1–7. Deputy Chief of Staff, G–1
The DCS, G–1 will —

c. Maintain functional responsibility for LOD determinations. The following specific tasks may be delegated, but not below The Adjutant General (TAG):

(1) Have functional responsibility for LOD determinations and act for the Secretary of the Army (SECARMY) on all LOD determinations and appeals referred to Headquarters, Department of the Army and all exceptions to provisions described in this regulation.

i. From USAHRC's 7 February 2023 appeal response:

The Army's Casualty and Mortuary Affairs Operations Division regrets to inform you that, after careful review of the Line of Duty (LOD) Investigation, a final determination was made that Sergeant First Class [SM] was "Not in Line of Duty" at the time of his death. Evidence contained in the investigation indicated Sergeant First Class [SM] used illicit substances that led to his death."

j. The widow asserts the SM had a heart condition and that this contributed to his death. As noted above, this was not listed as a contributing condition on his death certificate.

k. When the SM was admitted to the hospital in December 2020 for a pulmonary condition, he was noted to have elevated cardiac enzymes and an abnormal EKG consistent with myocardial injury. An echocardiogram obtained on 8 December 2020 was revealed mild abnormalities.

"1. Technically adequate study performed in sinus tachycardia. No prior studies.

2. Normal left ventricular size and systolic function. Mild to moderate concentric LVH [left ventricular hypertrophy]. Grade 1 diastolic dysfunction. LVEF [left ventricular ejection fraction] 55-60% [Normal = 50-70]. No gross regional wall motion abnormalities. No apical thrombus.

3. Normal right ventricular size and systolic function.

4. Normal valvular morphology, structure, and function.

5. Pulmonary artery pressure cannot be accurately assessed.

6. Normal visualized thoracic aorta dimensions and flow.

7. Dilated IVC. No significant pericardial effusion."

l. During this admission, the SM was evaluated by cardiology and directed to schedule a cardiac stress test after discharge. The cardiology consult was not located in the EMR. The diagnosis listed in medical problem list is "Other myocardial infarction type."

m. Based on the information currently available, it is the opinion of the ARBA Medical Advisor that a reversal of USAHRC's line of duty determinations based on a medical condition is not warranted.

BEHAVIORAL HEALTH REVIEW:

a. The applicant, the spouse of the deceased service member (SM), is applying to the ABCMR requesting the SM's death be determined to be in the line of duty (LOD). She contends the SM experienced substance/alcohol abuse, traumatic brain injury (TBI), and mental health conditions including PTSD at the time of his death. The specific facts and circumstances of the case can be found in the ABCMR Record of Proceedings (ROP). Pertinent to this advisory are the following: 1) The SM enlisted in the Regular Army on 29 January 2008; 2) The SM had evidence of multiple overseas deployments and combat deployments. He had promoted to SFC on 01 May 2019; 3) On 03 March 2021, the SM received a GOMAR for operating a vehicle while under the influence of alcohol; 4) The SM died on 27 January 2022. The Report of Investigation by Medical Examiner, 07 February 2022, stated the probable cause of death was pending, but he had cocaine and fentanyl toxicity, and the manner of death was an accident; 5) On 23 November 2022, the Report of Investigation LOD and Misconduct Status

concluded there was intentional misconduct or neglect, which was the proximate cause of the SM's death, and the SM was mentally sound. His death was an accidental overdose. He died as a result of cocaine and fentanyl toxicity; 6) Letters from AHRC on 07 February 2023, informed the applicant their determination the SM's death was not LOD but to the SM's own misconduct at time of death; 7) On 02 May 2024, the Chief, Casualty and Mortuary Affairs Operations Division, AHRC, provided an advisory opinion which included a short review of the SM's recent medical history prior to his death and some of his behavioral health treatment history. It was also noted the SM was not retained by the Qualitative Management Program (QMP) and requested a voluntary release discharge. He was not scheduled to sign out of his unit until 4 February 2022. It was also noted AR 600-8-4, Appendix D, Rule 3a, which states incapacitation because of the use of alcohol or other drugs that results in injury, illness, disease, or death is due to misconduct and is not in the LOD.

b. The Army Review Boards Agency (ARBA) Behavioral Health Advisor reviewed the SM's military electronic medical record, AHLTA, ROP, JLV, casefiles, and documenation provided by the applicant.

c. The SM started his engagement with military substance abuse treatment following a Command referral to the Substance Use Disorders Clinical Care (SUDCC) clinic located in Stuttgart, Germany. He was referred as a result of his recent DUI. The SM was identified as being temporarily deployed to Germany, but his permeant duty station was located at Ft. Bragg. The SM did not report a history of alcohol or drug abuse prior to his military service, and he described having multiple drinks prior to his DUI and "simply made a poor choice." At the time, he reported increased stress related to the negative consequences of his DUI, being separated from his spouse, and ongoing COVID restrictions. However, he also endorsed additional symptoms of anxiety and PTSD. The SM did deny any suicidal or homicidal ideation, and he was not diagnosed with a mental health condition or substance use disorder beyond Tobacco use.

d. After the SM returned from Germany, he was seen at a civilian Emergency Room, on 06 April 2021, for anxiety and panic symptoms. He was diagnosed with a Moderate episode of recurrent Major Depressive Disorder, prescribed an anxiolytic (PRN) and an antidepressant, and determined to not require inpatient psychiatric treatment. The SM followed up with his BN PA on 08 April 2021 where he reported continued and increasing anxiety related to the consequences of his DUI and occupational stress. The SM requested to have his anxiolytic medication refilled, because he had only a few pills remaining of the medication prescribed only a few days prior. The PA agreed to refill the medication, but the SM had to go to behavioral health services to be evaluated. On 19 April 2021, he was seen by behavioral health services at Ft. Bragg. He was reporting suicidal ideation with plan, but he denied intent when completing computerized behavioral health self-report measures. He also reported depression, anxiety, overall

distress, and PTSD symptoms. He was released without a diagnosis or a recorded treatment plan at that time.

e. The SM and the applicant walked into behavioral health services on 30 April 2021 due to the SM's increased suicidal ideation, plan, and intent. He again was reporting ongoing and increased stressors. The SM reported increased excessive drinking and also cocaine use. This resulted in the SM feeling at increased risk of committing suicide with a firearm. His command team was notified, and he was admitted into military inpatient psychiatric treatment. Also, during this appointment, the SM reported high levels of depression, anxiety, and PTSD symptoms and alcohol dependence. He was discharged from inpatient psychiatric treatment on 03 May 2021, and he reengaged in outpatient behavioral treatment the following day. Upon discharge from the inpatient program, it was noted the SM was on a temporary no weapons profile and also had burn pit and nuclear exposure from his previous multiple deployments. The SM did report during his outpatient behavioral health appointment that for the last 5 years he had been experiencing an increase in behavioral health symptoms due to occupational stressors (i.e., repeated year-long deployments, field exercises, etc), personal stressors (i.e., loss of brother and mother, extensive time away from family, infertility due to environmental toxins, etc), and COVID restrictions. However, he had not previously attended behavioral health treatment when he should have due to military responsibilities. The SM was diagnosed with an Adjustment Disorder with Depressed mood and Anxious Distress with a rule out of Unspecified trauma/stressor related Disorder. He was also diagnosed with an Alcohol Use Disorder Moderate-Severe, and he was referred to SUDCC for further evaluation and treatment.

f. During his SUDCC evaluation, the SM admitted his alcohol abuse had escalated starting in January 2021 following his DUI, and he was using alcohol to "manage anxiety." He reported that he did not use cocaine regularly, but he was drinking with "the wrong people" and chose to do cocaine, which likely also contained trace amounts of opiates. He was diagnosed with Alcohol Dependence. He was recommended for Intensive Outpatient Substance Abuse treatment with attendance to weekly individual behavioral health appointments till the start of the program along with medication management appointments, and the SM and his Command agreed to this treatment plan. During his initial behavioral health appointments, the SM reported increased insight to his symptoms of PTSD, and he reported experiencing an increase in intensity of these symptoms. Also, he was reporting ongoing anxiety related to his occupational duties and legal consequences of his DUI. The SM began the Intensive Outpatient Substance Abuse Treatment Program in May 2021 and completed in November 2021. Despite the SM having a history of suicidal ideation with plan and intent and was determined to be at intermediate risk for suicide, he was only seen for a few individual behavioral health appointments before discontinuing in May 2021. There was insufficient evidence reported to the reason the SM was not followed up to make another appointment beyond one recorded attempt to follow-up with him to reschedule.

However, during these appointments, the SM continued to report ongoing stress and anxiety related to occupational/legal/financial problems, issues related to infertility, concerns he had an untreated TBI, and his nuclear exposure. During his substance abuse appointments, in early August 2021, the SM again reported increased stress and concern if he could maintain his sobriety. The SM was also again identified as experiencing PTSD, but the focus of his individual and group therapy was maintaining his sobriety predominately from alcohol. The SM was determined to have completed the SUDCC program in November 2021 and was able to maintain sobriety the length of the program, which was determined not only by behavioral observation and self-report, but by UA as well.

g. In August 2021, the SM also began to engage in treatment at neurology for TBI. He had reported significant TBIs during his military career (close proximity to heavy weapons fire, hits to face/head, combatives, car crashes, and hard airborne landings with loss of consciousness). He was diagnosed with a history of TBI and was actively engaged in treatment to include Occupational and Physical Therapy.

h. Based on the available information, it is the opinion of the Agency Behavioral Health Advisor that there is sufficient evidence to support the applicant's death was likely a result of a self-inflicted suicide by overdose of illegal drugs due to unresolved mental health conditions including PTSD and TBI. In addition, the SM's mental health conditions and TBI are directly a result of to his duties, experiences, and injuries on active military service. The SM had no prior history of alcohol or substance abuse prior to his enlistment or early in his military career. Following his DUI, he noted a dramatic increase in anxiety and stress. He admitted to struggling for almost five years prior to this event with increase behavioral health symptoms due to increased personal and occupational stressors. However, he did not report or admit his behavioral health symptoms due to military responsibilities and OPTEMPO. He was quoted in one medical record as saying: "he has been operating at a high op-tempo for so long that he has not stopped to deal with accumulated stressors. 'I've been the guy everyone goes to get the job done, I go above and beyond for my job, I've always been that way…I've always gotten top blocks on my NCOER and now they want to crucify and make an example of me.'" Retrospectively, the focus of the SM's treatment was placed on his recent alcohol abuse/dependence, instead of the cause of the alcohol abuse/dependence. The SM even noted that he had not abused alcohol till he could no longer manage his mental health symptoms with his previous coping strategies. He was quoted to say he abused alcohol to "manage his anxiety." In addition, he was repeatedly reporting PTSD, anxiety, and depression symptoms when engaged in individual behavioral and SUDCC therapy. However, these mental health conditions were not the primary focus of his treatment plan. Instead, the focus was on the natural sequala of these conditions: his short-term alcohol abuse/dependence.

i. In regard to the SM's illegal substance use, there is insufficient evidence the SM was regularly using illegal drugs beyond the previous incident which resulted in his admittance to inpatient psychiatric treatment due to suicidal ideation plan and intent. The SM was regularly tested for illegal drug use, and he did not test positive nor for alcohol abuse. In addition, it is unclear if the SM's personal firearms had been returned to him following his no-weapons profile after his previous plan to kill himself. It is likely the SM did not have access to his weapons at that time. Also, there is no evidence the SM had any history of using fentanyl at any time previously before his death. There is, however, sufficient evidence that the SM had a history of: 1) TBI predominately related to military deployment and training exercises, which resulted in notable physical injuries and pain; 2) physical concerns as a result from nuclear and burn pit exposure; 3) unresolved mental health concerns including PTSD; 4) a history of suicidal ideation with plan and intent; 5) significant occupational and legal stressors; and 6) facing the difficult transition from military service to civilian life.

j. Therefore, there is a preponderance of evidence in support that the SM did not become incapacitated because of his abuse or use of illegal drugs, which resulted in his death. Instead, there is sufficient evidence that it is more likely than not that the SM unfortunately completed suicide by overdosing on illegal drugs due to his unresolved mental health conditions including PTSD and TBI. This is also IAW Army Regulation 600–8–4, Line of Duty Policy, Procedures, and Investigations. While the SM had voluntarily ingested a lethal amount of illegal drugs, he was mentally unsound at the time of his death, as the result of ongoing unresolved mental health issues. Therefore, his death should be determined to be in the LOD.

BOARD DISCUSSION:

After reviewing the application and all supporting documents, the Board determined relief was warranted. The applicant's contentions, the military record, and regulatory guidance were carefully considered. Based upon the available documentation and the findings of the behavior health advisor, the Board concluded there was sufficient evidence to reverse the previous HRC line of duty determinations. As a result, the Board recommends changing the findings of the LOD investigation related to the FSM's death to in the line of duty.

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 Army records of the individual concerned be corrected by amending the FSM's DD Form 261 (Report of Investigation Line of Duty and Misconduct Status), dated 10 November 2022, to reflect in the line of duty.

2/13/2025

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. Army Regulation 600-8-4 prescribes policies and procedures for investigating the circumstances of disease, injury, or death of a Soldier providing standards and considerations used in determining LOD status.

a. A formal LOD investigation is a detailed investigation that normally begins with DA Form 2173 completed by the medical treatment facility and annotated by the unit commander as requiring a formal LOD investigation. The appointing authority, on receipt of the DA Form 2173, appoints an IO who completes the DD Form 261 (Report of Investigation Line of Duty and Misconduct Status) and appends appropriate statements and other documentation to support the determination, which is submitted to the general court-martial convening authority for approval.

b. An injury, disease, or death is presumed to be in LOD unless refuted by substantial evidence contained in the investigation. LOD determinations must be supported by substantial evidence and by a greater weight of evidence than supports any different conclusion. The evidence contained in the investigation must establish a degree of certainty so that a reasonable person is convinced of the truth or falseness of a fact.

c. The worsening of a pre-existing medical condition over and above the natural progression of the condition as a direct result of military duty is considered an aggravated condition. Commanders must initiate and complete LOD investigations, despite a presumption of Not In the Line of Duty, which can only be determined with a formal LOD investigation.

2. Army Regulation 600-8-1 (Army Casualty and Memorial Affairs and Line of Duty Investigations) prescribes policies and procedures for investigating the circumstances of disease, injury, or death of a Soldier. It provides standards and considerations used in determining Line of Duty (LOD) status. It states:

a. LOD determinations are for protecting the interest of both the individual concerned and the U.S. Government where service is interrupted by injury, disease, or death. A person who becomes a casualty because of his or her intentional misconduct or willful negligence can never be said to be injured, diseased, or deceased in LOD. A person stands to lose substantial benefits because of his or her actions; therefore, it is critical that the decision to categorize injury, disease, or death as not in LOD only be made after following the deliberate, ordered procedures described in this regulation.

b. LOD investigations (LODI) are conducted essentially to arrive at a determination of whether misconduct or negligence was involved in the disease, injury, or death and, if so, to what degree. Depending on the circumstances of the case, an LODI may be required to make this determination. A formal LODI must be conducted in circumstances where an: (1) injury, disease, death, or medical condition that occurs under strange or doubtful circumstances or is apparently due to misconduct or willful negligence; (2) injury or death involving the abuse of alcohol or other drugs; and/or (3) self-inflicted injuries or possible suicide.

c. A formal LODI is a detailed investigation that normally begins with DA Form 2173 (Statement of Medical Examination and Duty Status) completed by the Medical Treatment Facility (MTF) and annotated by the unit commander as requiring a formal LODI. The appointing authority, on receipt of the DA Form 2173, appoints an IO who completes DD Form 261 (Report of Investigation LOD) and appends appropriate statements and other documentation to support the determination, which is submitted to the General Court-Martial Convening Authority (GCMCA) for approval.

d. Decisions on LOD determinations will be made in accordance with the standards set forth in this regulation. Injury, disease, or death proximately caused by the Soldier's intentional misconduct or willful negligence is "not in LOD—due to own misconduct." Simple or ordinary negligence or carelessness, standing alone, does not constitute misconduct. An injury, disease, or death is presumed to be in LOD unless refuted by substantial evidence contained in the investigation. LOD determinations must be supported by substantial evidence and by a greater weight of evidence than supports any different conclusion. The evidence contained in the investigation must establish a degree of certainty so that a reasonable person is convinced of the truth or falseness of a fact, considering: (1) All direct evidence, that is, evidence based on actual knowledge or observation of witnesses; and/or (2) All indirect evidence, that is, facts or statements from which reasonable inferences, deductions, and conclusions may be drawn to establish an unobserved fact, knowledge, or state of mind.

(1) No distinction will be made between the relative value of direct and indirect evidence. In some cases, direct evidence may be more convincing than indirect evidence. In other cases, indirect evidence may be more convincing than the statement of an eyewitness.

(2) The weight of the evidence is not determined by the number of witnesses or exhibits but by the IO and higher authorities accomplishing the following actions: (1) Considering all the evidence; (2) Evaluating factors such as a witness's behavior, opportunity for knowledge, information possessed, ability to recall and relate events, and relationship to the matter to be decided; and (3) Considering other signs of truth.

(3) The rules in appendix B will be considered fully in deciding LOD determinations. These rules elaborate upon, but do not modify, the basis for LOD determinations.

e. The investigation will ascertain dates, places, persons, and events definitely and accurately. The commander must ensure that the investigation contains enough pertinent information and data to enable later reviews to be made without more information. All findings of fact should be supported by exhibits. Copies of military or civilian police accident reports, pertinent hospitalization or clinical records, autopsy reports, and written statements shall be attached as exhibits when appropriate. The commander will thoroughly review chapters 3 and 4 for any additional pertinent procedures or special considerations before conducting and completing the investigation. Promptness in conducting the investigation is of great importance. Delays often result in failure to secure important data and information, possibly resulting in an improper determination.

f. An injury incurred as the "proximate result" of prior and specific voluntary intoxication is incurred as the result of misconduct. For intoxication alone to be the basis for a determination of misconduct with respect to a related injury, there must be a clear showing that the Soldier's physical or mental faculties were impaired due to intoxication at the time of the injury, the extent of the impairment, and that the impairment was a proximate cause of the injury.

g. The MTF must identify, evaluate, and document mental and emotional disorders. A Soldier may not be held responsible for his or her acts and their foreseeable consequences if, as the result of mental defect, disease, or derangement, the soldier was unable to comprehend the nature of such acts or to control his or her actions. Therefore, these disorders are considered "in LOD" unless they existed before entering the Service and were not aggravated by military service. An injury or disease intentionally self-inflicted or an ill effect that results from the attempt (including attempts by taking poison or drugs) when mental soundness existed at the time should be considered misconduct.

h. Appendix F states in every formal investigation, the purpose is to find out whether there is evidence of intentional misconduct or willful negligence that is substantial and of a greater weight than the presumption of "in line of duty." To arrive at such decisions, several basic rules apply to various situations. The specific rules of misconduct are listed below.

(1) Rule 1 states injury, disease, or death directly caused by the individual's misconduct or willful negligence is not in line of duty. It is due to misconduct. This is a general rule and must be considered in every case where there might have been misconduct or willful negligence. Generally, two issues must be resolved when a soldier is injured, becomes ill, contracts a disease, or dies: (1) whether the injury, disease, or death was incurred or aggravated in the line of duty; and (2) whether it was due to misconduct.

(2) Rule 2 states mere violation of military regulation, orders, or instructions, or of civil or criminal laws, if there is no further sign of misconduct, is no more than simple negligence. Simple negligence is not misconduct. Therefore, a violation under this rule alone is not enough to determine that the injury, disease, or death resulted from misconduct. However, the violation is one circumstance to be examined and weighed with the other circumstances.

(3) Rule 3 states injury, disease, or death that results in incapacitation because of the abuse of alcohol and other drugs is not in line of duty. It is due to misconduct. This rule applies to the effect of the drug on the soldier's conduct, as well as to the physical effect on the soldier's body. Any erratic or reckless conduct caused by the effect of the drug, which directly causes his injury or disease is misconduct. The fact

that the meme may have a pre-existing physical condition which caused him to be susceptible to the effects of the drug does not excuse such misconduct.

3. Section 1556 of Title 10, USC, 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.

//NOTHING FOLLOWS//