ARMY BOARD FOR CORRECTION OF MILITARY RECORDS

RECORD OF PROCEEDINGS

IN THE CASE OF: [redacted]

BOARD DATE: 19 August 2025

DOCKET NUMBER: AR20240009368

APPLICANT REQUESTS:

- correction of the narrative reason for separation
- referral to the Integrated Disability Evaluation System (IDES) to determine whether he should have been medically discharged or medically retired

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

- Online Application, 25 June 2024
- DD Form 214 (Certificate of Release or Discharge from Active Duty), 25 August 2023
- Medical documentation, service dates of 4 June 2024 12 June 2024, 14 June 2024, and 22 October 2024 showing the applicant's medical assessments, referrals, past and present illnesses, and final reports with medical findings
- letter to the Department of Veterans Affairs (VA), showing his request for a change in narrative reason for separation due his health issues occurring while in training and not being referred to a Physical Evaluation Board (PEB) or Medical Evaluation Board (MEB)
- VA decision letters, showing his service-connected disabilities total 100% with an effective date of 26 August 2023
- Medical documentation, showing current medications prescribed and a list of his health conditions
- Department of VA disability rating explanations and decisions letters, showing he receives 100% disability benefits for service-connected disabilities
- Character reference letter from P.E. in support of his requested VA claim
- Character reference letter from A.A. in support of his requested VA claim

FACTS:

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

2. The applicant states he was unable to continue his commitment due to injuries and health issues sustained during Army training, due to his health situation his commander discharged him the quickest way without making him go through a medical board, because the medical process was too tedious and lengthy in time. Due to the medical issued he suffered while in service he is requesting a PEB or MEB and removal of the narrative reason on his DD Form 214.

3. A review of the applicant's service record shows the following:

a. He was officially approved for Regular Army accession on 23 June 2022. He entered active duty on 13 November 2022, in the rank/grade of captain/O-3.

b. On 17 August 2023, the Deputy Assistant Secretary of the ARBA reviewed his request for resignation in lieu of elimination based on substandard performance of duty, accepted his resignation, and directed issuance of an honorable characterization of service.

c. Accordingly, he was honorably discharged on 25 August 2023, under the provisions of Army Regulation (AR) 600-8-24 (Personnel – General – Officer Transfers and Discharges), for substandard performance with separation code BHK. He served 9 months and 13 days of net active service this period.

4. He provides documentation from the VA showing he receives a 100% disability rating for his service-connected disabilities which include but are not limited to:

- gastroesophageal reflux disease
- traumatic brain injury (TBI)
- tinnitus
- migraines with visual aura
- pseudofolliculitis barbae
- post-traumatic stress disorder (PTSD) with TBI
- residual TBI, anosmia
- residual TBI, hypogeusia
- cervical strain with cervical spine hypermobility and degenerative arthritis
- lumbar radiculopathy, left lower extremity (femoral nerve)
- lumbar radiculopathy, left lower extremity (sciatic nerve)
- lumbar radiculopathy, right lower extremity (femoral nerve)
- lumbar radiculopathy, right lower extremity (sciatic nerve)
- lumbar radiculopathy, left lower extremity (external cutaneous nerve)
- lumbar radiculopathy, left lower extremity (ilio-inguinal nerve)
- lumbar radiculopathy, left lower extremity (obturator nerve)
- lumbar radiculopathy, right lower extremity (external cutaneous nerve)

- lumbar radiculopathy, right lower extremity (ilio-inguinal nerve)
- lumbar radiculopathy, right lower extremity (obturator nerve)

5. MEDICAL REVIEW:

1. The Army Review Boards Agency (ARBA) Medical Advisor reviewed the supporting documents, the Record of Proceedings (ROP), and the applicant's available records in the Interactive Personnel Electronic Records Management System (iPERMS), the Health Artifacts Image Management Solutions (HAIMS) and the VA's Joint Legacy Viewer (JLV). The applicant requests change on DD Form 214 from "substandard performance" to medical/health reasons or better. He contends that health issues he incurred while in service led to his discharge. He would like to be considered for IDES referral. He states that the VA has rated him at 90%. The applicant's mental health condition(s) were reviewed under separate cover by ARBA Medical specialist in mental health.

2. The ABCMR ROP summarized the applicant's record and circumstances surrounding the case. The applicant was commissioned as an officer in the Regular Army 13Nov2022. He was not awarded an MOS. His Resignation in Lieu of Elimination was approved 17Aug2023. He was discharged after 9.5 months of service on 25Aug2023 under provisions of AR 600-8-24 for substandard performance. His service was characterized as honorable.

3. Background. The applicant obtained a bachelor's degree in nursing from Purdue University and a doctorate in nursing from Grand Canyon University and worked in the nursing field before entering the Army as an officer on 13Nov2022. He was 39 years old working toward MOS Army Family Nurse Practitioner. While in BOLC he reported symptoms of anxiety and depressed mood within the context of course failure, family-related health issues, and stress associated with command. His mother was hospitalized in Nigeria, and he wanted to bring her to the states to live with him to receive better care. He had failed an exam in BOLC a third time on 08Feb2023. Rather than recycle, he wanted to separate from the Army. He indicated that he had filed an EO complaint and later an IG complaint alleging mistreatment due to feeling unfairly targeted— it was his perception that others in his class had received accommodations for similar circumstances. On 03Mar, he was told that he would not graduate with his peers (01May2023 BH Note BAMC AMC).

4. In the 9.5 months in service, the applicant exhibited a complicated array of symptoms represented (in part) by the physical conditions reviewed below: Lumbar Strain; Neck Strain; TBI Residuals (Migraines, Tinnitus, Loss of Taste, Loss of Smell); and Seizure Disorder, not confirmed. The accompanying ARBA Medical BH Review provided many interlocking details for the applicant's conditions. This review will focus

on the medical basis of the physical conditions, their treatment, and the status of the condition at or near the time of discharge.

5. Lower Back Pain; Upper Back Pain; and Lumbar Radiculopathy, involving bilateral sciatic, femoral, ilio-inguinal, external cutaneous, and obturator nerves.

a. 02Mar2023. In July 2023, the applicant began reporting that during training at Camp Bulls, he had injured his neck and back on 02Mar2023. *There was no contemporaneous documentation of the event except his report.*

b. 15Jun2023 Physical Therapy Outpatient Note BAMC AMC. The applicant's complaints included neck pain, upper back pain 7/10 and lower back pain 3/10. *This was the first note documenting back pain, 3 months after the reported fall in March 2023.* Method of injury was not discussed. Diagnoses included: Segmental autonomic dysfunction; Thoracic segmental dysfunction and Somatic dysfunction of pelvic region.

c. June and July 2023, he had 8-9 physical therapy/rehab sessions with mild decrease in pain. Back ROM (range of motion) was not recorded.

d. 12Jul2023 Physical Therapy Outpatient Note BAMC AMC. The applicant presented reporting "lightning bolt down my leg". *This was the first complaint of this sort.* Method of injury was reported as a fall from standing on 02Mar2023. He walked on the treadmill during therapy that day— no problems with gait were noted. ROM, muscle strength testing and reflexes were not recorded.

e. 25Aug2023 Emergency Department Triage and Provider Notes BAMC AMC. He reported that 2 weeks prior, on 11Aug2023 while carrying boxes loading a truck, he had a spell of vertigo and fell landing on his back. There was no associated loss of consciousness or head trauma. He described pain in his back and pain radiating down both legs as well. The exam showed midline thoracic-spine tenderness with associated bilateral L > R paraspinal tenderness. There was normal muscle strength, normal sensation and normal gait. Diagnosis: Back Pain/Injury. In the ER, he was given a shot of Toradol and oral Tylenol which improved his pain. He was prescribed a muscle relaxant, oral pain relief (NSAID and Tylenol regular strength) which were not filled; and topical pain relief which was filled. He was advised to follow-up with his primary care provider in the next 2 to 4 days. *It should be noted that the applicant was seen several times after the recent (11Aug2023) back injury without report of back pain/injury and normal musculoskeletal exams (16Aug2023, 17Aug2023, 18Aug2023 and 21Aug2023). During the 22Aug2023 Ambulatory Quick Intake visit, pain was documented as 0/10, and back pain was not mentioned during the 23Aug2023 Urology Outpatient Note BAMC AMC.*

f. 25Aug2023 CT of the thoracic spine showed no thoracic osseous abnormality.

g. 05Sep2023 Primary Care Outpatient Note VAMC. He was presenting to establish care at the VA "just in case he needs help". He reported a history of mental health concerns and back pain, but he did not have any medical complaints at the time. *A back exam was not documented during this visit*.

h. 25Oct2023 lumbar spine MRI: Multilevel degenerative changes of the lumbar spine with moderate central canal and moderate-severe bilateral foraminal stenosis at L4-L5. *This was two months after discharge from service. The study was completed at Lovell Federal Health Care Center (a DoD site)*.

i. 21Nov2023 Neurology Consult VAMC. He had a long history of low back pain, non-radiating. Exam: Normal gait, normal muscle strength; negative straight leg raise testing to 90 degrees bilaterally. The provider noted the lumbar spine degenerative disease (per lumbar MRI) but assessed that there was no clinical evidence for radiculopathy on that day.

j. 26Feb2024 Attending Emergency Department Note VAMC. He was seen for acute back pain. Exam: There was palpable left paraspinalis muscle spasm and tenderness to palpation. Straight leg raise testing was negative (normal). Muscle strength testing was normal (5/5) equivocally. Gait was normal and unassisted. Diagnosis: Left Paraspinalis Muscle Spasm. He was treated with a muscle relaxant and a shot of Toradol. *This was 6 months after discharge from service*.

k. 04Jun2024 Anesthesia/Pain Follow Up VAMC. He had epidural steroid injections (ESI) on 09Feb2024 and 18Mar2024, bilateral at L4-L5. He was on Gabapentin (nerve pain) and Cyclobenzaprine (muscle relaxant). *This was 10 months after discharge from service*.

l. 12Jun2024 rated back pain 9/10. He was using a cane.

m. 05Sep2024 Back Conditions DBQ. The applicant reported that he fell and hit his head on a wooden tree log during training (land navigation exercise) and injured his neck and back. Back flexion and extension were markedly reduced (by 50%). Bilateral straight leg raise testing was positive. Mild bilateral radiculopathy was diagnosed involving bilateral Involvement of L4/L5/S1/S2/S3 nerve roots (sciatic nerve). He walked with a cane regularly. *This was 13 months after discharge from service*.

n. 13Sep2024 Neurology Outpatient Note VAMC. Prior ESIs by pain management were noted to be unhelpful and laminectomy was reportedly being considered.

6. Cervical Strain; Cervical Radiculopathy, not confirmed

a. 15Jun2023 Rehabilitation Notes BAMC AMC. He presented with neck pain, and persistent post traumatic headache with a history of migraine. Relevant diagnoses by physical therapy included Segmental Autonomic Dysfunction; Cervical Spine Hypermobility; Cervical Radiculopathy; and Concussion Without loss of consciousness. He had 8-9 physical therapy appointments from June and July 2023 with little progress.

b. 25Aug2023 Emergency Department Triage BAMC AMC. He reported that on 11Aug2023 while carrying boxes loading a truck, he had vertigo and fell landing on his back. He reported back pain and left side neck pain.

c. 25Aug2023 CT of the cervical spine showed multilevel degenerative disc changes, present most notably at C5-C6. *These were chronic changes—not the result of the 11Aug2023 fall*. There was no acute cervical osseous abnormality. Paraspinal soft tissues were normal.

d. 05Sep2024 Neck Conditions DBQ. The applicant reported he fell and hit his head on a wooden tree log during training (land navigation exercise) and injured his neck and back (in March 2023). Neck flexion and extension ROMs were moderately and markedly reduced respectively.

e. 05Sep2024 x-ray of cervical spine showed mild degenerative disease of the cervical spine most pronounced at C4-C5 and C5-C6.

7. TBI

a. 07Feb2023 BH Therapist Outpatient Initial Note BAMC AMC. The TBI screen was positive. No further details were revealed in the note. Military trauma was denied.

b. The reported/recorded method of TBI injury/injuries on 02Mar2023 included the following: He fell into a ditch of about two feet (28Apr2023 BH Therapist Outpatient Triage Note BAMC AHC); he sustained a concussion due to a fall from standing (12Jul2023 Physical Therapy Outpatient Note BAMC AMC); he stumbled and hit his head on a log (25Jun2023 Emergency Department BAMC AMC).

c. 28Apr2023 brain/head CT (for headache work-up) showed no abnormality.

d. 02May2023 IPASS Admission Nurse Note BAMC AMC. He reported a traumatic event at a training exercise that took place two months ago at Camp Bullis: He reported that he was in the woods there and he has had "nightmares every night of the woods and people shooting me". He reported "I fell from my bed three days ago and I hit my head. Now my ears are ringing, and my headaches are worse."

e. 12May2013 Diagnosis: Concussion with No Loss of Consciousness (LOC).

f. 24 and 25May2023 Neurology Consultation Inpatient. He reported symptoms of constant headaches nonresponsive to medications, phonophobia/photophobia, vertigo, tinnitus, and 3 episodes of LOC where he was witnessed to be clenching hands and having movements in his lower extremities. Symptoms seem to have started after a TBI on 02Mar2023 during officer training in the woods when he hit his head on a trunk. He reports constant vertigo described as room spinning. Today he had 2 more episodes of LOC which prompted him to visit the TBI clinic. Diagnosis: Post Concussive Syndrome with Migrainous Features.

g. 24May2023 brain/head CT showed no acute abnormality.

h. 25May2023 brain MRI: Nonspecific changes in white matter. No acute intracranial abnormality.

i. 25Jun2023 Emergency Department BAMC AMC. He stated that while doing land navigation he stumbled and hit his head on a log on 02Mar2023. He was being seen for a headache. He had run out of Maxalt.

j. 07Jul2023 Physical Therapy Outpatient Note BAMC AMC. He stated that he was having trouble remembering things.

k. 18Aug2023 and 07Jun2023 Brain Injury Rehab PM&R BAMC AMC. He endorsed feeling significant guilt and regret over joining the Army and leaving his family in Nigeria, largely because of his parent's significant health issues. The chapter process was almost complete. Of note, the applicant endorsed cognitive symptoms (decreased memory) and vestibular symptoms (sensation of the room moving). The applicant was advised concerning the impact of exacerbating factors on cognitive function: Insomnia, life stressors, mood disorder and acute and chronic pain. The provider assessed that the applicant was without functional deficits related to 02Mar2023 head injury and that he did not require Brain Injury Rehabilitation Services at the time. Diagnoses included: Other Complicated Headache Syndrome and Concussion Without Loss of Consciousness.

l. 06May2024 Office Clinic Note VAMC. "Per patient he served in the US Army for 3 years as a contractor from 2020-2023. He was never deployed. He reported that during training in March 2023, he fell in the ditch and sustained a head injury... He was taken to the emergency room [and] was treated…." *This was the first time the applicant reported having received care for the fall on 02Mar2023. As previously noted, there was no record of the incident or related immediate/urgent treatment record on the date*.

m. 19Sep2024 Initial Residuals of TBI DBQ. He reported that he fell into a ditch and sustained a head injury but was not admitted to the hospital. TBI Residuals were listed as Hearing Loss and/or Tinnitus; Alteration of Sense of Smell or Taste; Headaches;

Mental Disorder (including emotional, behavioral, or cognitive). For cognitive issues, he complained of mild loss of memory (not confirmed by objective testing) and decreased concentration. The VA examiner indicated that there was overlap of symptoms with his mental health condition. Neuropsychological testing was not performed.

8. Migraines

a. 22Mar2023 ER PA and MD Provider Notes BAMC AMC. He was seen for recurrent headache. He denied headache and dizziness at the time of the ER visit—he reported 0/10 pain. He stated that he had not been sleeping well for the past 3 weeks and that he had been under an immense amount of stress. He was advised to take his home Tylenol (over-the-counter or OTC). *The was the first visit for headaches*.

b. 27Apr2023 ER BAMC AMC. He reported headache pain 8/10 and decreased hearing. He denied nausea, vomiting and tinnitus. He also denied photophobia or phonophobia and trauma. He had residual nasal congestion from a recent upper respiratory tract infection. The headache was likely exacerbated by lack of food/drink intake that day and ongoing sleep difficulties. He was treated with OTC strength Tylenol and ibuprofen.

c. 28Apr2023 Triage and Provider Note ER BAMC AMC. He had a history of months of headaches, night terrors, ringing in his ears with onset or worsening approximately 3 days ago.

d. 28Apr2023 head CT was negative.

e. 28Apr2023 Primary Care Follow up post ER visit. He stated that he had been having a headache for months. Treatment had been Tylenol and Motrin which helped a little. Today, the headache was 7/10. He went to the ER later in the evening.

f. 09May2023 Community Care Message Phone Call BAMC AMC. He reported a headache 7/10 but that he already had Motrin and just needed to take it.

g. 12May2023 ER BAMC AMC visit. He presented with headache and tinnitus reportedly for 2 months after a fall and hitting his head in BOLC without LOC. After completing a diagnostic work up, no emergency medical conditions were found. He was advised to pursue outpatient follow up. He stated that he was given Toradol injection in the past which helped.

h. 17May2023 Nursing Outpatient Note BAMC AMC. He was given another Toradol injection.

i. 24 and 25May2023 Neurology Consultation Inpatient. He reported symptoms

of constant headaches nonresponsive to medications, phonophobia/photophobia, vertigo, tinnitus, vertigo and 3 episodes of LOC. Symptoms seem to have started after a TBI on 02Mar2023 during officer training in the woods when he hit his head on a trunk. Regarding constellation of other symptoms, the provider suspected multifactorial etiology with major contribution from polypharmacy. Propranolol had been started recently for headache prophylaxis and may be related to LOC/syncope or near syncope. Diagnosis: Post Concussive Syndrome with Migrainous Features. Recommendations: Stop daily use of Ibuprofen and Tylenol. Start Depakote (maintenance med), continue Effexor. Consider referral to neurology for management of chronic headaches if headaches were not improved in 2 to 3 months. Propranolol was also discontinued.

j. 02Jun2023 and 05Jun2023 Emergency Department BAMC AMC. He presented to the ER for headache. Overall, there were no red flags for headache per reported history. He did not take consistent medication at home for his headache. He was given Toradol injection again and nausea medicine.

k. 07Jun2023 Brain Injury Rehab PM&R BAMC AMC. He was having daily headaches. He was educated on headache type: Cervicogenic, migraine/vascular/posttraumatic, tension, medication overuse and exacerbating factors (e.g. stress). Diagnoses included: 1. Chronic post-traumatic headache, intractable. 2. Concussion without loss of consciousness, subsequent encounter history of fall from standing on land navigation course at Camp Bullis on 02Mar2023. 3. Other symptoms and signs involving cognitive functions and awareness. He reported alteration of awareness x3 "Absence Seizure" since fall in March 2023 and memory decline. 4. Cervicalgia. 5. Psychophysiologic Insomnia. 6. Personal history of traumatic brain injury. He was counseled about concussion/mild traumatic brain injury (mTBI) and other causes of cognitive difficulties. Depakote was continued (migraine prevention) and Maxalt (migraine abortion) was started.

l. 15Jun2023 Rehab Notes BAMC AMC. He endorsed that Maxalt helped.

m. 17Jul2023 Neurology Clinic Encounter BAMC AMC. He was previously on propranolol however it was discontinued due to presyncope symptoms. He was taking daily Tylenol/ibuprofen with likely medication overuse headache component. He was started on Depakote while admitted in May. He continued to take Maxalt for abortive therapy (started in June). At present, he continued to report daily headache although Depakote had helped with severity slightly and he was tolerating it well.

n. 25Jul2023 Emergency Department Triage BAMC AMC. The applicant went to the ER for a headache and stuffy ears. He had already taken his migraine meds (30 minutes prior to ER arrival), but they hadn't started to work yet. He rested comfortably in the exam room bed and then was discharged home. No medications were administered in the ER for the headache. He was given quarters for 48 hours.

o. 28Jul2023 Primary Care BAMC AMC. He was actively engaged in brain injury rehab and neurology services. Currently, he reported headaches, light sensitivity and feeling fatigued and weakness. He presented requesting quarters.

p. 18Aug2023 and 07Jun2023 Brain Injury Rehab PM&R BAMC AMC. Diagnoses: Other Complicated Headache Syndrome and Concussion Without Loss of Consciousness. He was to remain on Depakote (maintenance/preventive) and Maxalt (abortive) for his headaches. *He was to be discharged shortly*.

q. 18Oct2023 Attending Emergency Department Note VAMC. He stated that his headache usually gets resolved with his medications rizatriptan (Maxalt) and Depakote which he ran out of after he got out of the Army. He was there for a refill of the medication. *This visit took place one month after discharge from service*.

r. 21Nov2023 Neurology VAMC. He endorsed relief with Maxalt sufficient for him to resume what he was doing. He also endorsed that frequency and intensity of his migraines were lessened on Depakote until he ran out 2-3 weeks ago.

s. 13Sep2024 Neurology Outpatient Note VAMC. He reported severe headaches every day 6-9/10 in the intensity accompanied with dizziness, spinning sensation and nausea. He took eletriptan (Relpax) every other day which improved his headaches for several hours only. He also took Effexor and Neurontin for headache prevention without help. He also reported that Aimovig did not improve his headaches. *This was more than one year after discharge from service*.

t. 10Jun2025 TBI Office Clinic Note VAMC. The applicant endorsed that his migraines were significantly improved since following with neurology. He was receiving Botox injections for management of his migraines every 3 months which had been excellent for him. He no longer had daily migraines. He only had migraine headaches 1 to 2 days/week and these were tolerable.

9. Tinnitus.

a. 27Apr2023 ER Provider Note BAMC. He was being seen for a headache with decreased hearing. The provider thought may be related to recent URI. He denied ringing in his ear. He also denied nausea, vomiting, fever and trauma. The physical ear exam was normal. He was referred to audiology.

b. 28Apr2023 Primary Care and Ambulatory Quick Intake BAMC AMC. Follow up post ER visit. He reported ringing in his ears (first report) since he started taking Vistaril.

c. 02May2023 IPASS Admission Nurse Note BAMC AMC. He reported a traumatic event at a training exercise that took place two months prior at Camp Bullis: He reported that he was in the woods there and he had "nightmares every night of the woods and people shooting me". He reported "I fell from my bed three days ago and I hit my head. Now my ears are ringing, and my headaches are worse."

d. 24 and 25May2023 Neurology Consultation Inpatient. He reported symptoms of constant headaches nonresponsive to medications, phonophobia/photophobia, vertigo, tinnitus, and 3 episodes of LOC. Symptoms seem to have started after a TBI on 02Mar2023 during officer training in the woods when he hit his head on a trunk. He reported constant vertigo described as room spinning.

e. 26May2023 BAMC AMC Audiology Note. Hearing test was completed which showed a threshold shift. He was scheduled for diagnostic hearing evaluation with an audiologist.

f. 06Jun2023 Audiology Note BAMC AMC. He reported a head injury at Camp Bullis during BOLC training on 02Mar2023. He reported bothersome constant tinnitus and muffled hearing since that date. He also reported vertigo when bending forward. He was seen in this clinic on 26May for a puretone threshold test revealing mild hearing loss bilaterally. He reported a history of noise exposure (small arms). He denied exposure to blasts/explosions within close enough proximity to feel the heat and/or pressure wave. He denied history of recreational noise exposure. Impressions: Normal hearing in both ears at all standard speech frequencies. Normal middle ear function in both ears with robust cochlear outer hair cell function in both ears. Plan: Return to duty without restrictions for hearing. He met H-1 hearing profile criteria IAW DA PAM 40-502.

10. Loss of Taste (Hypogeusia) and Loss of Smell (Anosmia).

a. 01May2023 Emergency Department BAMC AMC. The applicant presented to the ER stating that he needed inpatient psychiatric admission for medication adjustment. He complained of sleeplessness, nightmares and headache. During COVID screening questions, he denied new loss of taste or smell. *COVID-19 infection was associated with loss of taste and sense of smell in some individuals.*

b. 18Aug2023 Brain Injury Rehab PM&R BAMC AMC. There was no decrease in smell.

c. Of note, he underwent COVID testing 07Feb2023 and 17Aug2023 for Upper Respiratory Infections to try to rule out COVID infection. The tests were negative. *It should be noted that a negative test did not exclude COVID infection 100%.*

d. 19Sep2024 Initial Residuals of TBI DBQ. Alteration of sense of smell or taste was endorsed as a TBI residual. *This was more than one year after discharge*.

11. Seizure Disorder, not confirmed; Syncope, not confirmed; Pre-syncopal Episodes; Dizziness

a. 24May2023 Provider Note BAMC AMC. He complained of "absent" seizures x 2 since yesterday. The last one occurred at 0800. Since yesterday, he had experienced persistent dizziness with 2 episodes of jaw clenching and feeling like he was losing control of his body. He did not remember exactly what happened but woke up on the floor. The seizures were unwitnessed. There was no loss of bowel/bladder control and no tongue biting. He also noted a constant headache that waxed and waned, accompanied with photophobia, and phonophobia since a TBI in March 2023 while on a land navigation course. Neurology was consulted in the ER. They recommended inpatient admission for possible seizure evaluation.

b. 24 and 25May2023 Neurology Consultation Inpatient. During this encounter, the applicant reported that he suffered a TBI on 02Mar2023 during officer training in the woods where he hit his head on a trunk. He reported 3 episodes of LOC where he was witnessed to be clenching hands and having movements in his lower extremities. Symptoms seem to have started after a reported TBI on 02Mar2023. He reported constant vertigo described as room spinning. Today he had 2 more episodes of LOC which prompted him to visit the TBI clinic. Diagnosis: Post concussive syndrome with migrainous features. Neurology did not diagnose a seizure disorder. They assessed that the reported symptoms were not typical of seizures or syncope. Given the recurrent nature of his symptoms, a brain MRI was completed which showed no acute intracranial abnormality. EEG also showed no abnormalities. They suspected multifactorial etiology with major contribution from polypharmacy especially since the recent start of propanol— propanol may be related to his postural intolerance and possible LOC. They recommended Depakote to help with his headaches.

c. 31May2023 and 13Jun2023 Correspondence/Primary Care Note. The applicant was stating that he was diagnosed with seizures. However, it was clarified that he did not currently have a seizure disorder diagnosis although he was restricted from driving for 6 months per Texas law.

d. 14Jun2023 Correspondence. The applicant was requesting a refill on meclizine. He expressed that it really helped his vertigo. He stated that he was tired of going to the emergency room “10 to 15 times in a period of 3-4 months”. *It is noted that meclizine is also available over-the-counter.*

e. 15Jun2023, the description was provided for his dizziness: Sense of vertigo and

lightheadedness, lasting minutes, occurring several times per day when he bends down or gets up from standing.

f. A seizure disorder was not diagnosed by the Army. Of note, the VA has not service-connected the applicant for a seizure disorder.

g. The VA did not find a vestibular condition that would account for the applicant's dizziness symptoms or that required treatment (10May2024 Vestibular Evaluation Audiology VAMC).

12. Separation medical records.

a. 07Jun2023 Chapter 13 Separation Health Physical Examination (SHPE). He endorsed pain 8/10 although he also endorsed being in good condition exercising vigorously 5-6 times per week. Physical exam: He appeared to be in no acute distress. He changed positions on the exam table and climbed off and on the exam table without any signs or symptoms of distress or discomfort. The musculoskeletal exam was normal. Sensation and deep tendon reflexes were normal. Straight leg raise testing was negative (normal). Gait was normal. Diagnoses included Adjustment Disorder with Mixed Anxiety and Depressed Mood; Anosmia (loss of sense of smell); Acquired Pes Planus, Bilateral; and Positive Depression Screening. The complicated past medical history was noted; however, he was deemed qualified for Chapter 13 separation. He was advised to follow up with primary care for his ongoing symptoms/conditions.

b. 07Jun2023 PCM (primary care manager) follow up after SHPE. Diagnoses: Chronic Post-traumatic Headache, Intractable; Concussion Without Loss of Consciousness (history of fall from standing during land navigation course at Camp Bullis); Other symptoms and signs involving cognitive functions and awareness—reported alteration of awareness x3 "Absence Seizure" since a fall in March and memory decline; Cervicalgia; Adjustment Disorder with Mixed Anxiety and Depressed Mood; Psychophysiologic Insomnia; and Personal History of TBI. It was recommended that he follow up with his PCM or the VA for further evaluation and care for all service-connected injuries and illnesses as needed.

13. Summary/Opinion

a. The VA Rating Decision dated 23Oct2024 showed that the combined total VA disability rating was 100% effective 26Aug2023, the day after discharge; however, in the ARBA Medial Reviewer's opinion, the applicant did not have conditions which failed medical retention standards of AR 40-501 chapter 3 at the time. The applicant was discharged for substandard performance due to not passing BOLC. Although initially, the applicant endorsed that his problem passing BOLC testing was due to concentration/retention and sleep disturbance due to worry about his sick parents in

Nigeria and brother's death (one year prior); later, the applicant repeatedly endorsed that his failure in the BOLC was attributable to his reported head injury and the alleged sequelae. However, per evidence in medical records, he failed multiple times prior to the reported head injury in March 2023. Per BH note, 'LTC [redacted] stated "SM was unable to complete BOLC academic requirements. SM has expressed his inability to continue in the Army and feels he is not suited for service, thus, he refused to train"' (12Jul2023 Behavioral Health Note BAMC AMC).

b. It was also noted that there was a high usage (sometimes every other day) of emergency services for non-urgent symptoms (for example, shaving bumps on 03Dec2022) that would normally be managed in a primary care or outpatient specialty clinic setting. In the undersigned's opinion, this interfered with both continuity of care and standard of care. This is reflected strongly in the management of his headaches: At the onset of the headaches, primary care did not have adequate opportunity to appropriately manage his headaches. For example, instead of being placed on first line abortive/preventive migraine specific/directed medications; he frequently received injections in the emergency room sometimes multiple times in a week. This high usage of emergency services began within 2 weeks of entry into service, prior to the reported head injury. For these reasons, despite numerous visits to the emergency room for headaches rated as severe, and the VA rating his migraine condition a 50%, the Migraine condition did not fail retention standards: The condition was recent (started only 5 months prior to discharge). The condition reportedly started in March; however, abortive medication was not started until June. The applicant was seen by outpatient neurology only once. Moreover, the applicant endorsed benefit with Maxalt and Depakote use. And finally, neurology did not indicate that the migraine condition failed retention standards.

c. Likewise, the neck and back strain conditions were not reported/treated until June 2023 and treatment was ongoing at the time of discharge. Concerning the neck and back injury on 11Aug2023, it did not require immediate medical attention and there was no report of symptoms for 2 weeks. In addition, historically, the applicant's symptoms were frequently augmented by his circumstances. At the time, he was anxious to leave service, and a delay may have worsened his symptoms. CT of the cervical and thoracic spine did not show acute abnormality.

d. A seizure disorder was not confirmed and while in service, there were no further reported instances of syncope after May 2023. And finally, in August 2023, Brain Injury Rehabilitation Services indicated that he did not require treatment for brain injury at the time. Therefore, based on records available for review, in the ARBA Medical Reviewer's opinion, there was insufficient evidence to support that the applicant had physical conditions which failed medical retention standards at the time of chapter separation from service. Referral to IDES is not warranted.

BEHAVIORAL HEALTH REVIEW:

a. The applicant is applying to the ABCMR requesting a correction of the narrative reason for separation and a referral to IDES to determine whether he should have been medically discharged or medically retired. On his application, the applicant contends his request, as it pertains to BH concerns, is related to Traumatic Brain Injury (TBI), Posttraumatic Stress Disorder (PTSD), and Other Mental Health Issues. Given the sequelae of TBI were primarily documented as being related to physical health concerns, consideration of the applicant's request as it pertains to this condition will be addressed in a separate opine, as will his other physical health conditions. 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 applicant entered active duty on 13 November 2022 in the rank/grade of Captain/O-3, 2) on 17 August 2023, the Deputy Assistant Secretary of the ARBA reviewed his request for resignation in lieu of elimination based on substandard performance of duty, accepted his resignation, and directed issuance of an honorable characterization of service, 3) the applicant was discharged on 25 August 2023 under the provisions of AR 600-8-24, for substandard performance with a separation code of BHK. He served 9 months and 13 days of net active service this period.

b. The Army Review Board Agency (ARBA) Medical Advisor reviewed the ROP and casefiles, supporting documents and the applicant's military service and available medical records. The VA's Joint Legacy Viewer (JLV) was also examined. Lack of citation or discussion in this section should not be interpreted as lack of consideration.

c. Military medical records available in JLV were reviewed. The applicant presented to his primary care manager (PCM) on 07 February 2023 and was diagnosed with common cold (symptoms noted as headaches, cough, body aches, and sore throat for four days). He also reported experiencing anxiety secondary to having sick family members at home and he was immediately referred him to BH. The BH provider documented that he failed his most recent test in BOLC and then failed the retake test due to having a hard time retaining the information and was feeling stressed due to his sick parents and the loss of his brother one year ago. His TBI screener was noted as positive, though no further information was documented and his Insomnia Severity Index (ISI) was 12. The applicant subsequently presented to the Emergency Department (ED) on 05 and 07 March 2023 due to problems sleeping, racing thoughts, and anxiety about his parents' health. He reported his worries about his mother's health impacted his performance during BOLC. It was further documented that he said he would prefer to separate from the military rather than being recycled. It was documented that he denied experiencing headaches. His diagnoses were documented as Anxiety, Insomnia, and Other Signs and Symptoms Involving Emotional State.

He presented for a BH triage on 10 March 2023 with the chief complaint noted as 'mistreatment,' stating that he had failed a test in BOLC and would be recycled. He reiterated that he told his command he wanted out of the military and was afraid something would happen to his mother like it did with his brother who passed away one year prior. He was diagnosed with Other Problems Related to Employment. The applicant presented to the ED on two more occasions in March 2023 due to problems with headache, blurred vision, problems sleeping, stress, anxiety, panic attacks, palpitations, and chest pain. His diagnoses reflected Headache, Injury of Kidney, Palpitations, and Insomnia. On 31 March 2023, he was prescribed Hydroxyzine in the ED for treatment of insomnia and anxiety.

The applicant presented to BH on 13 April 2023 reporting an increase in his anxiety and panic attacks, which were documented to be connected to his first duty assignment being cancelled after completion of military training in March 2023. He was diagnosed with Other Symptoms and Signs Involving Emotional State. He was diagnosed with Anxiety during a BH intake on 14 April 2023. He reported feeling discriminated against during a BH visit on 18 April 2023.

The applicant presented to the ED on 19 April 2023 due to intermittent episodes of problems with sleep, jumping out of bed, and chest pain, which he reported had been going on since March after training at Camp Bullis. He was diagnosed with Anxiety. During a primary care follow-up on 20 April 2023, he reported problems with sleep and anxiety which he attributed to his training at Camp Bullis, stating that he was having nightmares about Camp Bullis but did not go into detail about his anxiety. He presented to the ED on 22 April 2023 due to problems sleeping, pacing, and anxiety. He reported experiencing flashbacks of training at Camp Bullis. It was documented that he denied experiencing vision changes, headache, chest pain, shortness of breath, abdominal pain, nausea, vomiting, rashes, numbness, weakness, or loss of sensation. He was diagnosed with Anxiety and prescribed hydroxyzine. During a BH triage on 24 April 2023, the applicant stated command wanted him evaluated for a Medical Evaluation Board (MEB) as he started having anxiety after a traumatic experience during training at Camp Bullis. He reported significant problems with sleep, frequent awakenings, nightmares (though does not remember the content), decrease in appetite, and passive suicidal ideation (i.e., thoughts of being better off dead without plan or intent). He was diagnosed with Adjustment Disorder with Mixed Anxiety and Depressed Mood.

He presented to the ED on 27 April 2023 due to a severe headache after awakening from a nightmare and reporting decreased hearing bilaterally. It was noted he had recently experienced upper respiratory infection symptoms. He was diagnosed with Anxiety Disorder. The applicant also presented to the ED the following day reporting headache and ringing in the ears. The diagnosis was documented as nightmares. He reported that his headaches had worsened due to lack of sleep, nightmares, and medication side effects. The applicant further stated he had experienced a headache for

months. Psychiatry was consulted and he expressed concern that Vistaril may be causing the headaches. It was documented that his nightmares were due to an accident in BOLC wherein he fell in a ditch that was bout 2 feet and since then had been having dreams about getting shot and lost in the field. During the psychiatry appointment it was documented that he presented to the ER due to headache and ringing in the ears that started three days prior after falling out of bed and hitting his head. He was offered psychiatry admission for stabilization of his sleep related issues, to which he declined. The evaluating provider diagnosed him with Adjustment Disorder with Mixed Anxiety and Depressed Mood. It was also documented that he reported experiencing a frightening event where he was lost in the woods during a hailstorm which led to his inability to complete training and since then has experienced anxiety, restlessness, and insomnia. During a follow-up from his visit to the ED, it was documented that his CT scan of the head showed no intracranial abnormality. He reported experiencing multiple months of headaches, night terrors, ringing in ears, which had worsened approximately three days prior.

The applicant presented to BH on 01 May 2023 requesting inpatient psychiatric admission for a medication adjustment due to insomnia and nightmares. He also endorsed morbid ideation (i.e., thoughts of being better off dead) and experiencing auditory hallucinations telling him to "go back to camp or his life will never be the same." He was psychiatrically hospitalized from 01 through 01 May 2023. On 01 May 2023, the provider documented that, although the applicant was reporting some symptoms consistent with PTSD (e.g., nightmares about an event), he did not meet criteria for the condition due to lack of a Criterion A event. His hospital notes show that he reported improvement in his sleep and less frequent nighttime awakenings during his hospital stay. At the time of discharge, it was recommended to command to order a command-directed behavioral health evaluation (CDBHE) as he was not suited for the rigors of military training. His discharge diagnosis was documented as Adjustment Disorder with Mixed Anxiety and Depressed Mood, and he was prescribed Trazodone (sleep), Venlafaxine (mood), and Omeprazole (used to treat acid reflux). He was also prescribed acetaminophen, ibuprofen, and hydroxyzine as needed. He was placed on a temporary 90-day profile following his discharge from inpatient. He completed a BH safety check on 05 May 2023 following hospitalization and a primary care visit on 09 May 2023. On 09 May 2023, the applicant was escorted to BH due to 'not acting right' during a hearing examination. It was documented that he reported headaches, anxiety, and distress due to difficulty sleeping and nightmares.

During a visit to the ED on 12 May 2023, he was diagnosed with concussion with no loss of consciousness. It was documented that the event took place two months prior without loss of consciousness. He was referred to neurology and TBI clinic. He reported he fell and hit his head during BOLC and since then has had a constant headache and tinnitus that gets worse during physical exercise or when stressed.

The applicant underwent a routine CDBHE on 11 May 2023. The reason for referral was documented as the applicant reporting severe anxiety, sleep disturbances, nightmares, and emotional distress which has resulted in numerous ED visits. It was also noted that he had family care plan concerns regarding his adolescent daughter and his parents who were both admitted to the hospital in Nigeria. The commander documented that he had failed his mid-term and final examinations at BOLC and was scheduled to be recycled. His past and present performance was documented as marginal, and the commander reported he did not feel the applicant had the potential to be retained in the military. It was documented that he took the exam three times before passing and two days later he was required to take the final which he said he was not prepared for due to preparing for the mid-term. He also reported during a hailstorm at Camp Bullis he slipped in a ditch and fell, though immediately got back up and continued with the exercise. He stated he thinks he hit his head with his forehead being the point of injury. The provider documented that the final examination was completed prior to the last field exercise of BOLC at Camp Bullis. It was documented that on or around 03 March 2023 he was informed he would be recycled for training and finding out that he failed and would not be able to return home or pick up his daughter was the "most miserable point of his life" and that is when his mental trauma began. Since that time, he reported experiencing sleepless nights, nightmares about Camp Bullis, increased blood pressure, panic attacks, chronic headaches, blurred vision, and difficulty hearing. The evaluating provider documented the positive screening for TBI; however, when asked further, he reported no history of TBI. The applicant was diagnosed with Adjustment Disorder with Mixed Anxiety and Depressed Mood. It was documented that his anxiety and depressive symptoms were in response to the identified stressor of failing BOLC and that these symptoms began after notification of his failed examination. It was documented that he had not yet engaged in a trial of treatment through BH and thus individual and group therapy as well as medication management were recommended by the provider to increase coping skills and reduce symptomatology. During a BH intake, Adjustment Insomnia was added to his diagnoses.

On 17 May 2023, his primary care provider diagnosed him with headache and ordered an MRI due to his multiple ER visits, chronic headaches with tinnitus, and reported TBI history. A profile was submitted. He presented to the ED on 22 May 2023 due to ringing in the ears, headache, and dizziness. On 24 May 2023, the applicant presented to the ED expressing concerns about absence seizures that occurred twice since yesterday with the last one unwitnessed. He reported he did not know how much time he was down, found himself on the floor and remembers the room spinning. The applicant also stated he was laying on the ground shaking with his jaw clenched. His labs and CT scan were noted as unremarkable. He was admitted for further observation and a seizure evaluation. The evaluating neurologist diagnosed him with post concussive syndrome with migrainous feature. The neurologist further indicated that the etiology of the symptoms were likely multifactorial citing polypharmacy and recent addition of propranolol, in addition to some medication overuse of daily acetaminophen and

ibuprofen for headaches. The neurologist recommended he discontinue those medications and start a preventative medication for headaches/migraines such as Topamax. The MRI was overall unremarkable with a few subcortical flair hyperintensities, white matter foci, which were non-specific. The provider documented that there was a broad differential to include chronic migraines, prior demyelination, or gliosis from other remote infectious, inflammatory, vascular, or traumatic insults. His EEG was within normal limits. He was started on Depakote to help with acute headache. His discharge diagnoses were documented as Adjustment Disorder with Mixed Anxiety and Depressed Mood, Concussion with no LOC, GERD, loss of consciousness, Post Concussive Syndrome with Migrainous Features, and Syncopal Episodes Secondary to Suspected Polypharmacy. His PCM doctor noted that he required a 6-month driving profile per Texas law. The applicant had several additional visits to the ED until he was discharged from the military primarily related to recurrent headaches/migraines. His diagnoses were documented as Chronic post-concussion headache, headache recurrent, Migraine, cold symptoms, and back pain.

The applicant engaged in individual psychotherapy and medication management through behavioral health including cognitive behavioral therapy and supportive therapy. Although he had underwent intake and several triages from March 2023, his engagement in treatment appears to have started in June 2023. Beginning June 2023, the applicant began expressing frustration and concern that PTSD was not documented in his records and that his civilian provider expressed concern that he was not being treated for PTSD. His primary diagnoses through BH were documented as Adjustment Disorder with Mixed Anxiety and Depressed Mood and Adjustment Insomnia. In addition to Trazodone, he was trialed on Seroquel (antipsychotic) for sleep.

The applicant underwent a Chapter 13 behavioral health evaluation on 12 July 2023 and was diagnosed with Adjustment Disorder with Mixed Anxiety and Depressed Mood. It was documented that a diagnosis of PTSD was considered; however, he did not meet full criteria for the condition as he denied experiencing a Criterion A event and denied criterion C behaviors. It was documented that he did not appear to fall below medical retention standards per Chapters 3-31 through 3-33. The applicant was psychologically cleared for any administrative action deemed appropriate by command, to include under the provisions of AR 635-200, Chapter 13. The applicant was deemed medically cleared during a SHPE examination on 07 June 2023.

The applicant was also engaged in treatment through the TBI clinic, and his diagnoses were documented as Chronic Post-Traumatic Headache, Intractable, Tension-type Headache, Unspecified, Intractable. It was recommended he continue Effexor (antidepressant) for mood, was started on Maxalt for abortive treatment of migraines, and Depakote ER for prophylaxis. His BH notes show he reported in July 2023 some improvement in his headaches with his new medication; however, he was still reporting poor sleep to psychiatry. On 18 August 2023, a Brain Injury Clinic note documented that

the applicant did not have any functional deficits related to the head injury that occurred on 02 March 2023 and that he did not warrant brain injury rehabilitation services at the time.

A VA note dated 21 August 2023 shows the applicant was transitioning out of the military and wanted to establish care. He was diagnosed with PTSD, Unspecified and Panic Disorder, Unspecified.

The applicant was discharged on 25 august 2023. He presented to the ED that day noting that he had been loading a truck, had vertigo and fell while carrying boxes and landed on his back. He reported experiencing back and left sided pain and denied any LOC. He was diagnosed with back pain.

d. A VA Rating Decision Letter dated 23 October 2024 shows the applicant was granted 100% service-connection for PTSD with TBI, effective 26 August 2023. He was also granted service-connection for Residual of TBI, Anosmia (10%), and Residual of TBI, Hypogeusia (0%). The letter also shows he was granted service-connection for numerous physical health concerns. The applicant underwent an Initial PTSD VA Compensation and Pension (C&P) examination on 06 September 2024 showing that he was diagnosed with PTSD with the associated stressor documented as 'military injury.' His symptoms were documented as distressing memories, dreams, physiological reactions to internal or external cues, avoidance of or efforts to avoid external reminders that arouse memories, thoughts, or feelings associated with events, diminished interest or participation in significant activities, feelings of detachment, or estrangement from others, irritable behavior, hypervigilance, concentration difficulty, and sleep disturbance.

A Residuals of TBI Compensation and Pension (C&P) examination dated 19 September 2024 shows he was diagnosed with TBI with the date of diagnosis documented as 2023. His judgment, orientation, communication, and consciousness were documented as within normal limits. His social interaction was documented as occasionally inappropriate, his visual-spatial orientation was documented as moderately impaired. It was also documented that he had three or more subjective symptoms that mildly interfered with work including frequent headache, frequent insomnia, irritability, and tinnitus. The residuals were documented as hearing loss and/or tinnitus, alteration in sense of smell or taste, headaches, including migraine headaches, and mental disorder. The provider documented there was an overlap between symptoms of PTSD and residual symptoms of TBI, particularly in the area of concentration, memory, and moodiness.

The applicant included VA treatment notes as part of his application which, in effect, show his problems with sleep, anxiety, panic attacks, depression, and passive suicidal ideation have persisted, in addition to memory issues, vertigo, and breakthrough seizures while on Depakote.

e. Based on the available information, it is the opinion of the Agency Medical Advisor that there is insufficient evidence that the applicant failed medical retention standards from a behavioral health perspective in accordance with AR 40-501, Chapter 3 while in-service and thus a referral to the Disability Evaluation Service (DES) is not warranted.

The applicant was diagnosed with several BH conditions while in-service including Adjustment Disorder with Mixed Anxiety and Depressed Mood, Adjustment Insomnia, Insomnia, Anxiety (Unspecified). He was also diagnosed with TBI and Post-Concussive Syndrome. His in-service diagnoses of Adjustment Disorder do not fall under the purview of AR 40-501 as the condition was less than 6 months in duration at the time separation proceedings were initiated. A VA provider also diagnosed him with PTSD, Unspecified and Panic Disorder, Unspecified prior to his discharge and he is 100% service-connected through the VA for PTSD with TBI. It is of note that there is a discrepancy between his military treatment records and VA service-connected disability as it pertains to a diagnosis of PTSD, with his military records documenting that he did not meet criteria for PTSD due to the absence of a qualifying Criterion A event. Per DSM-5, a qualifying event requires exposure to actual or threatened death, serious injury, or sexual violence. Although it is acknowledged that the applicant has been diagnosed with TBI and has ongoing residuals as a result of the event, the description of the event and chronology of his symptomatology are insufficient to establish that it constitutes a serious injury as there is no evidence he sought medical treatment at the time of the event (thus indicating seriousness/severity), he was able to continue with the task he was performing, and the event was not documented until 8 weeks afterwards despite seeking medical care between the time of the incident and the date of the report. It is also of note that VA examinations are based on different standards and parameters, they do not address whether a medical condition met or failed Army retention criteria or if was a ratable condition during the period of service. Therefore, a VA disability rating does not imply failure to meet Army retention standards at the time of service or that a different diagnosis rendered on active duty is inaccurate. A subsequent diagnosis of PTSD through the VA is not indicative of a misdiagnosis or other injustice at the time of service. Furthermore, even an in-service diagnosis of PTSD is not automatically unfitting per AR 40-501 and would not automatically result in medical separation processing.

Despite the discrepancy in his in-service and VA diagnoses, as it pertains to his request for disability, all anxiety and trauma-and-stressor-based conditions fall under AR 40-501, Chapter 3-33, paragraph c and therefore the criteria for referral to the DES are the same for Anxiety Disorder, Unspecified and PTSD. Per regulation, a referral to IDES for anxiety and trauma-and-stressor-based conditions is required when there is 1) persistence or recurrence of symptoms sufficient to require extended or recurrent hospitalization or 2) persistence or recurrence of symptoms that interfere with duty

performance and necessitate limitations of duty in a protected environment. The applicant was psychiatrically hospitalized on one occasion while in-service in order to stabilize his medications due to ongoing problems with sleep, which resulted in a temporary 90-day BH profile upon discharge. One hospitalization and a one-time profile do not meet the threshold for recurrence of symptoms. His military medical records consistently documented that he met medical retention standards and was psychiatrically cleared for administrative separation. Thus, there is insufficient evidence that the applicant's BH condition fell below medical retention standards IAW AR 40-501, Chapter 3 at the time of his separation and a referral to DES is not warranted.

f. Kurta Questions:

(1) Did the applicant have a condition or experience that may excuse or mitigate the discharge? N/A-the applicant is requesting medical retirement.

(2) Did the condition exist or experience occur during military service? N/A-the applicant is requesting medical retirement.

(3) Does the condition or experience actually excuse or mitigate the discharge? N/A-the applicant is requesting medical retirement.

BOARD DISCUSSION:

1. After reviewing the application, all supporting documents, and the evidence found within the military record, the Board found that relief was not warranted. The Board carefully considered the applicant's request, supporting documents, and evidence in the records. The Board considered the applicant's statement, record of service, the narrative reason for separation and the reason for separation

a. Narrative Reason for Separation. Deny. The Board noted that the applicant voluntarily requested resignation in lieu of elimination based on substandard performance of duty, his request was accepted, and he was issued an honorable characterization of service. The Board found no error or injustice in the narrative reason for separation assigned during separation processing and denied relief.

b. Type of Separation - Referral to IDES – Medical Retirement/Discharge. Deny. The Board concurred with the medical advising official stating there was insufficient evidence to support that the applicant had physical conditions which failed medical retention standards at the time of chapter separation from service that warranted a referral to IDES. In addition, the medical advisor found the applicant failed medical retention standards from a behavioral health perspective in accordance with AR 40-501, Chapter 3 while in-service and thus a referral to the Disability Evaluation Service (DES)

is not warranted. Therefore, the Board determined there was insufficient evidence to warrant a referral to a medical board for the purpose of a medical discharge or retirement.

2. Based upon the misconduct leading to the applicant's separation and the following recommendation found in the medical review related to the liberal consideration:

(1) Did the applicant have a condition or experience that may excuse or mitigate the discharge? N/A-the applicant is requesting medical retirement.

(2) Did the condition exist or experience occur during military service? N/A-the applicant is requesting medical retirement.

(3) Does the condition or experience actually excuse or mitigate the discharge? N/A-the applicant is requesting medical retirement.

The Board concluded there was insufficient evidence of an error or injustice warranting a change to the applicant's narrative reason and type of separation of service.

BOARD VOTE:

Mbr 1	Mbr 2	Mbr 3	
:	:	:	GRANT FULL RELIEF
:	:	:	GRANT PARTIAL RELIEF
:	:	:	GRANT FORMAL HEARING
XX	XX	XX	DENY APPLICATION

BOARD DETERMINATION/RECOMMENDATION:

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

X //signed//

CHAIRPERSON

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

REFERENCES:

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

2. Section 1556 of Title 10, U.S. Code, requires the Secretary of the Army to ensure that an applicant seeking corrective action by 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.

3. Army Regulation 600-8-24 (Officer Transfers and Discharges) sets forth the basic authority for the separations for all officers on active duty for 30 days or more. Chapter 4 (Eliminations) outlines the policy and procedure for the elimination of officers from the active Army for substandard performance of duty, misconduct, moral or professional dereliction, and in the interest of national security. Paragraph 4–2 (Reasons for Elimination), sub-paragraph a. specifically covers substandard performance of duty.

4. Army Regulation 635-5-1 (Separation Program Designator (SPD) Codes) provides the specific authorities (regulatory or directive), reasons for separating Soldiers from active duty, and the separation codes to be entered on the DD Form 214. It identifies the separation code "BHK" as the appropriate code to assign officer Soldiers who are

discharged under the provisions of Army Regulation 600-8-24, Chapter 4, paragraph 4-2a, for substandard performance.

5. Title 38, U.S. Code, sections 1110 and 1131, permits the VA to award compensation for a medical condition which was incurred in or aggravated by active military service. The VA, however, is not required by law to determine medical unfitness for further military service. The VA, in accordance with its own policies and regulations, awards compensation solely on the basis that a medical condition exists and that said medical condition reduces or impairs the social or industrial adaptability of the individual concerned. The VA can evaluate a veteran throughout his or her lifetime, adjusting the percentage of disability based upon that agency's examinations and findings. However, these changes do not call into question the application of the fitness standards and the disability ratings assigned by proper military medical authorities during the applicant's processing through the Army IDES.

6. Army Regulation 635-40 (Disability Evaluation for Retention, Retirement, or Separation) establishes the Physical Disability Evaluation System (PDES) and sets forth policies, responsibilities, and procedures that apply in determining whether a Soldier is unfit because of physical disability to reasonably perform the duties of his or her office, grade, rank, or rating. It provides that an MEB is convened to document a Soldier's medical status and duty limitations insofar as duty is affected by the Soldier's status. A decision is made as to the Soldier's medical qualifications for retention based on the criteria in Army Regulation 40-501 (Standards of Medical Fitness). Disability compensation is not an entitlement acquired by reason of service-incurred illness or injury; rather, it is provided to Soldiers whose service is interrupted and who can no longer continue to reasonably perform because of a physical disability incurred or aggravated in service.

a. Paragraph 2-1 provides that the mere presence of impairment does not of itself justify a finding of unfitness because of physical disability. In each case, it is necessary to compare the nature and degree of physical disability present with the requirements of the duties the member reasonably may be expected to perform because of his or her office, rank, grade, or rating. The Army must find that a service member is physically unfit to reasonably perform his or her duties and assign an appropriate disability rating before he or she can be medically retired or separated.

b. Paragraph 2-2b(1) provides that when a member is being processed for separation for reasons other than physical disability (e.g., retirement, resignation, reduction in force, relief from active duty, administrative separation, discharge, etc.), his or her continued performance of duty (until he or she is referred to the PDES for evaluation for separation for reasons indicated above) creates a presumption that the member is fit for duty. Except for a member who was previously found unfit and retained in a limited assignment duty status in accordance with chapter 6 of this regulation, such

a member should not be referred to the PDES unless his or her physical defects raise substantial doubt that he or she is fit to continue to perform the duties of his or her office, grade, rank, or rating.

c. Paragraph 2-2b(2) provides that when a member is being processed for separation for reasons other than physical disability, the presumption of fitness may be overcome if the evidence establishes that the member, in fact, was physically unable to adequately perform the duties of his or her office, grade, rank, or rating even though he or she was improperly retained in that office, grade, rank, or rating for a period of time and/or acute, grave illness or injury or other deterioration of physical condition that occurred immediately prior to or coincidentally with the member's separation for reasons other than physical disability rendered him or her unfit for further duty.

7. Directive-Type Memorandum (DTM) 11-015 explains the IDES. It states:

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

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

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

//NOTHING FOLLOWS//