DEPARTMENT OF HOMELAND SECURITY
BOARD FOR CORRECTION OF MILITARY RECORDS

Application for Correction of
the Coast Guard Record of:

BCMR Docket No. 2020-107

EMC (Retired)

FINAL DECISION

This proceeding was conducted according to the provisions of 10 U.S.C. § 1552 and 14 U.S.C. § 2507. The Chair docketed the case after receiving the completed application on June 26, 2019, and assigned the case to a staff attorney to prepare the decision pursuant to 33 C.F.R. § 52.61(c).

This final decision, dated December 8, 2022, is approved and signed by the three duly appointed members who were designated to serve as the Board in this case.

APPLICANT'S ALLEGATIONS

The applicant, a former Chief Electrician's Mate (EMC/E-7), who was medically retired on March 14, 2017, asked the Board to correct his record by awarding him Service Member Group Life Insurance Traumatic Injury Protection (TSGLI)[1] benefits for the spinal injuries he incurred on January 13, 2015, that prevented him from performing Activities of Daily Living (ADL) for greater than 30 days, as described in his TSGLI application dated April 1, 2016, which is summarized in the Summary of the Record below.

SUMMARY OF THE RECORD

The applicant enlisted in the Coast Guard on November 27, 2001, and served on active duty until he was medically retired on March 14, 2017. The medical records he provided to support his request for TSGLI benefits are summarized below.

On January 13, 2015, the applicant was evaluated at an emergency room (ER) for pain in his lower back and numbness down his left side. A CT scan revealed that the applicant had L4-L5 and L5-S1 bulging discs with mild stenosis. The treating physician diagnosed the applicant with

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[1] TSGLI provides short-term financial support to help eligible service members recover from a severe injury.

left sided sciatica, discharged him with pain killers, and placed him on Sick in Quarters (SIQ) status for six days.[2]

On January 20, 2015, the applicant returned to the ER with worsening pain and numbness down his left leg. The physician noted the following:

> 01/21/[2015] 12:41. This is a 34 year old male patient of Dr. [redacted] with a PMHx of HTN [hypertension] who was recently seen in the ED [Emergency Department] on 01/13/15 by Dr. [redacted] who discharged the patient with a diagnosis of left sided sciatica and prescriptions for Motrin and Vicodin. At that time the patient had a lumbar spine CT which showed disc bulging of L4-5 and L5-S1 with mild stenosis. Today the patient returns to the ED alone via POV with complaints of worsening pain and numbness down his left leg, Initially he developed pain and numbness down his left leg last week after doing yardwork. He took a week off of work as a Coast Guard and went back today. The pain has improved and has been a steady 5/10 in severity but notes that the numbness has been constant. Today while at work the patient suddenly "couldn't use [his] left calf." He notes that he was able to move his left thigh but there was moderate pain when involving his left calf. Patient reports some relief from the Vicodin during the day but minimal relief when attempting to sleep. He has since run out of Vicodin and notes to no sleep last night. Patient was sent to the ED for an MRI but was unaware that the MRI machine is down. He denies any weakness, bowel or bladder incontinence, saddle anesthesia, vomiting, diarrhea, urinary symptoms, shortness of breath, fever, chills or any other associated symptoms or recent injuries.
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> 1/20/[2015] 15:18. 34-year-old male with history of hypertension, presented to the ER today for evaluation of worsening sciatica symptoms that have progressed from pain along the left lower extremity to significant paresthesia over the anterior, lateral, and posterior portions of the left leg with calf weakness and decreased plantar flexion strength. Patient was seen approximately 2 [*sic*] ago at which time he underwent a CT of the lumbar spine which demonstrated significant disc herniation at the L4-L5 and L5-S1 levels. The patient appeared to respond well to symptomatic treatment with anti-inflammatory and narcotic pain medications. The patient also decreased exertional levels or followed up with his PCP. The patient felt more comfortable with returning to work today despite his pain being approximately 5/10, however after approximately half a day at work, the patient's symptoms exacerbated severely and she [*sic*] noticed that he had significant difficulty stepping off to the left foot and no significant weakness in his left calf muscle. No presentation today, the patient was noted to be in moderate distress secondary to significant low back pain radiating down to the distal end of his left lower extremity with paresthesias and significant loss of sensation in the anterior, lateral, and posterior regions of his left lower extremity. The patient was also noted significant weakness to plantar flexion in his left foot. The patient denied any loss of bladder or bowel control and also denied any signs of neurogenic bladder.
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> Critical care time for this patient was [45] minutes not including time for procedures. The treatment of this patient required direct personal management and the withdrawal of, or failure to initiate these interventions on an urgent basis could have resulted in a significant threat to health or life.
>
> SURGERY HX: Appendectomy. (Orthopedic (left wrist, right knee, left ankle, right shoulder)). NO HISTORY OF TRAUMA.

On January 20, 2015, the applicant was transferred to a nearby medical center to obtain an MRI. The MRI results are as follows:

> Findings: Vertebral body heights and vertebral alignment are normal. There is no aggressive bone marrow lesion or evidence of acute injury. There are mild degenerative endplate signal changes at L5-S1. The visualized caudal spinal cord is normal in signal and terminates at a normal level. The visualized paraspinal soft tissues are unremarkable.

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[2] The Board was unable to locate the applicant's medical records from his January 13, 2015, ER visit. The facts provided here were obtained from the report of the ER physician that treated the applicant on January 20, 2015.

> **<u>Disc levels</u>**: T12-L1: Normal. L1-2: Normal. L2-3: Normal. L3-4: Normal.
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> L4-5: Degenerative disc desiccation, slight disc height loss, and a small central to right paracentral disc protrusion in contact with the right LS nerve root in the lateral recess without nerve root displacement (best seen on image 18 of series 7). No significant spinal canal or neural foraminal stenosis. L5-S1: Very large left posterolateral disc extrusion with cranial and caudal migration causing severe spinal stenosis and substantial mass effect on the left S1 nerve root in the lateral recess, which correlates with history left foot drop.
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> **<u>Impression</u>**:
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> 1. L5-S1 large disc herniation causing pronounced spinal canal stenosis and mass effect on the cauda equina particularly the left S1 nerve root, which correlates with the history of drop. Discussed with the Emergency Department attending Dr. [redacted] at 1956 hours, 1/20/2015.
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> 2. L4-L5 degenerative disc disease without significant spinal stenosis or nerve root displacement.

On January 21, 2015, the applicant underwent emergency L5-S1 discectomy surgery.

On March 19, 2015, following the applicant's January 21, 2015, emergency discectomy, the applicant was seen by a neurosurgeon. The neurosurgeon found that the applicant was not fit for return to full duty. The neurosurgeon's notes are as follows:

> 34 yo man is seen in follow up after left L5-S1 discectomy on 11/21/2015, Medevac from [redacted] for intolerable left leg pain, numbness and profound weakness of the left calf for a week, preceded by worsened low back pain for months. He became ambulatory with cane post op with significant decrease of left leg radiating pains, and was able to return to essential office work for few hours at a time over past weeks, on 7 occasions. He had follow up MRI of lumbar spine in [redacted] because of continued severe [pain] although improved low back and left leg pains and calf weakness on 3/12/2015; MRI was done with and without Gad, showing no evidence of left L6-S1 disc herniation, and removal of the large left lateral recess mass comprised of large collection of extruded disc migrated superiorly up behind the body of L5. The left S1 nerve root i s no longer compressed. He has been afebrile and the constrasted [*sic*] MRI shows no signs of post op infection. He is very concerned about his inability to return to duty because of persistent symptoms although improved, which is not unusual in the setting of very severe nerve root compression preop. He remains on roxicet [*sic*], gabapentin and Flexeril [*sic*], and is followed by Dr. [redacted] in, [redacted].
>
> Aftercare Postprocedural: Patient had Left LS-S1 discectomy on 1/21/2015 and although [*sic*] improved and now ambulating with cane, he has persistent significant [*sic*] low back and left leg pains and calf weakness, such that he is unable to toe raise on the left. He needs a cane to walk, he is judged not lit for return to duty, and likely will need be off another 60 days, depending on progress. I spoke to Dr. [redacted] in [redacted] today, and she will make referral to Physiatry and Pain Management physicians in [redacted] to further evaluate and treat residual symptoms. I offered to do that here, but he has family in Hilo with little children, and would prefer to be cared for In Hilo. I have also advised being evaluated [*sic*] by Coast Guard Clinic today before return to discuss convalescent leave extension, ramifications, options, etc.

On May 9, 2015, the applicant was evaluated on an outpatient basis for the purpose of the Initial Medical Evaluation Board. The applicant received diagnoses for the following medically disqualifying conditions:

> 1) Back Pain secondary to herniated L4 with pronounced spinal canal stenosis, mass effect on the cauda equina particularly the left S1 nerve root,
> 2) L5/S1 painful Radiculopathy,
> 3) L foot drop
> 4) L foot flexion weakness,
> 5) L5-S1 TLIF with cage, bolts, rod and L5 discectomy

6) Urinary Retention

At a follow-up appointment on May 11, 2015, the doctor noted that the applicant "doesn't exactly know how or when he injured his back. Back pain was so bad until November 2014, when he was at work and started to feel severe pain, followed by weakness and severe calf pain of left lower extremity."

On September 15, 2015, the applicant received a second opinion from a neurosurgeon. Medical notes from the second neurosurgeon are as follows:

> The patient is a 35-year-old gentleman referred for evaluation of low back pain and left leg pain. He noted onset of low back pain in November 2014 with no specific event precipitating the pain. He was injured at work on January 13, 2015. Patient is active duty coast guard and was involved in a drill while on a ship that required a lot of twisting and crouching. He noted increasing back pain and paresthesias [numbness] radiating into the left leg. He stayed home for 6 days and when he tried to go back to work he noted that his left leg was dried. He was subsequently evacuated to [redacted] Medical Center and underwent surgery after a MRI reportedly showed a herniated disc The surgery was performed on or about January 20, 2015. Dr [redacted] performed the surgery and approximately 4 weeks postoperatively the patient began noticing increasing back pain and left leg pain along with weakness in his left ankle. The patient followed up with Dr. [redacted] who told him that he needed more conservative treatment including pain management and epidural steroids. The patient was referred to a physical medicine specialist and he did undergo several epidural steroid injections without any significant improvement. He also went to physical therapy The patient continues to have low back pain which he describes as a constant dull ache and constant left leg pain in LS distribution He has some occasional symptoms on the right mostly in the buttocks and thigh which are less severe The patient states that his left leg weakness is slowly worsening He also states that the back pain is worse than the leg pain He's been unable to work since June 2015.

First TSGLI Application

On April 1, 2016, the applicant applied for TSGLI benefits for the back injuries he incurred on January 13, 2015. In support of his application, the applicant provided the following:

> **<u>Applicant Narrative</u>**. On 13 JAN 15, at approx. 1115 while running fire drills in a training environment onboard the CGC [redacted], I rapidly moved from the fantail down a ladder into the engine room to assess the fire team and carry out the drill scenario. After entering the engine room, I began crawling around the engines and bilges placing lights around in tight areas to act as hot spots. While prepping for the drill I was slammed into starboard main diesel engine and the impact hit my lower back. I began to feel the worst pain in my back, and my left leg began to hurt followed by the feeling of stabbing, burning, and pins and needles from my back down. Later that evening after work, while changing in my berthing area, I noticed a large egg shaped bulge on my lower spine. I left at 2005 from the CGC [redacted], and went straight to the emergency room and was checked in at 2109. They did a CT scan and told me that I had 2-bulged disc's, to rest for 3 days, and that I was "getting old." I stayed on my couch for the next 6 days. Alternating between heat and ice.
>
> On 20 JAN l5 I returned to work still swollen and suffering from pain, burning, stabbing, and numbness from my lower back and down my entire left leg. I was up and down fixing the ships Auto Pilot system, when my left calf stopped working and my left foot started dragging. I notified my command that I was going back to the ER. By the time my wife picked me up, which was less than an hour, my right leg began to go numb, and I started having weakness in my left thigh. At the ER, [I] was told that I was misdiagnosed on 13 JAN 15, and it was an emergency. I was medevac'd to [redacted] Hospital. Where I had an MRI and was told I needed emergency surgery to remove a portion of my disc at the L5-S1 that was impacted into my nerve bundles.

I had surgery 21 JAN 15 and was released from [redacted] 3 days later. After one week the surgeon released me to my PCP, I flew home and began to recover at home.

On 05 FEB I5 I saw my PCP [primary care provider] and was on track.

By 24 FEB 15 I saw my PCP and informed her that something was wrong. The nerve pains in my left leg to my foot and lower back pains were heavily increasing. *****Surgery was a failure and I was in severe pain. l was unable to use my left calf and my left foot was dragging more than ever.
PC ordered a POST OP MRI on 12 MAR 15 and on 17 MAR 15 I flew back to [redacted] to see the surgeon, Dr. [redacted], at [redacted] to figure out what to do. At that point, I was told by Dr. [redacted] that he "did not cut my nerve" and that he couldn't do anything else for me. He contacted my PCP and told me to see a pain management specialist and a physiatrist.

After returning home the evening of 17 MAR 15, I was in more severe pain than I could have imagined. I wasn't able to move, and was bed bound for five days. l realized I would not be able to fly again unless something was resolved physically.

24 MAR 15 I followed up with my PCP and informed her of the visit with the Dr. [redacted] and the difficulties of flying to [redacted] and how I had become increasingly bed bound. I continued to experience debilitating back spasms that showed no signs of easing up and left me bed-ridden all day except for using the bathroom from the assistance of my wife. At this point I had become significantly impaired and required my wife to assist me with daily activities, everything from safely being able to move around the house, to move to any place from my bed when needed, from my bed to bathroom, assistance moving and walking, bathing, showering, washing from my waist down. I was unable to use the restroom without help to remove my pants, wipe myself, or pull my pants back up. I became unable to dress myself from the waist down. I can't bend to put on underwear, shorts, sock s, or shoes. At that visit my PCP referred me to see a physiatrist, and physical therapy.

On 11 MAY 15 I had my first appoint with the physiatrist, Dr. [redacted], where she performed an EMG test to verify my physical condition and complaints. The results showed significant damage to my left S1 nerve bundle. I began physical therapy and had begun getting a series of epidurals. Through the summer I continued physical therapy and had 3 epidurals dated on 28 MAY 15, 23 JUN 15, 01 JUL 15 and well over 100 steroid injections with zero improvement or long term helpful effects.

On 24 AUG 15 I had my third MRI.

On 03 SEP 15 I finally saw another neurosurgeon for my 2nd opinion regarding my nerve damage and spine condition. After the neurosurgeon, Dr. [redacted], reviewed my MRI, I was told that he could help me by cleaning up my spine from the first surgery, and would be installing a cage and fusing the L5-S1. This physical torment that I had become my life since this injury in JAN 15 would be finally addressed.

21 SEP 15 I had an AP/LAT Full length spine, scoliosis series x-rays

PRE OP was 23 OCT 15 Dr [redacted] reviewed my x-rays and informed me that he would not only fix my back but that he would be able to relieve my nerve pain. At that point I had a huge burst in Hope and Trust.

29 OCT 15 I had surgery at [redacted] Community Hospital by Dr [redacted]. Left L5-S1 transfacet interbody fusion, micro dissection, interbody fusion using cage prosthetic device and moralized allograft, with posterior fixation was performed.

30 OCT 15 I spoke with Dr. [redacted] about my spine. He informed that he was unable to repair my S1 nerve, that during surgery after repairing everything, it was like “stimulating a wall.” Since the surgery I have not improved. I have had monthly follow up visits with Dr. [redacted] office.

On 10 FEB 15 I had POST OP MRI

On 19 FEB 16 I took MRI to visit Dr [redacted] nurse practitioner [redacted], I was told my L4 is an issue we need to address. At this visit I was referred to a Urologist, Gastroenterologist, Pain Management Specialist, and AFO fitting. I am back in physical therapy and receiving steroid injections bi-weekly from my physiatrist.

EMC [Applicant] Activities of Daily Living

Throughout this entire period, my life has come to a halt. Everything I knew and was able to do on my own has stopped. I have been living in pain! I have been suffering from nerve damage, muscle spasms, muscle atrophy, excruciating back pain and constant firing of the nerves. I was a professional sailor and electrician, father of 2 children, sponsored surfer, and active independent man. Since this injury I have been unable to live my life. I am in constant pain, requiring assistance from my wife to do the most basic activities of daily living. The only time I leave my home is to go to medical appointments because it hurts so much to do anything.

BATHING- (pg. 13) ** Unable to bend down to wash anything from my waist down that includes the rectum, penis, and testicles.
-Assist with walking to the bathroom for all showers
-Assist with removing clothes
-Assist with getting in and out of the shower
-Wash lower body in the shower including back, right and left legs and both feet
-Dry off lower body from waist down including back, right and left legs and both feet
-Sponge bathing when necessary for the nerve pain was so destructive it did not allow [applicant] to move from the bed

DRESSING-(pg. 13)
-Have to get all clothing everyday for [applicant] both from his dresser and closet that includes underwear, socks, shoes, slippers, pants, shirts, belt.
-Assist with changing clothes and dressing. Including pulling underwear and pants on from feet up to waist, as well as socks, shoes and leg/calf support hose. Including pulling down underwear and pants from waist to feet, as well as for socks, shoes, leg/calf support hose.

TOILETING-(pg.14)
-Assist with walking to the bathroom to use the bathroom. Ranges from holding [applicant] up as he walks, and provide physical support to walk to and from bathroom.
-Hold him under both armpits and lower him onto the toilet.
-Including pulling clothes up and down for toilet use
-Hold him under both armpits and raise him up
-Assist in cleaning after use, wiping, rinsing, etc.

TRANSFERRING-(pg.14)
-When bedbound, l am constantly rotating [applicant] side to side for pillows and ice packs under spine. Adjust linens to support with leg wedge, physically assisting to hold [applicant's] body to adjust from standing, and/ or sitting position to lay in g flat. Have to set up laying down area so that [applicant's] spine is not directly impacted by any material, and prop up multiple pillows for left leg to be supported. All of this lifting, twisting, and transferring [applicant] into positions is now the norm where I physically lift and move him when needed.
-Rolled [applicant] onto his side to position him to be able to sit up
-Held under both armpits to provide physical support to help raise and lower [applicant] in and out of sitting position
-Roll [applicant] onto his side for helping to position him to lying down
-Assist with walking to and from bed and couch to other areas of the home when necessary, requires physical assistance and other time must be at the ready in arms reach
-Constantly transferring [applicant] for up and down positions to take medication around the clock

> **<u>January 25, 2016, Letter from Medical Center Treating Physician.</u>** Specifically, the doctor provided the following:
>
> [Applicant's] work required a lot of twisting, bending, and crouching. While working he had an acute episode of low back pain and severe left leg radiculopathy. He had left calf weakness and left foot drop as a result. MRI at the time showed a large disc herniation with pronounced spinal canal stenosis at L5-S1. He also degenerative disc disease at the L4-L5. He was airlifted to [redacted] where a discectomy and hemilaminectomy at L5-S1 was performed on 1/21/2015. The herniation at L4-L5 was not addressed at that time.
>
> [Applicant's] post surgical [*sic*] course was complicated by continued pain, numbness and weakness in his low back and legs. He participated in physical therapy and saw Physiatry with little relief of his pain. He was able to work briefly until March 2015. He sought a second Neurosurgical opinion in August 2015. At that time MRI showed collapsed disc space at L5-S1 with lateral stenosis affecting both L5 nerve roots. It also showed persistent degenerative disc disease at L4-L5. He underwent a transfacet interbody fusion with an expandable cage in October 2015.
>
> Since his second back surgery [applicant's] overall pain has improved marginally. He continues to have severe muscle spasms, back pain and numbness, tingling and weakness in both legs. The pain is so severe that he is unable to perform the activities of daily living. Due to the back pain and spasms he is unable to bend. This makes transferring, standing, sitting, twisting and lifting very difficult. His wife assists him totally with his bathing, dressing, toileting and transferring.

On April 19, 2016, the Commander of PSC for the TSGLI Certifying Office issued a memorandum, "TSGLI Claim Determination," wherein he informed the applicant that his request for TSGLI benefits had been denied based on a finding that the applicant's loss was not a direct result of a traumatic injury caused by a traumatic event. The Commander noted the following:

> The supporting documentation submitted with your claim indicates that your loss was a result of an internal injury to the lower back (not caused by external force), which does not meet the definition of a traumatic event resulting in a traumatic injury under the TSGLI Program. Your statement indicates that on 13 Jan, while working aboard CGC [redacted] you were 'slammed into the starboard main diesel engine and the impact hit my lower back.' Medical documentation provided does not support your statement of traumatic injury. Medical notes from your initial Emergency Room visit on 13 Jan states 'he noticed swelling in his low mid back since this afternoon', and 'patient did yardwork yesterday.' [Redacted] Medical Center notes dated 20 Jan state 'initially he developed pain and numbness down his left leg last week after doing yardwork.' [Redacted] Medical Center notes dated 20 Jan states 'denies any trauma.' Medical notes dated 11 May state 'he doesn't exactly know how or when he injured his back.'

On November 9, 2016, a MISHAP report was filed for the applicant's January 13, 2015, back injuries.

Medical Board

On November 15, 2016, the Informal Physical Evaluation Board (IPEB) published its "Findings and Recommended Disposition Report" wherein it found that the applicant was unfit for continued duty by reason of physical disability. The Board recommended that the applicant be placed on the Permanent Disability Retirement List due to the following service-related injuries:

- Intervertebral Disc Syndrome with forward flexion of the Thoracolumbar Spine 30 degrees or less. (40% disability percentage.)
- Left-sided incomplete paralysis (Radiculopathy) of the Sciatic Nerve (Severe). (60% disability percentage.)
- Left-sided incomplete paralysis of the Femoral Nerve (Moderate). (20% disability percentage).

- Right-sided Neuralgia of the Femoral Nerve (Mild). (10% disability percentage).
- Neurogenic Bladder rated as voiding dysfunction with obstructed voiding with urinary retention requiring intermittent or continuous catherization.

The following notes from the board's narrative summary are relevant:

According to a review of health record [*sic*], systems, and social and family histories, the evaluee started noticing intermittent low back pain in 2006. Between 2006 until November 2014 he experienced occasional episodes of 8/10 pain with a spontaneous onset and resolving with attenuated activity, NSAIDs and/or Vicodin after a few days. In November 2014, evaluee had a spontaneous flare of his low back pain that was more severe and lasted longer than previous episodes. By December 2014 he had mostly recovered from this episode and resumed FFFD status, engaging immediately in small boat operations at [redacted] for most of December 2014 in a consistently severe sea state.

On 3 JAN 2015, while engaged in a training evolution on his USCGC, the evaluee rapidly moved from the fantail down a ladder into the engine room. After entering the engine room, evaluee began crawling around the engines and bilges to prepare for the drill. In the midst of these preparations evaluee was slammed into the starboard main diesel engine with the main force of the impact centered on his lower back. evaluee felt immediate severe pain in his back as well as a stabbing L leg pain, burning, and pins and needles from the Lumbar area down the left leg. Later that evening after work, while changing in my berthing area, evaluee noticed a large egg shaped bulge on his lower spine. Due to the unremitting and severe nature of those symptoms, upon reaching shore, evalee [*sic*] was sent immediately to the ER in [redacted]. CT scan revealed a bulging disc (L4/L5). He was made SIQ and ultimately spent over 6 days immobile on a couch at home. While his pain and mobility improved somewhat, he was still not fit for duty. By mid JAN 2015 he had limited strength in the L calf and R leg numbness. These symptoms prompted a visit to the ER in [redacted] again, which in turn led to air transport from [redacted] to [redacted] to optimize diagnostic and treatment capacity. In the [redacted] ER, evaluee received MRI and neurosurgery consultation. MRI showed L5-S1 large disc herniation with pronounced spinal canal stenosis, mass effect on the cauda equina particularly the left S1 nerve root, correlating with history of foot drop and L4-L5 degenerative disc disease without significant spinal stenosis or nerve root displacement. Urgent LS discectomy surgery was recommended and performed the day after he was admitted by Dr [redacted]. Evaluee returned to [redacted], experiencing excruciating back pain throughout the entire trip.

On 2/6/15, 3 months after his initial onset of leg numbness and severe pain, evaluee followed up with his surgeon with complaints of continued L leg numbness, mild improvement in pain, and a new symptom of no "lift off" strength with use of L calf. Evaluee was informed this would be chronic with no chance for improvement. Evaluee left office with anxiety about his prognosis, which has persisted in varying degrees until the present. By 2/15/15 evaluee noted severely worsening low back pain. On 3/1/15 evaluee received an MRI that showed nerve compression and scar tissue around S-1. During his neurosurgical follow up visit on 3/15/15, evaluee's neurosurgeon made a referral to a physiatrist and pain management doctors. No physical therapy was recommended as evaluee's pain was felt to be chronic with little chance for improvement. On 3/24/15 evaluee saw a primary care provider with complaints of still worsening low back pain, worsening foot drop and calf strength. Evaluee was unable to fly commercially due to pain. At this time, evaluee requested a second neurosurgical opinion and physical therapy. On 5/1/15 he was seen by a physiatrist. EMG on 5/11/16 showed permanent nerve damage of S1/L5.

…

Evaluee remains under the care of a physiatrist, urologist, psychologist, gastroenterologist for stomach pain GBRD and constipation, a nephrologist and a neurosurgeon all being coordinated by a civilian family medicine doctor. He continues to have intermittent tingling from his knee to foot on the R. Major symptoms include left sided foot drop, no L foot push off strength (0/5), chronic calf pain, numbness on the whole leg, L buttock cramping pain and numbness, L>R lower back pain (8/10) with swelling on the left lumbar area. This is attributed to his initial disc herniation. Expectation for improvement is minimal. His urinary retention improved initially with the second surgery, but is still severe. Initiation of stream is delayed, requiring up to

> 20 minutes of coaxing through the use of warm showers and other relaxation techniques. When his stream does start, it is accompanied by severe (10/10) stabbing pain in his L heel.

On November 18, 2016, the applicant's Sector Commander issued a memorandum wherein he ordered an investigation into the applicant's January 13, 2015, back injury.

TSGLI Request for Reconsideration

On December 7, 2016, the applicant, through counsel, filed for reconsideration of the denial of his TSGLI claim. The applicant argued the following:

> This decision appears to have been based upon conflicting hospital entries regarding the onset of the injuries and subsequent statements made by the Respondent while suffering from chronic debilitating pain that raised questions as to the onset of his injuries and whether his claimed losses met the TSGLI criteria.
>
> However, in the past few months, Sector [redacted] has completed a mishap report that clearly outlines how the Respondent's injuries were directly attributable to a reportable mishap that occurred on the CGC [redacted] on 13 Jan 15. See Enclosure One.
>
> Two crew members from the CGC [redacted] who were direct witnesses to his injuries have provided statements corroborating the Respondent's description of events as originally outlined to you in ref (b). See Enclosure Two.
>
> Additionally, the Respondent's spinal and peripheral nerve injuries have been thoroughly reviewed, assessed and adjudicated as being 90% disabling, combat-related and in the line of duty by the PDES system on 15 Nov 16. See Enclosure Three.
>
> This is in keeping with the findings of CAPT [redacted], MD, USPHS- the senior Coast Guard provider who drafted the initial medical board in this case. See Enclosure Four.
>
> Counsel concedes that the severity of these injuries was not initially clear to either the command or the Respondent, thereby accounting for the initial failure of the command to file a mishap report as they deemed it to be a minor injury. See Enclosure One.
>
> However, upon reviewing the medical board narrative and the findings of the IPEB in this case, there could be no other logical cause for these injuries in the absence of a supervening intervening traumatic event- a review of the Respondent's medical records within the PDES process disclosed no such events and that is why all the injuries claimed in ref (b) were deemed to be combat-related in Enclosure Three.
>
> At the time of the initial emergency room visit upon which the adverse decision in ref (a) was based, it appears that the hospital staff either incompletely or inaccurately recorded what the Respondent said to them during the initial triage of his condition.
>
> It would be far from the first time that statements made by patients were misheard or mischaracterized by medical personnel in a busy emergency room setting; in addition, the statements of his two crew members and the mishap report submitted by Sector [redacted] clearly corroborate the Respondent's account of the onset of his injuries.
>
> Thus, no reasonable person could conclude that the Respondent suffered intervertebral disc syndrome, a neurogenic bladder, bilateral femoral nerve paralysis and severe paralysis of the left sciatic nerve from a back strain whilst mowing his lawn.
>
> By the same token, any statements regarding the Respondent being uncertain as to the source or cause of his pain in later records may logically be put in context as chronic pain patient being unclear as to the immediate

source of any recent flare or exacerbation of his existing injuries vice being a conflicting statement with respect to the onset of the injuries or nexus for his symptoms.

Findings & Recommendations: Line of Duty (LOD) Injury Investigation

On March 1, 2017, the investigating officer released his findings into the applicant's back injuries. The following findings and opinions from the investigator's report are relevant:

FINDINGS OF FACT

7. As a member of [redacted] OBIT, EMC started the drill on the fantail, observing the rapid response team conduct its initial response to the engine room fire. After this portion of the drill was complete, EMC [applicant] moved to the Engine Room. In preparation for the next part of the drill, EMC needed to place fire simulators in the bilge and hard to reach areas of the Engine Room and observe the fire attack team fought the fire. (Exhibits 2, 16)

8. EMC put fire simulators in the bilge by the starboard Main Diesel Engine. The last fire simulator he needed to place was between the aft portion of the starboard Main Diesel Engine and the reduction gear. (Exhibit 16).

9. Above the reduction gear is a permanently installed workbench. This workbench made it difficult to go into the bilge between the starboard Main Diesel engine and the reduction gear. This was not EMC [applicant's] first time going into the bilge between the reduction gear and the starboard Main Diesel Engine. (Exhibit 16)

10. The attack team entered the Engine Room as EMC was placing the final fire simulator. EMC heard them enter the space and hurried to exit the bilge to observe the attack team. He stood up rapidly and, while trying to avoid the work bench, struck his back on part of the Starboard Main Diesel Engine. This caused significant pain to EMC's back and legs as well as a "pins and needles" sensation in his left leg. (Exhibits 4, 16)

11. EMC exited the bilge and leaned on the workbench. He watched the attack team members conduct the drill and also provided them on scene training. When the drill was done, EMC radioed the Executive Officer (XO) to secure the drill and he let the XO know that he needed to talk to him. (Exhibit 16)

12. EMC [applicant] immediately walked to the fantail to meet the XO. The Engineering Petty Officer (EPO) was also on the fantail. EMC reported to the EPO and the XO that he had struck his back on one of the Main Diesel Engines, which caused back and leg pain and a tingling sensation in his leg. EMC [applicant] stated to the XO and EPO that the pain that he experienced felt like no other pain he had experienced before and that the pain was felt throughout his entire left leg from bis spine to his toes. He likened the pain to the feeling of pins and needles. (Exhibit 14)

13. The XO told EMC [applicant] that he had a similar experience where he had felt numbness and the feeling of needles in a part of his body that was sciatic, and reassured EMC [applicant] that the pain went away after a couple of weeks. (Exhibit 14)

14. The EPO told EMC [applicant] that he had heard of this pain happening to others before and that the injury was probably minor. (Exhibit 14)

15. In response to XO and EPO's assurances that what he was experiencing was probably minor, EMC informed them that what he was feeling was very strange and painful. The EPO suggested that EMC relax after the crew debriefed the drill. (Exhibit 14)

16. There was no medical casualty listed in [redacted] smooth logs on 13 January 2015. (Exhibit 3)

17. After the drill debrief, EMC went to his berthing area. He looked at his back in a mirror in the bathroom to see if he was bleeding. He observed a red mark on his lower back the size of a quarter. EMC's uniform was very dirty so instead of lying in his rack, EMC decided to lie on the floor and rested his head on his rack. He rested in his berthing area for approximately 15-20 minutes. He then went to the galley and made himself an ice pack. (Exhibit 14, 16)

18. The only work that EMC [applicant] completed for the rest of the day was non-strenuous administrative work, using the computer on the mess deck. (Exhibit 14).

19. EMC [applicant] went home around 1700. He lived 13-14 miles away by car from [redacted] and drove himself home. The drive took about 20 minutes. (Exhibit 2, 14)

20. At 1910 on 13 January 2015, [redacted] was recalled by the Sector Command Center for a Search and Rescue (SAR) case involving a disoriented kayaker. (Exhibit 3)

21. EMC [applicant] arrived to [redacted] at around 1935. When EMC [applicant] arrived he proceeded to change into his uniform in his berthing area. EMC had difficulty putting his uniform on. While changing he took his shirt off and MK2 M, a member of EMC [applicant's] berthing area, along with other members of the berthing area saw a large bump on EMC's back and went to get MKC [redacted] to witness the injury. MK2 M noted that the bump was about ½"to¾" in diameter and about the thickness of his thumb. (Exhibits 4, 16, 17)

22. The EPO was notified and observed the bump on EMC's back (Exhibit 5)

23. Immediately after the EPO was informed of EMC [applicant's] back pains, he took EMC to see the XO who also observed the bump on EMC [applicant's] lower back. (Exhibit 6)

24. Based on the visible manifestation of EMC [applicant's] injury and his apparent physical pain, the Command decided to conduct the SAR mission without him and directed him to go to the emergency room. EMC [applicant] left [redacted] at 2005 and drove himself to the emergency room in [redacted]. (Exhibits 4, 9, 14)

25. Neither EMC [applicant's] injury nor EMC's departure to the emergency room were noted in the CGC [redacted] smooth log. (Exhibit 3).

26. According to the CO of CGC [redacted], if a member is injured on board [redacted] or if the command is notified of a member injury, that injury should be logged in the smooth log. (Exhibit 12)

27. EMC checked into the emergency room at 2109. While in the emergency room, EMC [applicant] received a CT scan, which revealed a bulging disc (L4/L5), He was placed on Sick in Quarters (SIQ) status for six days. EMC [applicant] was told to lie flat on his back while SIQ. (Exhibits 1, 4, 11)

28. On 20 January 2015, EMC [applicant] returned to work on [redacted]. To get to work that morning, EMC [applicant] received a ride from GM2 P. (Exhibit 16)

29. Upon arrival at work, EMC went to morning muster then called the EPO. EMC [applicant] reported to the EPO that he was still experiencing the same pins and needles sensation on his leg and that his lower back was still hurting. EMC also let the EPO know that the circuit card for the auto-pilot had arrived and that his plan for the day was to install the circuit card to fix the auto-pilot and then go to medical to see his Primary Care Manager to get his back examined. (Exhibits 13, 16)

30. EMC [applicant] successfully repaired the auto-pilot. The auto-pilot repairs took three to four hours. EMC needed to walk up and down one ladderwell between the bridge and main deck in order to install the circuit card and perform a calibration of the auto-pilot and system groom. FN [B] assisted him with the auto-pilot repair by stationing himself in the aft steering room to verify rudder responsiveness. (Exhibits 13, 14, 16)

31. While EMC was walking from the bridge to the main deck, he lost feeling in his leg from his knee to his foot. EMC went to the ET shop and called the EPO and XO who were working in the office building near where the ship moors and told them that he needed to go to the emergency room, He also called his wife to come pick him up and drive him to the emergency room. (Exhibit 14, 16)

32. On 20 January 2015, shortly after arriving at the emergency room in [redacted], EMC [applicant] was air transported from [redacted] to [redacted] Medical Center on [redacted]. While at [the medical center], EMC [applicant] received an MRI which revealed a large disc herniation with pronounced spinal canal stenosis, mass effect on the cauda equine particularly the left S1 nerve root, correlating with history of foot drop and L4-L5 degenerative disc disease without significant spinal stenosis or nerve root displacement. (Exhibit 1)

33. Due to these back issues, Urgent LS discectomy surgery was performed the following day. (Exhibit 1)

34. EMC [applicant's] health record revealed treatment for intermittent lower back pain from 2006 - 2014 triggered by his work, participation in sports, and working out at the gym. The pain would normally last a couple of days to a week. To remedy the pain, EMC would stretch and apply heat and ice to his back, and get massages. Thereafter, the pain would dissipate, allowing him to continue his normal routines (Exhibit 1)

35. The former EPO stated that EMC [applicant] reported sporadic lower back pain in the past. The pain was never debilitating until after the 13 January 2015 injury. Until the 13 January 2015 incident, EMC [applicant] had never missed work due to back pain. (Exhibits 5, 13, 14)

36. In November 2014, EMC [applicant's] lower back pain suddenly worsened, resulting in pain that was more severe and long lasting than his previous episodes. There was no apparent particular cause; EMC [applicant] attributed it to his work on the ship, including underway time and standing duty, as well as taking care of his kids, jogging, and surfing. EMC treated this injury by stretching and applying ice and heat. (Exhibits 1, 14)

37. Prior to 13 January 2015, EMC [redacted] lived a very active lifestyle. He was an avid surfer who surfed daily. (Exhibit 5)

OPINIONS

1. Death, injury, or disease is the result of a member's misconduct if it is either intentionally incurred or is the result of willful neglect that demonstrates a reckless disregard for the foreseeable and likely consequences of the conduct involved. Simple or ordinary negligence or carelessness, standing alone, does not constitute misconduct. EMC [applicant] sustained the injury while on active duty assigned to [redacted] and performing the duties of an OBTT member during an assigned drill. He stood up rapidly when the attack team entered the engine room and accidentally hit his back. This incident was just an accident. EMC [applicant] had a reputation for being very good at his job and having a very good work ethic. Intentionally hurting oneself is not the action indicative of someone who is described in this manner. Since there is no evidence of willful neglect, the injury incurred by EMC [applicant] was not due to misconduct. (Facts 1, 7, 10, Reference b)

2. It is more likely than not that this accident aggravated EMC [applicant]s pre-existing back condition. While EMC [applicant] had episodes of back pain for nine years, he was able to get dressed in uniform and move around in the bilges of the Engine Room and never missed a day of work for his back before the incident. After he hit his back, he was not even able to don his boots and has missed numerous days of work. After this incident his condition significantly worsened to the point where EMC lost feeling in his leg. (Facts 7, 22, 32, 36)

3. The fire simulators should have been set up before the start of the drill. The attack team entered the space as EMC was still placing fire simulators. Because he was not ready when they entered the engine room, he rushed out of the bilge to meet them, striking his back in the process. If he had set up for the drill before it started, he would not have rushed out of the bilge and been more cautious when leaving the bilge and probably not have injured himself. (Fact 10)

> 4. If there had been better lighting in the engine room, EMC probably would have seen where he was in relation to the engine making him more cautious when maneuvering around it. While it is important to make drill environments as realistic as possible, it is more important to ensure crew safety while properly assessing all potential risks in order to effectively mitigate those risks. (Fact 4)
>
> 5. EMC [applicant's] medical casualty and departure to the emergency room should have been recorded in the ship's smooth log. EMC's casualty was not logged in the ship's smooth log because the severity of the injury was not understood at the time by the [redacted] command. According to the current Commanding Officer of [redacted], people bump their knees, heads, elbows, and backs multiple times a day on board the ship. If the command was under the impression that this injury was a major incident, they would have ensured that it was entered into the smooth log and that EMC sought medical attention immediately. EMC's departure to the emergency room was not recorded in the smooth log because due to stressful and hectic environment the crew of the [redacted] was in while trying to prepare the cutter to get underway, that entry into the smooth log was overlooked and eventually forgotten. The mishap report was not completed at the time of injury because initially, the Commanding Officer and Executive Officer of [redacted] did not think the incident constituted a mishap nor warranted a mishap report to be submitted. When EMC was hospitalized, a mishap report should have been submitted but was not due to administrative oversight by the command of [redacted]. (Exhibit 12, Facts 25, 26)

On March 3, 3017, the Coast Guard TSGLI Certifying Office once again denied the applicant's request for reconsideration stating, "Under the regulations that govern the TSGLI Program, there must be a clear connection between a traumatic event and resulting loss. Initially, there was no record or documentation to support your claim of a traumatic event as the cause of your loss." The Certifying Office also found that the supporting documentation provided in the applicant's reconsideration request did not substantiate the detailed medical information documented during his initial hospital visits.

On March 8, 2017, the Sector Commander, a Captain, issued a memorandum wherein he concurred with the recommendations from the Investigating Officer in the Line of Duty determination. Specifically, he found that the applicant's injuries were incurred in the line of duty and were not the result of misconduct. The Captain also stated the following:

> The investigation also highlights several instances where EMC [applicant's] command, both onboard CGC [redacted] and at Sector [redacted], failed to document the injury in a timely manner to include properly noting the injury in the ship's log, submitting a MISHAP report and documenting an initial LOD determination. I ask that you do not let this oversight on the part of his command to reflect negatively on the member. Furthermore, the member has been extremely forthcoming throughout this trying experience and has shown the utmost integrity throughout his career. I ask he receive the full benefit of the doubt in any matters pertaining to the circumstances surrounding his injury.

On June 27, 2017, the applicant formally appealed the Certifying Office's decision. The applicant argued that his Sector had recently completed a comprehensive Line of Duty (LOD) investigation wherein it found that the applicant had suffered an injury on January 13, 2015, which exacerbated his existing back injuries. The investigation concluded that the applicant's injury occurred while in the LOD, and was not due to misconduct. The applicant further argued that the Sector found that his Command failed him by not documenting the traumatic injury in a timely manner in the ship's log, not submitting a MISHAP Report, and not documenting an initial Line of Duty Investigation determination. The applicant did not dispute that the early medical record entries conflict with his later description of the traumatic onset of his injuries, but he alleged that the conflicting earlier statements were provided while he was suffering from debilitating pain and was therefore not an accurate historian at the moment. The applicant further argued that when the

evidence is reviewed, it is clear that his existing back injuries were exacerbated by his work-related trauma on January 13, 2015, and January 20, 2015. The applicant stated that after undergoing an MRI, he was diagnosed with a large disc herniation at L5-S1, which caused severe spinal stenosis and substantial mass effect upon his left S1 nerve root that correlated with the recent onset of left foot drop. According to the applicant, this evidence supports a finding that his injury was logically attributed to a trauma-related event and would not normally occur through natural progression of an existing disease or defect.

In support of his appeal, the applicant submitted the following:

- A November 23, 2016, Memorandum, "Final Mishap Report…," wherein the applicant's Sector filed a Mishap Report to the Coast Guard's health, Safety, and Work-Life Servicing Center (HSWL SC) for a reportable mishap that occurred onboard the applicant's cutter. The memorandum noted that although the Mishap was classified as a "Class C" mishap, the notes from SHWL SC stated that the final determination on the classification is still under review and would be made by a competent medical authority. The memorandum also noted that the applicant's cutter failed to meet Coast Guard prescribed mishap reporting requirements in accordance with the Coast Guard Safety and Environmental Health Manual, COMDTISNT M5100.47b, because it initially categorized the mishap as a "Minor On-Duty" incident, which exempts a unit from reporting a mishap.

  Mishap Narrative. At 0715 on 13 JAN 15, [cutter] began a main space fire drill for training in the engine room. As a member of the On Board Training Team (OBTT), the member was positioned in the engine room to observed [*sic*] the attach team and place fire simulators (i.e., lights to simulate hot spots of a fire) in the bilges and hard to reach areas of the engine room. After placing the final fire simulator prop around the starboard main diesel engine for the attack team to identify during their indirect attack of the main space fire, the member quickly stood up striking his back on a portion of the starboard main diesel engine while moving out of the bilge. After completion of the drill, the member reported to the EPO that he had struck his back on one of the main diesel engines which resulted in momentary left leg numbness. At the conclusion of the work day, the member went home when liberty was granted. However, [cutter] was recalled for a search and rescue case later that evening. When the member arrived to the cutter and attempted to change into uniform, he was unable to don his boots due to intense lower back pain. The XO was notified and observed protruding bulges on the lower back of the member. The Command determined immediately to leave him behind from the search and rescue case and sent him to the emergency room. Following his ER visit on the 13th, he was sent home to rest (3 days SIQ)[3] and returned to work on 20 JAN 2015. The member returned to work on the 20th, it was determined he required immediate medevac to [redacted medical center] for surgery which occurred on 21 JAN 2015. Four weeks after surgery, the member noticed increasing back pain, left leg pain, and weakness in his left ankle. The member was referred to a physical medicine specialist and underwent several epidural injections and trigger point injections with no improvement in pain. In August 2015, he underwent an MRI which revealed progressive nerve damage compared to his initial MRI (March 2015). In SEPT 2015, his new neurosurgeon recommended another surgery, which occurred on 29 October 2015. Following the surgery, the member continued to experience severe pain and mobility problems which led to a third surgery on 22 JUL 2016. As of this date, the member is bedbound, must utilize a wheelchair for mobility lasting longer than 10 minutes, and only leaves the house for medical appointments (physical therapy, neurosurgeon, etc).

- A November 20, 2016, personal statement issued on behalf of the applicant from the service member who "personally witnessed" the applicant's injury the day it occurred, and was with the applicant at the emergency room when the applicant was medically evacuated from the ship due as a result of his injuries. The service member stated that he was aware that the applicant's TSGLI claim was denied based on local hospital records that seemed to contradict the applicant's description of events, but contended that greater weight should be given to the observations of the applicant's servicing Coast Guard provider, shipmates, mishap report, and

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[3] The record shows that the applicant was sent home for 6 days of SIQ, not 3.

the IPEB findings, which concluded the applicant was 90% disabled as a result of the injuries he incurred on January 13, 2015.

- A November 20, 2016, personal statement from one of the applicant's shipmates at the time, who personally witnessed the swelling in the applicant's spine, caused by the injuries the applicant incurred during training exercises. The shipmate stated that he notified the chain of command about the applicant's swelling. Similar to the first personal statement, the shipmate argued that the greater weight should be given to the testimony and findings of those who witnessed the event and the subsequent investigations that concluded the applicant suffered an injury.

Commander's LOD Determination

On March 8, 2017, the applicant's Sector Commander issued a memorandum wherein, after reviewing the facts, he agreed with the LOD determination that the applicant's back injuries were sustained in the LOD and were not due to misconduct. The Captain also stated that the investigation highlighted several instances where the applicant's Command, both onboard his vessel and within his Sector, failed to document the injury in a timely manner, including properly noting the injury in the ship's log, submitting a MISHAP Report, and documenting an initial LOD determination. The Captain asked that PSC not let the applicant's Command's oversight reflect negatively on the applicant. According to the Captain, the applicant had been extremely forthcoming throughout "this trying experience" and had shown the utmost integrity throughout his career. Finally, the Captain asked that the applicant be given the full benefit of the doubt in any matters pertaining to the circumstances surrounding his injury.

APPLICANT'S ALLEGATIONS

The applicant, through counsel, argued that despite evidence demonstrating that the injuries he sustained on January 13, 2015, were logically related to the incident while onboard a Coast Guard vessel, taking part in required drills, the Certifying Office denied his multiple claims for benefits.[4]

The applicant explained that while reasonable minds may differ as to whether the onset of his injuries occurred on January 13, 2015, or January 20, 2015, the evidence of record is sufficient to find that he suffered a trauma-related injury that was sufficiently severe to require him to be medically evacuated to a nearby hospital to undergo emergency surgery the following day. Despite medical evidence to the contrary, the applicant stated that the TSGLI Certifying Office still denied his claims, finding that his injuries were not the direct result of a traumatic injury caused by a traumatic event. However, the applicant argued that the Certifying Office's findings are contrary to the LOD investigation, Medical Board Narrative Summary, and the PDES Board. In addition, the applicant noted that he has been awarded Combat-Related Special Compensation (CRSC) for the very same spinal injury the Certifying Office denied TSGLI benefits for. The applicant argued that the weight of evidence submitted to support his application supports a finding granting him TSGLI benefits for the spinal injuries he incurred on January 13, 2015.

[4] The applicant presented identical arguments in his memorandum to this Board as he did in his appeal to the Certifying Office's denial of his TSGLI benefits. For a reveal of those arguments look to his June 27, 2017, appeal found on page 13 of this decision. Only those arguments not previously articulated in this decision will be summarized here.

VIEWS OF THE COAST GUARD

On November 4, 2020, a judge advocate (JAG) of the Coast Guard submitted an advisory opinion in which he recommended that the Board deny relief in this case and adopted the findings and analysis provided in a memorandum prepared by the Personnel Service Center (PSC).

The JAG argued that the applicant cannot sufficiently establish that his spinal condition was a direct result of a January 13, 2015, traumatic injury. The JAG explained that the formula established by the Department of Veterans Affairs (DVA) for the receipt of Traumatic Injury Protection benefits is "All members covered under SGLI who experience a traumatic event that ***directly results*** in a traumatic injury causing a scheduled loss defined under the program are eligible for TSGLI payment." (Emphasis added).[5] The JAG argued that this same procedural guide defines direct result as, "there must be a clear connection between the traumatic event and resulting loss and no other factor, aside from the traumatic event, can play a part in causing the loss."[6] As such, the JAG claimed that the very construction of the statute requires a strict "cause in fact" theory of causation. According to the JAG, if this framework contemplates proximate causation at all, its straightforward terms tend towards a "but for" rule, rather than a more expansive construction. Applying this construction to the applicant's case, the JAG argued that the Coast Guard TSGLI Certifying Office has yet to find that the applicant has sufficiently demonstrated that his spinal condition was the direct result of a traumatic event. The JAG argued that the records speak for themselves. In summary, the JAG argued that multiple determinations and investigations found that the applicant's injuries were the result of an internal force and not an external force, and that the applicant's evidence did not outweigh the evidentiary weight of medical statements and records. The JAG conceded that the applicant suffers from a debilitating condition incurred while in the LOD, but the applicant has failed to prove that the incident on January 13, 2015, was a traumatic event that directly resulted in a traumatic injury. The JAG explained that the discretion afforded to the Coast Guard's TSGLI Certifying Office by regulation and policy, has consistently placed greater credibility on the medical records most contemporaneous with the date of the alleged incident. According to the JAG, these medical records indicate a longstanding condition, possibly aggravated by yardwork, and "the stress or strain of the normal work effort that [was] employed by" the applicant onboard his vessel on January 13 and 20, 2015.

The JAG further argued that the applicant has failed to provide "new and material" evidence to meet the standard for a TSGLI appeal. According to the JAG, the new documents provided by the applicant in his current application, specifically a November 9, 2017, letter from the DVA and an April 6, 2018, letter from PSC granting CRSC benefits, are both immaterial to TSGLI benefits. First, the JAG alleged that the DVA does not address the issue of causation. Second, the JAG alleged that CRSC determinations use different standards of proof to establish causation, incurred or aggravated vs. strict causation, and the CRSC committee did not rely on the same evidence as the TSGLI Certifying Office in reaching their conclusion. Lastly, the JAG alleged that the DVA requires that the evidence be construed in the service member's favor, whereas TSGLI is much stricter. As such, the JAG argued that the applicant has failed to satisfy his burden with new and material evidence, and his request for relief should therefore be denied.

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[5] Traumatic Injury Protection Under Servicemembers' Group Life Insurance (TSGLI): A Procedural Guide, Version 2.47 (September 2020), Page 5.

[6] *Id.*; *See also*, 38 C.F.R. §9.20(d)(2).

APPLICANT'S RESPONSE TO THE VIEWS OF THE COAST GUARD

On November 5, 2020, the Chair sent the applicant a copy of the Coast Guard's views and invited him to respond within thirty days. As of the date of this decision, no response has been received.

APPLICABLE LAW AND POLICY

Title 38 C.F.R. § 9.20 provides the necessary guidance on matters related to Traumatic Injury Protection. The following subsection are pertinent to the case before us.

> 38 C.F.R. §9.20(b)(1) states in pertinent part that "A traumatic event is the application of external force, violence, chemical, biological, or radiological weapons, or accidental ingestion of a contaminated substance causing damage to a living being occurring on or after October 7, 2001."
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> …
>
> §9.20(c)(1) defines a traumatic injury as "physical damage to a living body that is caused by a traumatic event as defined in paragraph (b) of this section.
>
> …
>
> §9.20(c)(3) states "For purposes of this section, all traumatic injuries will be considered to have occurred at the same time as the traumatic event."
>
> …
>
> §9.20(e)(6)(vi) defines the inability to carry out activities of daily living as the inability to independently perform at least two out of the six following functions:
>
> (A) Bathing.
> (B) Continence.
> (C) Dressing.
> (D) Eating.
> (E) Toileting.
> (F) Transferring in or out of a bed or chair with or without equipment
>
> …
>
> §9.20(g) states that each service will certify its own members for traumatic injury protection benefits based upon section 1032 of Public Law 109–13, section 501 of Public Law 109–233, and this section. The uniformed service will certify whether you were at the time of the traumatic injury insured under Servicemembers' Group Life Insurance and whether you have sustained a qualifying loss.

TSGLI Procedures Guide – Basic Definitions

> **External Force** - An external force is a force or power that causes an individual to meet involuntarily with an object, matter, or entity that causes the individual harm. There is a distinct difference between ***internal*** and ***external*** forces. "***Internal forces***" are forces acting between body parts, and "***external forces***" are forces acting between the body and the environment, including contact forces and gravitational forces as well as other environmental forces.
>
> **Traumatic Event** - A traumatic event is the application of external force, violence, chemical, biological, or radiological weapons, accidental ingestion of a contaminated substance, or exposure to the elements that causes damage to the body.

The event must involve a physical impact upon an individual. Some examples would include: an airplane crash, a fall in the bathtub, or a brick that falls and causes a sudden blow to the head. It would not include an injury that is induced by the stress or strain of the normal work effort that is employed by an individual, such as straining one's back from lifting a ladder.

Physical impacts do not require penetrating injuries to occur. Non-penetrating blast injuries, such as those common with the use of improvised explosive devices that cause concussive injuries, still involve external force and violence from the power of the blast coming into contact with an individual.

Exposure to the elements includes heat stroke and frostbite. In such cases the severe exposure to the heat and cold are traumatic events in and of themselves. For example, being diagnosed with heat stroke after collapsing during a physical training run in scorching temperatures would be a traumatic event.

Direct Result– Direct result means there must be a clear connection between the traumatic event and resulting loss and no other factor, aside from the traumatic event can play a part in causing the loss.

Traumatic Injury - A traumatic injury is the physical damage to your body that results from a traumatic event.

TSGLI Procedures Guide - Evaluating Losses: 7. Activities of Daily Living (ADL)

7. Activities of Daily Living (ADL). Activities of Daily Living (ADL) are routine self-care activities that a person normally performs every day without needing assistance. There are six basic ADL: eating, bathing, dressing, toileting, transferring (moving in and out of bed or chair) and continence (managing or controlling bladder and bowel functions). The following aspects of ADL loss are covered in this section:

…

g. Loss of ADL due to traumatic injury (other than traumatic brain injury)

…

7.a. Determining if a member has a loss of ADL. A member is considered to have a loss of ADL if the member REQUIRES assistance to perform at least two of the six activities of daily living. If the patient is able to perform the activity by using accommodating equipment (such as a cane, walker, commode, etc.) or adaptive behavior, the patient is considered able to independently perform the activity.

REQUIRES assistance is defined as:

Physical assistance - when a patient requires hands-on assistance from another person

Stand-by assistance - when a patient requires someone to be within arm's reach because the patient's ability fluctuates and physical or verbal assistance may be needed

Verbal assistance - when a patient requires verbal instruction in order to complete the ADL due to cognitive impairment. Without these verbal reminders, the patient would not remember to perform the ADL.

Without this physical, stand-by, or verbal assistance, the patient would be incapable of performing the task.

FINDINGS AND CONCLUSIONS

The Board makes the following findings and conclusions based on the applicant's military record and submissions, the Coast Guard's submission and applicable law:

1. The Board has jurisdiction over this matter under 10 U.S.C. § 1552(a) because the applicant is requesting correction of an alleged error or injustice in his Coast Guard military record. The Board finds that the applicant has exhausted his administrative remedies, as required by 33 C.F.R. § 52.13(b), because there is no other currently available forum or procedure provided by the Coast Guard for correcting the alleged error or injustice that the applicant has not already pursued.

2. The applicant requested an oral hearing before the Board. The Chair, acting pursuant to 33 C.F.R. § 52.51, denied the request and recommended disposition of the case without a hearing. The Board concurs in that recommendation.[7]

3. The application is timely because it was filed within three years of the applicant's discovery of the alleged error or injustice in the record, as required by 10 U.S.C. § 1552(b).

4. The applicant alleged that the Coast Guard PSC TSGLI Certifying Office erred when it found that his January 13, 2015, back injury was not a traumatic injury. When considering allegations of error and injustice, the Board begins its analysis by presuming that the disputed information in the applicant's military record is correct as it appears in the military record, and the applicant bears the burden of proving, by a preponderance of the evidence, that the disputed information is erroneous or unjust.[8] Absent evidence to the contrary, the Board presumes that Coast Guard officials and other Government employees have carried out their duties "correctly, lawfully, and in good faith."[9]

5. The applicant alleged that the Coast Guard TSGLI Certifying Office erred when it found that his injuries were not the direct result of a traumatic event, even after the IPEB and CRCS boards had both found that the applicant had suffered from a debilitating injury while on duty. Title 38 C.F.R. § 9.20(b)(1) states, "A traumatic event is the application of external force…causing damage to a living being occurring on or after October 7, 2001." The TSGLI Procedures Guide states that, "All members covered under SGLI who experience a ***traumatic event*** that directly results in a ***traumatic injury*** causing a ***scheduled loss*** defined under the program are eligible for TSGLI payment."[10] (Emphasis provided in original text). The following definitions, taken from the TSGLI Procedures Guide, are relevant to the Board's analysis:

- **External Force** - An external force is a force or power that causes an individual to meet involuntarily with an object, matter, or entity that causes the individual harm. There is a distinct difference between ***internal*** and ***external*** forces. "***Internal forces***" are forces acting between body parts, and "***external forces***" are forces acting between the body and the environment, including contact forces and gravitational forces as well as other environmental forces.

- **Traumatic Event** - A traumatic event is the application of external force, violence, chemical, biological, or radiological weapons, accidental ingestion of a contaminated substance, or exposure to the elements that causes damage to the body.

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[7] *Armstrong v. United States*, 205 Ct. Cl. 754, 764 (1974) (stating that a hearing is not required because BCMR proceedings are non-adversarial and 10 U.S.C. § 1552 does not require them).
[8] 33 C.F.R. § 52.24(b).
[9] *Arens v. United States*, 969 F.2d 1034, 1037 (Fed. Cir. 1992); *Sanders v. United States*, 594 F.2d 804, 813 (Ct. Cl. 1979).
[10] TSGLI Procedures Guide, Pg. 5

- **Direct Result**– Direct result means there must be a clear connection between the traumatic event and resulting loss and no other factor, aside from the traumatic event can play a part in causing the loss.

- **Traumatic Injury -** A traumatic injury is the physical damage to your body that results from a traumatic event.

With these statutes and procedures in mind, the question before the Board is whether or not the applicant's January 13, 2015, injury was the direct result of a traumatic event, as defined under TSGLI guidelines. The applicant's medical records show that the applicant suffered from debilitating back pain that was not alleviated by surgery. The applicant argued that based on the findings of the LOD investigation and the IPEB, the only logical conclusion is that his injuries were the direct result of the incident that occurred on January 13, 2015. For the following reasons, the Board disagrees.

a. ***ER Records.*** The record shows that on January 13, 2015, the applicant informed medical staff that his back had been hurting for approximately two months.[11] This same note also stated that the applicant denied any history of trauma.[12] The applicant also denied any history of trauma on January 20, 2015, to the third ER physician that treated him, while also telling him that the numbness from his left hip, down to his fourth and fifth toes had taken place over the last eight days, indicating that the numbness started on January 12 or 13, 2015, while doing yardwork.[13] This statement is further supported by a January 13, 2015, medical note from the original ER treating physician that stated the applicant had done yardwork the day before and by a January 20, 2015, medical note by a second ER physician that stated the applicant initially developed pain and numbness down his left leg last week after doing yardwork.

b. ***IPEB & LOD Investigation.*** The record further shows that the applicant had been suffering from back pain that was not attributed to any trauma for several months prior to January 13, 2015. The November 15, 2016, IPEB Narrative Summary states, "[t]he evaluee started noticing intermittent low back pain in 2006. Between 2006 and November 2014 [applicant] experienced occasional episodes of 8/10 pain with a spontaneous onset…" This same summary stated, "In November 2014, evaluee had a spontaneous flare of his low back pain that was more severe and lasted longer than previous episodes. By December 2014, he had mostly recovered from this episode and resumed a FFFD statues…" The March 1, 2017, LOD investigation made similar findings stating, "EMC [applicant's] health record revealed treatment for intermittent lower back pain from 2006-2014 triggered by his work, participation in sports, and working out at the gym. The pain would normally last a couple of days to a week." The investigation also found that in November 2014, the applicant's back pain suddenly worsened, resulting in pain that was more severe.

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[11] January 20, 2015, nurse's notes, Pg. 69 applicant's application.
[12] *Id.,* Pg. 70
[13] *Id.*, Pg. 72

c. ***MRI Scan & Neurosurgeon.*** The applicant's January 20, 2015, MRI scan revealed that the applicant had, "[n]o aggressive bone marrow legion or evidence of acute injury."[14] This statement seems to support the applicant's original statements to the ER doctors, wherein he denied experiencing any trauma and instead attributed his pain to recent yardwork. In addition, about four months later, medical notes from May 11, 2015, state, "He doesn't exactly know how or when he injured his back. Back pain was so bad until November 2014, when he was at work and started to feel severe pain, followed by weakness and severe calf pain of left lower extremity." Finally, medical notes from a September 15, 2015, visit with the applicant's second neurosurgeon stated, "He noted onset of low back pain in November 2014 with no specific event precipitating the pain." In addition, this neurosurgeon wrote that the applicant "was involved in a drill while on a ship that required a lot of twisting and crouching. He noted increasing back pain and paresthesias [numbness] radiating into the left leg." Notably, the neurosurgeon did not state that the applicant claimed to have slammed his back against anything.

This evidence supports a conclusion by the TSGLI's Certifying Office that the applicant's symptoms began prior to January 13, 2015, as a result of the applicant's active lifestyle, was therefore not erroneous. The evidence also supports a conclusion that his condition worsened in January 2015 because he had been doing yardwork. The applicant's own contemporaneous statements to medical staff do not support a finding of a "traumatic injury" caused by an outside force (diesel engine). The Board therefore finds that it was not unreasonable or erroneous for the TSGLI Certifying Office to conclude that the applicant's injuries were not a direct result of a traumatic event caused by an external force.

6. The applicant argued that because the LOD Investigation, IPEB, and CRSC concluded that the applicant had sustained a traumatic injury on January 13, 2015, by hitting his back against a diesel engine, the TSGLI Certifying Office's conclusion is clearly erroneous. The Board disagrees for the following reasons:

a. There are no contemporaneous records of a traumatic injury by an external force to the applicant's back on January 13, 2015.

b. The LOD Investigation, IPEB, and CRSC apparently relied not on the most contemporary medical records from January and May 2015 in assessing the cause of the applicant's injuries, but on the applicant's own claims and supporting statements from crewmates made well more than a year after the alleged incident. The applicant's TSGLI application, dated April 1, 2016, is the very first mention of the alleged traumatic injury from the diesel engine in the record before this Board. The Board finds that the contemporaneous medical records of what the applicant told three ER doctors regarding the cause of his pain and numbness and the lack of a traumatic event in January 2015; his repeated denial of a traumatic event on May 11, 2015; and the neurosurgeon's failure to note, on September 15, 2015, any report by the applicant of a traumatic injury while noting the applicant's report of "twisting and crouching" during the drill are substantially more reliable than

[14] *Id.*, Pg. 74

statements first made by the applicant more than a year after his injury in support of his TSGLI application.

c. The determinations rendered by the LOD Investigation, IPEB and CRSC are based on different issues, serve different purposes, and are not governed by the same requirements. None of these investigations or boards were charged with determining whether the applicant's injury was a direct result of an internal or external force. Whether a member's injury is a direct result of an external force and no other factor, as required for TSGLI eligibility, is not relevant to the purposes of an LOD investigation, an IPEB, or CRSC entitlement, and so those entities had no reason to scrutinize that issue. The TSGLI Certifying Office is not bound by the findings and conclusions of other boards and investigations.

7. For the reasons outlined above, the applicant has not met his burden, as required by 33 C.F.R. § 52.24(b), to overcome the presumption of regularity afforded the Coast Guard that its administrators acted correctly, lawfully, and in good faith.[15] He has not proven, by a preponderance of the evidence, that the Coast Guard TSGLI Certifying Office erred when it found that the applicant's injuries were not the direct result of a traumatic event, but were instead caused by other factors. Accordingly, the applicant's request should be denied.

[15] *Muse v. United States*, 21 Cl. Ct. 592, 600 (1990) (internal citations omitted).

ORDER

The application of EMC [redacted] USCG (Retired), for the correction of his military record is denied.

December 8, 2022