RECORD OF PROCEEDINGS
PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXXXXXX CASE: PD-2019-00225-2
BRANCH OF SERVICE: ARMY SEPARATION DATE: 20050706

SUMMARY OF CASE: Data extracted from the available evidence of record reflects this covered individual (CI) was a National Guard, O3, Field Artillery Officer, medically separated from the Temporary Disability Retired List (TDRL) for "history of cognitive disorder following traumatic brain injury" with a disability rating of 10%. This case was originally evaluated by the PDBR, and the panel, in accordance with (IAW) DoDI 6040.44 and DoD guidance, unanimously agreed that a 10% rating, but no higher, was supported for "occupational and social impairment due to mild or transient symptoms which decrease work efficiency and ability to perform occupational tasks only during periods of significant stress." The panel concluded there was insufficient cause to recommend a change in the PEB adjudication for the cognitive disorder. The CI disagreed with the determination and appealed to the United States District Court of the appropriate jurisdiction. The Court granted the parties' joint motion for remand and stay of proceedings. The case was remanded to the Army Review Boards Agency, which referred the case back to the PDBR for reconsideration of the disability rating. The complete case file, to include additional documentation provided by counsel representing the CI, was reevaluated by the current PDBR panel, comprised of different members, and these proceedings reflect a *de novo* review and analysis confined to the appropriate resolution of the "cognitive disorder following traumatic brain injury" appeal.

ANALYSIS SUMMARY:

Cognitive Disorder Following Traumatic Brain Injury. According to the service treatment record and MEB narrative summary (NARSUM), the CI was involved in a motor vehicle accident (MVA) on 28 November 2001 and sustained a closed head injury. He was reportedly rendered unconscious at the time of the accident and received intensive care treatment thereafter for several weeks. There were no records showing the CI received any psychiatric or mental health (MH) treatment following the accident to assist with any neuropsychological functioning recovery. At the time of the MEB NARSUM examination, he had not returned to work as a civilian police officer or resumed his normal military duties. The CI was separated and placed on the TDRL on 2 January 2004. During the TDRL period, he did not receive any MH care, but was treated for the physical side effects of his injury to include headaches/migraines, dizziness and pain.

At the 26 March 2004 VA Compensation and Pension (C&P) psychiatric examination, 15 months prior to TDRL removal, the CI reported frequent headaches, the inability to focus or concentrate on his job, and some depression, mood swings, and irritability. He also had occasional sleep difficulties, worried about getting to work on time, and became easily distracted by his children's noises. The psychiatrist administered psychological testing and performed a mental status examination (MSE). Results from these examinations revealed normal motor behavior, the ability to verbalize thoughts "quite well," and satisfactory communication skills. The CI demonstrated satisfactory attention, vigilance and perseverance, fluent speech, good comprehension, satisfactory general information fund, intact judgment and abstract thinking, and good insight. The examiner noted difficulties in concentration, shifting attention focus, and performing simultaneous cognitive tasks. While the MSE showed "fairly preserved" long-term memory, there were deficits in short-term memory, immediate visual memory, and visual perseverance. Based on the CI's history and objective examination findings, he met diagnostic criteria for postconcussional disorder IAW the Diagnostic and Statistical Manual of Mental Disorder, Fourth Edition (DSM-IV). However, since postconcussional disorder is grouped under cognitive disorders in the DSM-IV, the CI's formal diagnosis was cognitive disorder, not otherwise specific (NOS). The examiner noted he was mentally capable of performing activities of daily living, able to understand simple and complex commands, and posed no safety concerns to himself or others. However, the examiner opined that the CI "may have some difficulty establishing and maintaining his effective work and social relationships," and

that his cognitive disorder symptoms might "cause some difficulty performing his duties as a patrolman" with "some time lost at work." A second Axis I diagnosis of alcohol dependence, in full remission, was addressed and indicated the CI drank heavily from age 19-37. However, he participated in rehabilitation treatment for a year, stopped drinking completely about 2 years prior to the C&P examination, and was able to maintain total sobriety with occasional attendance at alcoholic support meetings.

At the 10 March 2005 TDRL psychiatric consultation, 4 months prior to TDRL removal, the CI reported he had returned to work as a police officer about a year prior, but felt he was not as sharp as before and would do 'dumb things' that typically involved short-term memory loss, such as forgetting what people told him and reporting once to a wrong address. He also stated that he lacked physical and hand-eye coordination and was unable to participate in sports or outdoor activities. He reported significant problems with short-term memory and concentration, and complained of anhedonia, decreased self-esteem, varying energy levels, difficulties adapting to changing situations, and getting easily frustrated. He admitted a tendency to verbally lash out at his wife and children and feeling 'bummed out' afterwards. His wife suggested he get prescribed medication because he got "too uptight and tense." He was reluctant to admit depression, but stated that he did not feel 'natural,' and was often sad with diminished self-worth. He worked 11-hour shifts 5 days a week, but thought he was not doing his job well, and worried that his coworkers talked about him and might think he was not "up to par." He denied sleep or appetite/weight problems. The MSE revealed the CI was alert and fully oriented, neatly groomed, and in appropriate attire. The examiner documented full and appropriate affect with normal speech and thought processes/content, memory grossly intact, and no overt suicidal or homicidal ideations. Mood was described as "down," and the CI was "concerned about his cognitive and motor functions." The Axis I diagnosis was "cognitive disorder, NOS, mild-moderate as manifest[ed] by slow mental processing speed, easily distractibility, poor verbal learning and memory, and executive dysfunction." The examiner noted "marked" impairment for further military duty and "definite" impairment for social and vocational adaptability; and opined that while the CI's mood would likely improve with treatment, his cognitive problems would probably persist, and the cognitive disorder would not likely improve. The examiner also stated the CI appeared mildly depressed and that his cognitive issues, which caused him difficulties as a police officer, would also present significant problems to functioning as a military officer in an operational setting. Although his specific ability to perform artillery officer duties was not clearly discussed, the examiner recommended a permanent profile for the memory impairment, with no assignment or temporary duty to combat zones, areas of continuous operations, or duties where cognitive problems might pose a danger to self or others. The CI was also given a diagnosis of depressive disorder NOS as manifested by his several months history of mildly depressed mood with anhedonia, irritability, decreased self-esteem and passive suicidal thoughts that began in 2004. The impairment for further military duty for this condition was "minimal" and the impairment for social and vocational adaptability was "mild." He met retention standards for this condition. The examiner recommended to seek care with a VA psychiatrist for treatment of his depression.

During the 5 July 2005 VA C&P psychiatric examination, one day prior to TDRL removal, the CI denied any history of inpatient or outpatient psychiatric treatment or suicidal attempts or ideation. He completed alcohol treatment in 2002 and had not drank since that time. While he used an over-the-counter pain reliever for arthritic pain, he took no other medications. He had good relationships with his wife and two young children, and could fully help with cooking, cleaning, laundry, shopping, and yard work with no issues. The CI had been employed as a patrol officer for the local police department for 8 years (the longest job he had held), and planned to retire from this job. He stated that work was 'good,' and his job evaluations were 'basically good,' but admitted his first evaluation was 'a swift kick' with no further elaboration. He worked from 0600-1630, went to bed by 2030, and slept well. His weight was stable and energy levels were satisfactory if he ate enough. He exercised by running or lifting weights; he also golfed but noted he did not play as well as before because of coordination problems. The CI spent most of his free time with his family, got along well with people, and had close friends at work. He acknowledged some short-term memory loss and trouble focusing, noting that he sometimes forgot his wife's instructions and struggled at times with directions, attention to details, and multi-tasking at work. He emotionally felt 'okay'

most of the time, but got upset quicker, as pointed out by his wife, and more easily distracted. If he dwelled on his physical problems, he would not feel good, and he described his self-esteem as 'all right.' He reported the Army wanted to remove him from the TDRL and this was stressful because he worried about losing insurance and benefits. Psychological testing revealed normal immediate recall but some difficulties with delayed immediate recall. The MSE results were normal, but the examiner noted "some subtle contradictions in aspects of his history having to do with minimizing his emotional cognitive difficulties." The Axis I diagnosis was cognitive disorder NOS "specified per difficulties with memory, learning, and concentration." The second Axis I diagnosis was "depressive disorder NOS for some mildly depressed mood with limited ability to enjoy, increased irritability, and diminished self-esteem." The examiner assessed that the CI was mentally capable of managing his own benefit payments and performing activities of daily living. He had some mild-to-moderate cognition difficulties, but was able to establish and maintain effective work and social relationships with some mild difficulties, and there were no safety concerns to self or others.

The panel directed attention to its rating recommendation based on the above evidence. The CI was removed from the TDRL with a permanent disability disposition of separation with severance pay for the cognitive disorder at 10%, coded 8045-9304 (residuals of traumatic brain injury-dementia due to head trauma). The PEB cited mild symptoms and noted that the CI " has returned to full time work as a police officer in former civilian job. Neuropsychiatric testing indicates mild-to-moderate impairment but descriptive data leans toward mild. No significant change in symptom or management in past interval. Symptoms are sufficient to prevent return to active service in prior MOS. Stable for final rating purposes." The VA rated the cognitive disorder 30%, coded 9304 (dementia due to head trauma), based on the C&P examination, citing the associated VASRD rating criteria and "some short-term memory loss" with decreased focus and difficulties with "misdirection and attention to detail at work" and "more difficult time with multi-tasking."

In its de novo review of the available treatment records, the panel agreed that the CI clearly and consistently reported short-term memory loss, difficulties maintaining attention and concentration, and problems with misdirection, multi-tasking, and distractibility because of his November 2001 head injury. He was diagnosed with cognitive disorder, NOS, and this condition was also consistently found to be unfitting for military service. However, there were significant differences in his levels of functioning from TDRL entry to removal, as well as disparate reporting during the VA and TDRL examinations.

The applicant received two independent VA psychiatric evaluations during the TDRL period. At the 26 March 2004 C&P examination, 3 months after TDRL placement, the impact of his cognitive impairments on his overall functioning was reported as: *"Since the above accident, **he has been having 'frequent headaches, lack of ability to focus or concentrate' on his job**. Also, he has been having 'some depression, mood swings and irritability.' In addition, he **occasionally has some sleeping difficulty and is worrying about coming to work on time**. While doing something at home, he becomes 'easily distracted by children's noise'…The patient may have **some difficulty establishing and maintaining his effective work and social relationships**. The patient's symptoms related to his cognitive disorder **may cause some difficulty performing his duties as a patrolman and may cause some time lost time at work**."*

The 5 July 2005 C&P examination, one day before TDRL removal, and 15 months after the first examination noted: "*He is able to drive all right. He does not have seizures…he noted that he does have **some short-term memory loss** 'I don't focus like I used to'…He has worked for the Spokane Police Department for eight years as a Patrol Officer. **Work is 'good**.' This is his longest job on the stretch…He gets up around 4:30. He works from 6 a.m. to 4:30 p.m. He goes to bed by 8:30 p.m. **He is sleeping well**. His energy is 'all right provided I eat enough'…**He gets along well with people. He has close friends at work**. His self-esteem is 'all right. I have limitations which is upsetting, but I don't focus on them.' His appetite is 'the same'…He helps with activities of daily living such as cooking, cleaning, laundry, and shopping. He does yard work. **There is nothing at home that he cannot do**. He has been married for ten years. **Things are going well with his wife**. This is his only marriage. **He gets along well with his children…**When asked about future plans, he indicated that **he wanted to continue working at Spokane Police Department until he retires**…**He indicated that his***

work evaluations are basically good*. He gets evaluated every six months. His first evaluation back to work after six months was 'a swift kick' however...diminished self-esteem…He is mentally capable of performing activities of daily living. He has* ***some mild-to-moderate difficulties with regard to his cognition****.* ***He is able to establish and maintain effective work and social relationships with some mild difficulties****.*"

The significant differences between the CI's functioning levels in the two VA examinations are bolded above and show that by the second psychiatric evaluation, he was no longer having sleep issues, not worried about getting to work on time, able to establish and maintain good work and social relationships with his colleagues (that he previously had some difficulties with), and receiving good work evaluations with no reports of lost time on the job. Additionally, he had no problems with activities of daily living or family relationships. Panel members also found several inconsistencies in the second evaluation. First, the psychiatrist determined the CI had mild difficulties establishing and maintaining effective work and social relationships, however, he reported getting along well with people and having close friends at work. Any mild problems in this area were not explained by the examiner and not supported by the CI's statement. Second, the examiner described his self-esteem as "diminished," but the CI said his self-esteem was 'all right.' These two descriptions do not have the same connotation. Lastly, the examiner assessed mild-to-moderate cognition difficulties, but verbiage used to describe these difficulties were "more easily distracted," "will forget some of his wife's instructions," "at work he indicated that he sometimes has some difficulties with misdirection and attention to detail," and "has a more difficult time multitasking." The panel agreed that these descriptions suggested mild rather than moderate symptoms.

The 10 March 2005 TDRL re-evaluation documented that the CI's cognitive problems "*appear to be causing him difficulties in his civilian job as a police officer. He would have significant problems functioning as an officer, especially in an operational setting*." Panel members noted that while the CI provided examples of his work difficulties such as going to the wrong address, forgetting what people had told him, and people having to repeat themselves 2-3 times, there was no evidence in the record that he was written up or disciplined, demoted, warned of potential termination, or provided special accommodations or training. He reported not being as sharp or having his former hand-eye coordination, but the panel noted this was expected considering he experienced an intervening event that caused the changes and limitations. Additionally, although the CI felt he was not performing his duties "as well as should," there were no reports to substantiate this comment. He was working extended shifts during the work week and was the sole provider for his family. There were no records of any financial or family problems caused by his cognitive disorder. Furthermore, the CI did not utilize, need, or require any psychiatric interventions to help him improve cognitive functioning. His difficulties with irritability and decreased mood that he displaced to his wife and children at times were attributed to mild depression, which was secondary to the cognitive disorder. According to the examiner, his mild depression did not impact overall functioning and minimally impaired his social and vocational adaptability. The CI had not performed any military duties since his MVA, but the examiner's assessment was consistent with the description that his symptoms would cause decreased work efficiency and ability to perform occupational tasks only during periods of significant stress, i.e., 'in an operational setting.'

During the TDRL period, the CI received psychiatric examinations from three duly qualified MH providers with varying reports reflected in the rating differences. Although he was unable to work in his civilian or military jobs for about 2 years following the MVA , he returned to his duties as a patrol man in January 2004, the same month he was placed on the TDRL. He continued to complain of cognitive issues, but there was no indication he was placed on modified assignment to accommodate his limitations. His challenges adjusting and adapting to his work environment and duties were not unexpected, considering he had not performed any type of police work for an extended period. The panel found no evidence of any counseling or poor evaluations for substandard performance, and no records showing he was ever in danger of losing his job because of reduced cognitive ability and functioning. The CI's occupation as a police officer itself also indicated he was functioning adequately and well. Panel members agreed that at TDRL placement, a 30% rating was justified for "occupational and social impairment with occasional decrease in work

efficiency and intermittent periods of inability to perform occupational tasks (although generally functioning satisfactorily, with routine behavior, self-care, and conversation normal), due to such symptoms as: depressed mood, anxiety, suspiciousness, panic attacks (weekly or less often), chronic sleep impairment, mild memory loss (such as forgetting names, directions, recent events)."

By TDRL removal, the CI had minimal work performance issues and no social impairments or sleep problems. His minor difficulties did not appear to be persistent, frequent, severe, or long lasting. At the July 2005 C&P examination, one day before TDRL removal, the CI had improved overall and was acclimating well to his long-term employment as a police officer with plans to retire from the same job. He had learned how to manage and function with his symptoms and, thus, effectively improved his functioning in multiple areas of his life. He had meaningful and good relationships with others. Panel members noted that the VARSD rating criteria for MH conditions is not solely focused on symptom severity and/or frequency, but also accounts for the degree of impairment on an individual's occupational and social functioning. The CI's holistic clinical picture changed from the beginning to the end of the TDRL period, and thus at TDRL removal, the panel agreed that his condition more closely met the VASRD 10% rating criteria for "occupational and social impairment due to mild or transient symptoms which decrease work efficiency and ability to perform occupational tasks only during periods of significant stress, or; symptoms controlled by continuous medication." After due deliberation, considering all the evidence and mindful of VASRD §4.3 (reasonable doubt), the panel concluded there was insufficient cause to recommend a change in the PEB adjudication for the cognitive disorder.

BOARD FINDINGS: In the matter of the cognitive disorder following traumatic brain injury and IAW VASRD §4.130, the panel recommends no change in the PEB adjudication. The CI requested that the PDBR consider the fitness of his cervical spine condition, however, since this condition was not considered an unfitting condition at TDRL removal, it is not within the scope of review. There are no other conditions within the panel's scope of review for consideration. Therefore, the panel recommends no modification or re-characterization of the CI's disability and separation determination.

The following documentary evidence was considered:

Exhibit D. U.S. District Court Order, dated January 17, 2023
Exhibit E. Counsel's Brief, dated May 17, 2023

AR20230006304, XXXXXXXXXX.

Dear XXXXXXXXXX

On remand from the United States District Court for the District of Columbia, the Department of Defense Physical Disability Board of Review (DoD PDBR) reviewed your application and found your separation disability rating and your separation from the Army for disability with severance pay to be accurate. I have reviewed the Board's record of proceedings. I reject the Board's recommendation and I elect to recharacterize your separation as a permanent disability retirement with the combined disability rating of 30% effective the date of your medical separation for disability with severance pay. Enclosed is a copy of the Board's recommendation, record of proceedings for your information.

The recharacterization of your separation as a permanent disability retirement will result in an adjustment to your pay providing retirement pay from the date of your original medical separation minus the amount of severance pay you were previously paid at separation.

The accepted DoD PDBR recommendation has been forwarded to the Army Physical Disability Agency for required correction of records and then to the U.S. Defense Finance and Accounting Service to make the necessary adjustment to your pay and allowances. These agencies will provide you with official notification by mail as soon as the directed corrections have been made and will provide information on your retirement benefits. Due to the large number of cases in process, please be advised that it may be several months before you receive notification that the corrections are completed and pay adjusted. Inquiry concerning your correction of records should be addressed to the U.S. Army Physical Disability Agency, (AHRC-DO) 1835 Army Boulevard, Building 2000, JBSA, Fort Sam Houston, TX 778234.

A copy of this decision has also been provided to the Department of Veterans Affairs and the counsel listed on your application XXXXXXXX.