RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: MARINE CORPS

CASE NUMBER: PD0900270 BOARD DATE: 20100428

SEPARATION DATE: 20070930

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SUMMARY OF CASE: This covered individual (CI) was a Staff Sergeant, Military Policeman (MP), medically separated from the Marine Corps in 2007 after 15 years of service. The medical basis for the separation was Post Traumatic Stress Disorder (PTSD). The CI was referred to the Physical Evaluation Board (PEB), determined unfit for continued military service, and separated at 10% disability using the Veterans Affairs Schedule for Ratings Disabilities (VASRD) and applicable Navy and Department of Defense regulations.

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CI CONTENTION: “My board returned with a 10% rating at which time I was advised that I was found unfit for duty but did not rate a retirement status. I wanted some of my other injuries to be looked at by the board as well but was told that only the PTSD issue was relevant as it pertained to the board. I have been diagnosed with traumatic brain injury (TBI) in conjunction with PTSD. I was rated by the VA at 70% for PTSD and an additional 30% for TBI. There (continued) seems to be a HUGE discrepancy in the accuracy and fairness between these two rating, which are for the same issue. Further I have since been diagnosed with an addition disability. I served my country with honor for nearly 16 years. These conditions that I will have to live with for the rest of my life are the result of my service to this country. And due to these issues, which I sustained during COMBAT OPERATIONS, I was unable to complete my career and retire. I do not understand how the DOD can rate me as 10% but the VA rates the same issue as 70%. And when adding in the TBI, it seems only just that I be found eligible for retirement. The decision to find me eligible for retirement will not entitle me to any more financial compensation. However it will allow me to provide insurance for myself and my family as well as be able to use facilities which are only authorized for Active Duty, Reserves and retired AFAD members.”

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RATING COMPARISON:

|  |  |
| --- | --- |
| **Service** | **VA (1 month before Separation)** |
| **Unfitting Conditions** | **Code** | **Rating** | **Date** | **Condition** | **Code** | **Rating** | **Exam** | **Effective** |
| 1. PTSD | 9411 | 10% | 20070815 | PTSD | 9434-9411 | 70% | 20070820 | 20071001 |
| 1.1 Major Depressive D/O  | CAT II |  | 20070815 |
| 2. Left Acromial Clavicular Arthritis | CAT III |  | 20070815 | Left Shoulder | 5203-5201 | 20% | 20070828  | 20071001 |
| 5. Mild Left Brachial Plexus Injury | CATIII |  | 20070815 | Neuropathy Upper Left Extremity | 8616 | 20% | 20070820 20070828 | 20071001 |
| 3. Gastroesophageal Reflux Disorder | CAT III |  | 20070815 | Gastroesophageal Reflux Disease | 7399-7346 | 10% | 20070820  | 20071001 |
| 4. Erosive Esophagitis) | CAT III |  | 20070815 |
|  |  |  |  |  |  |  |  |
| No PEB Entry |  | MEB H&P: Concussionx2 now with chronic HA and decreased memory; Headaches occur 1/week, last for couple hours, resolved w/Excedrin | Post Traumatic Headaches | 8045-8100 | 0%then30% | 20070820 20080506 | 2007100120071001 |
| No PEB Entry |  | MEB H&P: facial nerve damage |  Right Fifth & Seventh Cranial Nerve Palsy | 8305-8307 | 10% | 20070820 20070828 | 20071001 |
| No PEB Entry |  | Not in DES Package | Tinnitus | 6260 | 10% | 20070820 20070828 | 20071001 |
| No PEB Entry |  | MEB H&P: Chronic Low Back Pain S/P HNP | Musculoligamentous Strain of the Lumbar Spine | 5237 | 40% | 20070820 20070828 | 20071001 |
| No PEB Entry |  | MEB H&P: Multiple Scars  | Conditions x 4(Disfiguring Facial Scar; Right Lower Leg Scar; Tender Scars Abdomen & Chest; Tender Facial Scars)  |  | 10%Each | 20070820 20070828 | 20071001 |
| No PEB Entry |  | MEB H&P: Eczematoid dermatitis; Bilateral Elbow Pain; Chronic Bilateral Knee Pain | Condition x 5(Left Elbow Triceps Tendinitis; Right Elbow Triceps Tendinitis; Left Hip Strain; Right Knee Strain; Eczema) |  | 0%Each | 20080508 |  |
| **TOTAL Combined: 10%** | **TOTAL Combined (Includes Non-PEB Conditions):****100% effective 20071001** |

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ANALYSIS SUMMARY:

Analysis Mental Health Conditions: PTSD and Depression with Memory Problems: The CI was initially seen at the mental health department on 16 August 2006 and diagnosed with: Post-traumatic Stress Disorder and Major Depressive Disorder, Single Episode. The CI reported numerous incidents beginning in December 1992, involving witnessing or participating in combat actions in which people were injured or killed violently, observing "horrific" situations and being involved in direct combat. In his work as a MP he also was directly involved with traumatic events. Additionally, he sustained numerous injuries and wounds from combat in several situations. He stated that his functioning was affected by his accumulated reactions to these circumstances resulting in the above symptoms. Some of his most disturbing experiences will be described, first in his experience as a MP and, second in his several combat deployments.

As a MP, the CI witnessed/experienced a number of traumatic situations including: responding to a house fire in which a young girl was screaming as she burned to death and could not be rescued; being first on scene after a homeless man was run over on the railroad tracks--CI found his torn-off face; as a first responder to the air station where another MP had shot himself through the head--CI took the pistol from his hand; responding to a domestic abuse call where he found a man with a butane torch trying to burn his wife's face--CI physically subdued the man but in the fight his chest was burnt; as a first responder in base housing found a Marine with a massive head wound who had been murdered. Additionally he was involved in early response to numerous traffic accidents involving severe injuries and fatalities where he performed CPR a number of times. He was also assaulted in the performance of his duty many times, including being purposely struck by a car driven by a "fleeing felon" with resultant knee injury.

During his combat tour in Somalia and two tours in Iraq the CI was involved in numerous instances of combat action with extensive exposure/involvement in violent death. Of these, the following two events were most disturbing to him. In Iraq, 2004, one of his men was killed and 14 others injured in three incidents. On each occasion he and a fellow SSgt chose to personally clean the blood and tissue from the involved vehicles rather than having others have to do it. These experiences were intrusively remembered. In February 2006, while on foot patrol an improvised explosive device (IED) went off a few feet away from the CI on the other side of a tree. Another SSgt and close friend was killed immediately. The CI was wounded in the leg by shrapnel and knocked to the ground by the blast. He managed to reorient himself and properly lead his men in appropriate action. He was then taken to an emergency facility to surgically remove the shrapnel which was several inches in length. He refused any rest or removal from theater.

The CI has sustained several injuries with psychological impact in the performance of his duties. In 1994, he sustained a concussion during night training when his vehicle went into a ditch and he was pitched forward into a .50 caliber machine gun, breaking several facial bones and causing lacerations. In 1996, he was crushed between two Humvees sustaining fractured vertebrae, two bulging discs, torn posterior muscles and bruised internal organs. In 2003, he was hit by the vehicle of the fleeing felon. Then, in May 2006, while in pursuit of a vehicle containing three insurgents who were firing automatic weapons, his vehicle went off road and in the rough ride his left shoulder was injured--this required surgeries and resulted in pain and loss of both function and sensation down his left arm and hand. Throughout this event he kept firing his weapon, ultimately leading his unit in the capture of the three insurgents.

The CI had multiple and very frequent symptoms including: re-experiencing daily flashbacks, nightmares five times a week, avoidance of activities that remind him of the war, startle response, severe anxiety, hypervigilance, depressed mood everyday for numerous months, lack of ability to enjoy usually enjoyed pastimes, prefers to spend time alone, does not like crowds, disturbed sleep, increased anger and irritability, and loss of appetite, weight loss of 50 lbs, difficulty concentrating, daily anxiety attacks, severe anxiety with nausea and vomiting whenever he was anticipating coming to the base, anxious and dysphoric mood with some irritability, and memory problems.

The CI participated in regular outpatient psychotherapy from two to four times per month for approximately nine months. After some months in treatment, he consented to take an antidepressant, Paxil, and had been trying different sleep medications with variable success. He currently takes Ambien CR 12.5 milligrams. While he experienced some relief with outward acknowledgement of his re-experiencing and severe emotional distress, the symptoms of anxiety manifested in nausea and vomiting in anticipation of coming to base, and most recently having diarrhea as well, indicated a deeply conditioned reaction to most things "military connected with the traumas and horrific circumstances that he has experienced. He continued to hold the Marine Corps in high regard and was deeply troubled by his difficulty in continuing to perform well and to have these difficult symptoms. After an adequate period of observation, evaluation and treatment of over 10 months, the psychiatrist concluded the CI suffered from PTSD and Major Depressive Disorder that prevented him from remaining on active duty. His severe anxiety reactions and severe depressive symptoms made him incapable of performing as a Marine and for deployment to combat zones.

At the narrative summary (NARSUM) examination the CI appeared tired. His clothing and grooming were appropriate. Mood was anxious and dysphoric with some irritability that was not directed at the interviewer. His behavior demonstrated no psychomotor agitation. His affect was congruent with the mood. His level of consciousness was normal. Speech and thought process were without impairment. Thought content was relevant, with intense feeling and the ability to shift perspective to a less emotional state. Memory and cognition were grossly intact, although he indicated some problems with types of concentration. No suicidal ideation, homicidal ideation, auditory or visual hallucinations. Insight is fair to good and judgment good with no incidences of outbursts.

While the NARSUM and VA evaluations were very similar, the NARSUM done 20070621 noted a Global Assessment of Functioning (GAF) of 35-45, the VA Compensation and Pension (C&P) done 20070820 noted a GAF of 50 for PTSD and 50 for depression. Outpatient visits documented in the service treatment record (STR) noted a GAF of 50 on 20061221, 50-55 on 20070123, and 40 on 20070611. This shows declining function over the last nine months of service. All of these GAF ratings are consistent with serious symptoms and serious difficulties in functioning. The GAF of 35-45 on the NARSUM indicates a major impairment in multiple areas.

The VA initially rated PTSD at 70%. He met some elements of the 70% rating but his overall impairment appeared closer to the 50% rating. The NARSUM exam had elements that support a 70% rating in that a GAF of 35-45 implies major impairment in several areas, such as work or school, family relations, judgment, thinking or mood. However, the CI did not appear to have impaired judgment or thinking. He did have impairments in work and social relationships as well as mood and had reduced reliability and productivity due to his symptoms. Neither exam demonstrated impaired thought process or communication. The later (2 months) GAF of 50 assessed by the VA providers reflected lack of impairment in all areas but the presence of serious symptoms and serious impairments in social, occupational, or school functioning. In May 2008 he remained unemployed and not going to school. He was married but had no other social relationships. He had near continuous depression and anxiety that affected his ability to function effectively.

If the signs and symptoms of PTSD warrant an initial rating of 50% or more based on the actual functional impairments, a follow-up exam in six months is not required. The follow-up exam is only required if the initial evaluation does not warrant a rating of at least 50%, but a 50% rating is applied IAW 4.129.

This CI’s functional impairment at the time of separation warrants a 50% rating. Although a follow-up examination is not required, the VA exam of May 2008 does warrant a continuation of the 50% rating. The VA rated PTSD initially at 70% and continued this rating after the May 2008 exam. There is no evidence of any decline or improvement from the time of separation to May 2008, transient or sustained.

Other conditions adjudicated by the PEB

Left Acromial Clavicular Arthritis; Mild Left Brachial Plexus Injury; Gastroesophageal Reflux Disorder (GERD); and Erosive Esophagitis.

Limited duty (LIMDU) was for shoulder injury. No physical limitations or duty restrictions attributable to GERD or esophagitis. Shoulder injury with left brachial plexus injury appears to have been unfitting at the time of separation. The gastrointestinal (GI) conditions, GERD and Erosive Esophagitis, do not appear to have been unfitting at the time of separation. The frequent vomiting most likely resulted from the PTSD and contributed to the GI conditions, but the GI conditions were not unfitting.

Analysis Left Shoulder and Mild Left Brachial Plexus Injury

The CI is right handed and he sustained direct trauma to left shoulder while a vehicle passenger during a fire fight on 20060519 in Iraq. There was no penetration but he felt a pop and pain down his left arm and then his arm went numb. He did not require joint reduction and was not medevaced. He was able to complete his Operation Iraqi Freedom (OIF) tour but he continued to have significant shoulder pain and had limited activities due to shoulder pain. He regained feeling in arm but fingers continued to feel asleep. This phenomenon involved all left upper extremity fingers distal to the proximal interphalangeal joints.

He had temporary relief of his pain with a series of joint injections and ultimately underwent an open acromioclavicular joint excision, a Mumford procedure, on 21 March 2007. A half inch of the distal clavicle was excised and at two months post-op the skin and surrounding tissues had healed nicely and the CI had minimal crepitus on palpation. However at a neurology evaluation four months after surgery he noted persistent decrease strength in grip while doing pull-ups and chronic pain to left shoulder. An electromyogram nerve conduction study was done and was within normal limits. The neurologist noted decreased grip strength and sensation on his examination.

At the VA C&P examinations by orthopedics and neurology in August 2007 (five months after surgery and one month prior to separation) the CI reported his shoulder felt unstable and he had frequent “cracking" or “popping” sensations. He was unable to do any rotator type of movement, including throwing or swimming. His ability to do pushups was limited, and he was unable to do pull-ups in association with the feeling of instability in the shoulder. He was limited with regards to overhead work because of pain and limited motion in the shoulder. Weakness secondary to the pain also limited his activities. He had rather definite difficulties with not only activities of daily living but any occupational activities as well. The discomfort in his shoulder flared up on a daily basis in association with normal movements of the shoulder. The VA examiner indicated there was functional impairment on the basis of pain, weakness, fatigability and lack of endurance, in association with any activity involving movement of the shoulder, especially pushing, pulling, lifting or working at shoulder level or above.

The CI’s LIMDU restrictions were related to his shoulder condition only and included: No lifting, reaching, overhead duties, lifting more than 50 lbs with left arm; PT on own; no physical fitness testing (PFT). The non-medical assessment from the Commander mentions both physical and mental conditions that interfere with satisfactory performance of duties in garrison and while deployed and cause time away from work. It appears clear that the CI would not be able to perform all the functions of his military occupational specialty (MOS) or deploy with the duty restrictions described in his LIMDU.

The surgery on the CI’s left shoulder appears to have initially led to clinical improvement but his pain continued and his range-of-motion (ROM) decreased in the time between the NARSUM and the VA C&P exam. The VA exam was completed prior to separation but the PEB did not have access to this information as it had already completed its determination prior to this examination on 20070828.

The left shoulder ROM was limited by pain but the limitation did not meet the minimum compensable level of flexion or abduction limited to shoulder level (90 degrees). However, IAW §4.59 painful motion with joint or periarticular pathology is recognized as productive of disability. Painful, unstable, or malaligned joints, due to healed injury, are entitled to at least the minimum compensable rating for the joint. The minimum compensable rating for the shoulder is 20%.

Although an EMG/NCV (nerve conduction velocity) test done in December 2006 was normal, a mild brachial plexus injury was noted by both the Navy and VA neurologists. Decreased sensation and less than normal grip strength was consistently noted on multiple evaluations by multiple providers. However, these findings do not contribute to the CI’s inability to perform his required duties. If the CI had these neurologic symptoms accompanied by full shoulder ROM without pain, more likely than not, he would be able to perform all of his required duties. Therefore the neuropathy should not be considered separately unfitting.

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| --- | --- | --- |
| Shoulder(Left) | Normal ROM | Separation Date: 20070930; surgery 20070321 |
| MEB (Shoulder) Ortho Addendum 200705212 months post-op | C&P 20070828:(Limited by Pain)5 months post-op; 1 month prior to separation |
| Forward Elevation (Flexion) | 0 - 180 | 170 | 125 active |
| Abduction | 0 - 180 | 170 | 135 active  |
| External Rotation | 0 - 90 | Not Measured | 80 passive  |
| Internal Rotation | 0 - 90 | Not Measured | 70 passive |
| Notes: |  | - Nontender to palpation- Motor strength 5/5 in all planes of motionNeuro exam 20070718: 4+/5 grip strength; no wasting or atrophy; decreased sensation to pinprick and light touch in left hand and fingers; DTR 2+/symmetric | - Without crepitation - Feeling of hypermobility or laxity Neuro exam 20070828: deceased strength and finger flexion on left; Some give-way at the shoulder and the deltoid; Shoulder ROM causes severe pain but no change in numbness or tingling |

Other Conditions in the Disability Evaluation System (DES)

Two Concussions with Post Traumatic Headaches (HA); Right Fifth & Seventh Cranial Nerve Palsy; Musculoligamentous Strain of the Lumbar Spine; Scars: Disfiguring Facial Scar, Right Lower Leg Scar, Tender Scars Abdomen and Chest, Tender Facial Scars; Left Elbow Triceps Tendinitis; Right Elbow Triceps Tendinitis; Chronic Bilateral Knee Pain; and Eczema

The LIMDU was for shoulder injury and no limitations are attributable to back pain, bilateral elbow pain, bilateral knee pain, scars, eczema, or headaches. No duty restrictions are attributable to these diagnoses. The CI had many of these conditions for multiple years without duty restriction: Post Traumatic HA since April 1995, Back pain since 1996, Facial Injury since 1995. He was able to perform full duty with these conditions present and there is no evidence that any of them worsened to the point of becoming unfit at the time of separation.

Post Traumatic Headaches/Traumatic Brain Injury (TBI)

The CI had this problem at least since April 1995 and was not referred for an MEB until years later when he had his shoulder LIMDU and PTSD. While TBI was never diagnosed while on active duty, the CI, more likely than not, did have TBI with headaches and memory problems. No neuropsychological testing was done by either the VA or the Navy so the symptoms cannot be quantified. TBI does not appear to have been separately unfitting. However, memory problems can be included as a symptom of PTSD and contribute to the rating for PTSD as the VA did in their rating.

The VA also rated the post traumatic headaches separately but there is no evidence to support this condition was unfitting. The CI had this condition for years before separation, had no duty restrictions related to this condition, and was not referred to a medical board for this condition.

Other conditions Not in the DES

Tinnitus and Left Hip Strain

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BOARD FINDINGS: IAW DoDI 6040.44, provisions of DoD or Military Department regulations or guidelines relied upon by the PEB will not be considered by the Board to the extent they were inconsistent with the VASRD in effect at the time of the adjudication. After careful consideration of all available information the Board makes the following recommendations.

In the matter of the PTSD condition, the Board unanimously recommends an initial Temporary Disability Retired List (TDRL) rating of 50% in retroactive compliance with VASRD §4.129 as DOD directed; and a 50% permanent rating for PTSD after the initial 6 months IAW VASRD §4.130.

A 50% rating for PTSD is warranted by major impairment in several areas, including work or school, family relations, and mood. The CI had occupational and social impairment with reduced reliability and productivity due to: re-experiencing, daily flashbacks, nightmares five times a week, avoidance of activities that remind him of the war, startle response, severe anxiety, hypervigilance, depressed mood everyday for numerous months, lack of ability to enjoy usually enjoyed pastimes, prefers to spend time alone, does not like crowds, disturbed sleep, increased anger and irritability, and loss of appetite, weight loss of 50 lbs, difficulty concentrating, daily anxiety attacks, severe anxiety with nausea and vomiting whenever he was anticipating coming to the base, anxious and dysphoric mood with some irritability, and memory problems. The presence of these daily, pervasive symptoms causes serious functional impairment. This level of impairment was present at the time of separation from service and at the VA C&P evaluation eight months later.

The Board also determined by simple majority that the condition of Left Shoulder Pain and Arthritis was unfitting at the time of separation from service and is appropriately rated at 20%. The single voter for dissent (who did not consider the shoulder condition to be unfitting) did not elect to submit a minority opinion.

Duty restrictions secondary to the left shoulder condition with limited range-of-motion (ROM) (prevented the CI from satisfactorily performing his required duties as an MP. Although the left shoulder ROM limitations did not meet the minimum compensable level of flexion or abduction limited to shoulder level (90 degrees), painful, unstable, or malaligned joints are entitled to at least the minimum compensable rating for the joint IAW VASRD §4.59. Therefore, the disability rating for this condition is 20%.

While Traumatic Brain Injury was not specifically diagnosed while on active duty, the CI did have a clinical history and examination consistent with this diagnosis and post traumatic headaches were diagnosed. However, this condition was not unfitting at the time of separation and therefore no disability rating is applied.

The Board also considered the following conditions and determined that none were unfitting at the time of separation from service and therefore no disability rating is applied: Left Brachial Plexus Injury; Gastroesophageal Reflux Disease; Erosive Esophagitis; Concussions with Post Traumatic Headaches; Right Fifth & Seventh Cranial Nerve Palsy; Musculoligamentous Strain of the Lumbar Spine; Scars: Disfiguring Facial Scar, Right Lower Leg Scar, Tender Scars Abdomen and Chest, Tender Facial Scars; Left Elbow Triceps Tendinitis; Right Elbow Triceps Tendinitis; Chronic Bilateral Knee Pain; and Eczema.

The other diagnoses rated by the VA (Tinnitus and Left Hip Strain) were not mentioned in the Disability Evaluation System package and are therefore outside the scope of the Board. The CI retains the right to request his service Board of Correction for Naval Records (BCNR) to consider adding these conditions as unfitting.

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RECOMMENDATION: The Board recommends that the CI’s prior determination be modified as follows; TDRL at 60% for six months immediately following CI’s prior medical separation (PTSD at minimum of 50% IAW §4.129 and DoD direction) and then a permanent combined 60% disability retirement as below.

|  |  |  |  |
| --- | --- | --- | --- |
| UNFITTING CONDITION | VASRD CODE | TDRL RATING | PERMANENTRATING |
| Post-Traumatic Stress Disorder | 9411 | 50% | 50% |
| Left Shoulder Pain and Arthritis | 5299-5201 | 20% | 20% |
| COMBINED | 60% | 60% |

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The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20090326, w/atchs.

Exhibit B. Service Treatment Record.

Exhibit C. Department of Veterans' Affairs Treatment Record.

**DEPARTMENT OF THE NAVY**

SECRETARY OF THE NAVY COUNCIL OF REVIEW BOARDS
 720 KENNON STREET SE STE 309
 WASHINGTON NAVY YARD DC 20374-5023

**IN REPLY REFERTO**

1850 CORB:003 1 June 2010

From: Director, Secretary of the Navy Council of Review Boards

To:

Subj: PHYSICAL DISABILITY BOARD OF REVIEW (PDBR)

Ref: (a) 0001 6040.44

(b) PDBR ltr of 23 Apr 10

1. Pursuant to reference (a), the PDBR reviewed your case and forwarded its recommendation (reference (b)) to the Department of the Navy for appropriate action.
2. On 28 May 2010, the Assistant Secretary of the Navy (Manpower & Reserve Affairs) took action on your case by accepting the recommendation of the PDBR. Accordingly, your military records will be corrected to reflect your placement on the Permanent Disability Retired List effective 30 September 2007 with a combined disability rating of 60 percent (POST-TRAUMATIC STRESS DISORDER (50%) and LEFT SHOULDER PAIN AND ARTHRITIS (20%).
3. The Secretary's decision has been forwarded to the Deputy Commandant, Manpower & Reserve Affairs, who will make the above corrections to your records and advise you when those actions are completed.

Copy to: PDBR