RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: marine corps

CASE NUMBER: PD1000852 SEPARATION DATE: 20070228

BOARD DATE: 20110114

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty Lance Corporal (1371, Combat Engineer) medically separated from the Marine Corps in 2007 after three years and nine months of service. The medical basis for the separation was Post-traumatic Stress Disorder (PTSD). The CI was deployed to Operation Iraqi Freedom from January 2004 to October 2004. He was first evaluated by psychiatry in July 2005 for symptoms of depression that had been present for two months and suicidal ideation. He had been depressed since a significant religious conversion led him to apply for conscientious objector status which was denied. He was hospitalized for six days for severe depression. After discharge he continued to have symptoms and was eventually diagnosed with delayed PTSD. He received regular counseling, biofeedback, and was prescribed Zoloft and Ambien. He improved and was removed from limited duty in October 2006 but had another severe panic attack after learning that he would be redeploying. He followed up with psychiatry the next day and his Medical Evaluation Board (MEB) was completed. The CI was referred to the Physical Evaluation Board (PEB), found unfit for continued Naval service, and separated with a 10% disability using the Veterans Affairs Schedule for Ratings Disabilities (VASRD) and applicable Navy and Department of Defense regulations.

CI CONTENTION: “I was assigned less than 50% disability rating by the military for my unfitting PTSD upon discharge from active duty. In accordance with the class action notice, assign the highest final disability rating applicable consistent with 38 CFR4.I29 and DOD policy to the extent such increase will not adversely affect my total compensation, including but not limited to compensation pursuant to CRSC. Please see attached list of contentions regarding why the PDBR should make the changes request in Item 3.” He additionally lists all of his VA conditions and ratings as per the rating chart below. A contention for their inclusion in the separation rating is therefore implied. This case is court remanded under the *Sabo et al v. United States* class action suit.

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RATING COMPARISON:

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| --- | --- |
| **Service IPEB – Dated 20070104** | **VA (1 Month Prior to Separation) – All Effective 20070301** |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Posttraumatic Stress Disorder | 9411 | 10% | PTSD, with Social Anxiety, Depression and Occupational Problem | 9411 | 50% | 20070115 |
|  | NARSUM and MEB H&P  | Lumbar Strain and Spasm | 5237 | 20% | 20060803 |
|  | MEB H&P | Tinnitus | 6260 | 10% | 20060727 |
|  | Not in DES | Right Shoulder Strain | 5201-5021 | 10% | 20060803 |
| **TOTAL Combined: 10%** | **TOTAL Combined (*Includes Non-PEB Conditions*): 70%** |

ANALYSIS SUMMARY:

Post-Traumatic Stress Disorder (PTSD) Condition. The CI was deployed to Operation Iraqi Freedom from January 2004 to October 2004. In February 2005 (four months after return from deployment) he applied for conscientious objector status for ethical and religious beliefs that precluded the use of firearms. He became clinically depressed following a significant religious conversion that he believed made him incompatible with further combat service. His depression increased exponentially following news on 15 July 2005 that his petition to become a conscientious objector was denied by the Marine Corps. He became acutely suicidal, unable to see past his current situation. He first displayed symptoms of PTSD at this time, associated with this major depressive episode with suicidal ideations that led to a six-day psychiatric hospitalization. The admission history noted a two month history of depressedmood, anergia**,** decreased concentration, mild insomnia, anhedonia, psychomotor retardation, worthlessness, hopelessness and guilt, and decreased appetite. He stated that he could not go against his Roman Catholic principles by killinganyone and would rather kill himself than go to Iraq again. The CI improved dramatically while hospitalized after learning that his Commanding Officer supported his petition for conscientious objector status and planned to leave him behind as part of the Remain Behind Element, allowing him complete the final two years of his contract without deployment. His discharge diagnosis was Major Depression and no mention is made of PTSD in the discharge note from this admission.

After returning to his command his symptoms worsened and he presented to Division Psychiatry on 20050801 where his diagnosis remained Depression. Treatment was started with Ambien for sleep disturbance and he was referred to Mental Health at Camp Pendleton. The Camp Pendleton Mental Health note of 20060228 documented that he was later transferred to different job description and was assured that he would not have to handle weapons. He was later required to qualify at the range and had negative reaction to handling a firearm. He reported intense distress to memories of duty in Iraq, nightmares, panic feelings, and difficulty staying asleep. He denied suicidal or homicidal ideation. His past medical history did reveal a period of mental instability during his teen years when he made an attempt to hang himself. He received three years of counseling at that time but did not take medications. His Mental Status Examination (MSE) findings included a labile and anxious mood. The CI was placed on Limited Duty from 200600301 to 20060901 with no deployments, no access to firearms/weapons, no field duty, and no overnight duty. His diagnosis was Delayed Post-traumatic Stress Disorder; Depression with Anxiety; Paranoia and his Global Assessment of Functioning (GAF) was 51-60 indicating moderate symptoms or moderate difficulty with social or occupational functioning.

The CI continued to receive regular treatment at the Camp Pendleton Mental Health Clinic and was prescribed Zoloft. However, he only took this periodically and it does not appear to have decreased his symptoms. He was placed on a second Limited Duty from 20060902 to 20070302 with the same limitations continuing. By 20060929 he had experienced sufficient recovery to request return to full duty. This was approved and he apparently did well for four weeks until 20061025 when he was told that he would be deploying again. This precipitated an emergency room visit for a panic attack with symptoms of anxiety, chest pain, and chest tightness. He was referred back to the Mental Health Clinic that day and a decision was made to refer this condition to the MEB. The MEB Report of 20061030 reported the following: He first came to the attention of mental health in July 2005, as he was referred to psychiatry because of suicidal ideation. At this time he was intending to hang himself. He reported a two month history of depressed mood, most of the day, all of the day, lack of energy, and anhedonia, decreased concentration and appetite, feeling helpless, hopeless, and worthless, guilty, and wanted to kill himself. These symptoms worsened greatly in the context of learning that his conscientious objector status packet was denied. He was hospitalized for approximately nine days at Naval Hospital, San Diego. He did not return to the attention of mental health until 23 February 2006 when he went to his Battalion Aid Station and reported that he could not hold a rifle on the rifle range and was having nightmares. He described nightmares on and off since returning from Iraq in October 2004. He was referred back to Naval Hospital, Camp Pendleton where he reportedly continued to have symptoms in the context of having to handle weapons. He reported intense dreams due to memories of duty in Iraq including nightmares, panic feelings, and difficulty staying asleep. He was treated from 28 February 2006 till 29 September 2006 twelve times by the mental health clinic. He requested to be off of limited duty (he had been given two periods of six months limited duty) in order to rejoin unit in full duty status. He was reassured by command he would not be deployed again; however upon urgent evaluation in October 2006, he reported that he was told that he was going to be deployed again to Iraq. He was seen in the emergency room the night before with rapid heart rate, chest pain, felt like he was going die, felt dizzy, overwhelmed, and had difficulty functioning last evening. He presented to mental health clinic the next day in crisis reporting that "he can't redeploy, things are too bad, and he couldn't go back there".

The patient reported a period of mental instability during his teen years. At that point he made an attempt to hang himself. He received three years of counseling. Symptoms existed prior to enlistment including suicidal ideation, but symptoms not existing prior to present symptoms include post traumatic stress disorder symptoms. At the time of the MEB examination the patient was oriented to person, place, time, and circumstance. Appropriate eye contact was maintained. His speech was slow, but rhythm was normal, and so was his tone. He had mild psychomotor retardation. Mood was described as very tired and scared. Affect was constricted and dysphoric. At times the patient's eyes would tear up. Thought process was linear, logical, and goal directed. He denied auditory and visual hallucinations, and delusional thoughts. He was not responding to internal stimuli. He denied homicidal and suicidal ideation at present. Suicidal risk assessment was judged to be low to moderate based on presence of intermittent thoughts of death with lack of intent. Cognitive functioning was not formally tested, but grossly intact. Memory, attention, and concentration skills were unimpaired. Insight and judgment were fair. Impulse control was intact. He at that time still had panic attacks in the context of just thinking about deploying. His final diagnosis was Post-traumatic Stress Disorder, Delayed Onset. The GAF was 45 to 50, indicating severe symptoms and difficulty in social and occupational functioning. In summary the MEB stated that the “Medical Board agrees with the above findings and is of the opinion that the service member is unable to perform further military service as the result of a disability and the disability did not exist prior to entering into the service and therefore is considered to have been aggravated by a period of active military service. The Medical Board recommends that the member's case be referred to central Physical Evaluation Board.” The PEB, on 20070104, adjudicated only the PTSD condition (code 9411) and assigned a 10% disability rating.

His Commander’s Statement of 20061207 stated that “Lance Corporal Zuniga continues to provide useful service within the headquarters of this command. His combat experiences have undoubtedly taken a psychological toll on his ability to function effectively in a sustained combat environment. Nevertheless, his sense of belonging as a Marine in this battalion remains intact. I believe his long term health is best served by completing the remainder of his obligated service as a member of this command.” This statement seems to imply adequate occupational functioning in non-combat environments less than three months before separation.

The VA Compensation and Pension (C&P) Special Psychiatric Examination on 20060725 (seven months before separation) noted symptoms including depression, trouble sleeping, nightmares, flashbacks, sadness, crying, feelings of hopelessness and helplessness, being withdrawn and hypervigilance. He did not have suicidal or homicidal ideation. Continuous treatment is required with both medication and psychotherapy. MSE demonstrated a reliable historian who is oriented to time, place, and person. His affect and mood were somewhat flattened with the depressed mood. His concentration, communication and speech were normal. He did relate panic attacks, which varied in frequency, and cause shortness of breath, increased heart rate and nervousness. The symptoms lasted until he was out of the triggering situation. He did sometimes feel suspicious particularly in crowds. He had no hallucinations, delusions, or obsessional rituals. His thought processes, judgment, abstract thinking, and memory were normal. He had no suicidal or homicidal ideation. The Axis I diagnoses were PTSD and Depression. The examiner noted that these diagnoses could not be distinguished from each other. Significant stressors included seeing many dead bodies, body parts and having friends killed in front of him from explosions. His GAF score is 60 indicating moderate symptoms or moderate difficulty with social or occupational functioning.

The VA Special Psychiatric Examination on 20070115 (one month before separation) documented a history of anxiety, nervousness, shaking every time he thought about Iraq and seeing a fellow soldier who was killed. He avoided crowds and social places due to anxiety. He had dreams involving shooting people and people blowing themselves up. Every time he heard loud noises it reminded him of Iraq. He had a high level of anxiety, panic attacks, flashbacks, and depression. He had problems sleeping due to nightmares, lack of energy, fear of getting hurt, and lack of concentration. All of the symptoms he reported were still current and constant. He was being treated with Zoloft and Ambien. MSE noted normal orientation. Mood and affect were abnormal with anxiety and depression. He was irritable, had impaired impulse control, and had outbursts of anger. Communication and speech were normal. There were no hallucinations, ritualistic obsessions, or suicidal or homicidal ideations. Judgment was intact however abstract thinking was absent. Memory was mildly to moderately abnormal, in that the veteran had difficulty with the retention of highly learned materials and remembering to complete tasks. The Axis I diagnosis was PTSD with a GAF of 65 indicating mild symptoms only.

The VA Rating Decision of 20070723 granted service connection for PTSD, with social anxiety, depression, and occupational problem with an evaluation of 50% effective 20070301. A higher evaluation of 70% was not warranted as the VA examination did not show deficiencies in most areas, such as work, school, family relations, judgment, thinking, or mood, due to such symptoms as: suicidal ideation; obsessional rituals which interfere with routine activities; speech intermittently illogical, obscure, or irrelevant; near continuous panic or depression affecting the ability to function independently, appropriately and effectively; impaired impulse control (such as unprovoked irritability with periods of violence); spatial disorientation; neglect of personal appearance and hygiene; difficulty in adapting to stressful circumstances (including work or a work-like setting); inability to establish and maintain effective relationships.

The PEB rating, as described above, was derived from DoDI 1332.39 and preceded the promulgation of the National Defense Authorization Act (NDAA) 2008 mandate for Department of Defense (DoD) adherence to Veterans Administration Schedule for Rating Disabilities (VASRD) §4.129. IAW DoDI 6040.44 and DoD guidance (which applies current VASRD 4.129 to all Board cases), the Board is obligated to recommend a minimum 50% PTSD rating for a retroactive six month period on the Temporary Disability Retired List (TDRL). The Board must then determine the most appropriate fit with VASRD 4.130 criteria at six months for its permanent rating recommendation. In this case there are no psychiatric examinations or treatment notes beyond the VA Special Psychiatric Examination on 20070115 (one month before separation) making it the most proximate source of comprehensive evidence on which to base the permanent rating recommendation.

The MEB Report of 20061030 (four months before separation) documents four of six descriptors for occupational and social impairment at the 30% level and two of nine descriptors at the 50% level, with a GAF of 45-50, indicating severe symptoms and difficulty in social and occupational functioning. The VA Special Psychiatric Examination on 20070115 (one month before separation) documented all six descriptors at 30% and two of nine descriptors at the 50% level, with a GAF of 65 indicating mild symptoms only. Examinations were completed in July 2006, October 2006, and January 2007 and GAFs were estimated at 60, 45-50, and 65. These examinations were seven, four, and one month prior to separation from service. The three examinations were all done by different examiners. The service treatment record (STR) documents multiple GAFs in the 50s between February and October 2006. No examinations were completed after the CI separated from service; however, his symptoms appear to be relatively stable over the six month time period from July 2006 to January 2007. Although the GAF in January 2007 was higher than that reported in July or October 2006, the symptoms described appeared to be relatively similar throughout this time period. The final permanent rating must be based on The CI’s functional limitations as of six months after separation or August 2007. No information about the CI’s condition is available after January 2007. It was noted by the Board that prospect of redeployment to a combat environment was a major precipitating event for severe exacerbations of his PTSD symptoms. After separation that major stressor would no longer impact his condition. With this in mind, and noting that his condition appeared to be stable over the time period from July 2006 to January 2007, the Board has no basis for determining that his condition was better or worse in August 2007 and the final rating will be based on the January 2007 examination.

The Board directs its attention to its rating recommendations based on the evidence just described. All members agreed that the §4.130 criteria for a rating higher than 50% were not met at the time of separation, and therefore the minimum 50% TDRL rating (as explained above) is applicable. As regards the permanent rating recommendation, all members agreed that the §4.130 threshold for a 70% rating was not approached and that the criteria for a 10% rating were well exceeded. The deliberation settled on arguments for a 30% vs. a 50% permanent rating recommendation. The 30% description (“occupational and social impairment with occasional decrease in work efficiency and intermittent periods of inability to perform occupational tasks”) is a better fit with the occupational functioning in evidence since decreased efficiency can be assumed even though reliability and productivity were not affected. In addition to the general description of occupational and social impairment, the §4.130 general formula fleshes out each rating description with a list of features or symptoms as examples for this level of impairment. This helps to determine a potential level of psychiatric impairment regardless of how well or poorly the veteran is actually faring with work and social activities at the time. Of 6 such descriptors under the 30% rating, the MEB Report of 20061030 (four months before separation) documented four of the six and the VA Special Psychiatric Examination on 20070115 (one month before separation) documented all six descriptors. Two of the nine descriptors for occupational and social impairment at the 50% level are manifested for both evaluations. After due deliberation, considering the totality of the evidence and mindful of VASRD §4.3 (reasonable doubt), the Board recommends a permanent PTSD disability rating of 30% in this case.

Other conditions in the Disability Evaluation System (DES) (Low Back Pain/Lumbar Strain, Tinnitus, and Hearing Loss):

Low Back Pain/Lumbar Strain Condition. The STR shows treatment for low back pain in October 2005 after falling while running the physical fitness test. He was referred to Chiropractic for six visits which were not helpful. His low back pain continued until May 2006 when he was placed on seven days of Limited Duty. There is a final treatment note on January 2007 recommending Motrin and back service referral. The MEB Separation Examination on 20061030 noted a history of low back pain with the condition still existing. The examiner’s note stated that he had occasional exacerbations but the condition was not considered disqualifying. The spinal examination was noted to be normal. The VA C&P Examination of 20060803 demonstrated limited range-of-motion with painful motion and spasm. The VA Rating Decision of 20070723 granted service connection for lumbar strain and spasm with an evaluation of 20% effective 20070301. His range of motion with spasm did meet the 20% rating criteria. A higher evaluation of 40% was not warranted as the VA examination did not show forward flexion of the thoracolumbar spine of 30 degrees or less; or, favorable ankylosis of the entire thoracolumbar spine. The Low Back Pain/Lumbar Strain condition was noted in the DES File. The Commander’s Statement did not mention any physical limitations. Although the condition did appear to be chronic, requiring periodic treatment, there was no evidence that this condition interfered with performance of required duties or was unfitting at the time of separation from service. After careful consideration of all evidence the Board has no reasonable basis for recommending Low Back Pain/Lumbar Strain as an additional unfitting condition for separation rating.

Tinnitus Condition. Tinnitus was noted in the DES File. There was no evidence that supported finding that this condition interfered with performance of required duties or was unfitting at the time of separation from service. The Board, therefore, has no reasonable basis for recommending Tinnitus as an additional unfitting condition for separation rating.

Hearing Loss Condition. Hearing loss is noted in the MEB examination history. The audiogram of 20061030 demonstrated puretone threshold averages of 27.5 on the left and 16 on the right. No criteria for hearing loss or ratable hearing impairment was documented in accordance with §4.85. An earlier audiogram from 20051209 did document hearing loss but that loss was not permanent as evidenced by more recent testing and is thus not considered for rating. No link to fitness can be drawn for the hearing loss condition.

Other Conditions Not in the DES (Right Shoulder Strain). The Right Shoulder Strain condition is noted in the service treatment records however it is not noted in the DES File. It is therefore outside the scope of the Board however the CI retains the right to request his service Board of Correction for Naval Records (BCNR) to consider adding this condition as unfitting.

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 unanimously recommended an initial TDRL rating for PTSD of 50% in retroactive compliance with VASRD §4.129 as DOD directed; and a 30% permanent rating at six months IAW VASRD §4.130. The 30% permanent rating is warranted based on manifestation of all six descriptors for occupational and social impairment at the 30% level and only two of nine descriptors at the 50% level. His PTSD condition had appeared to remain stable over the year prior to separation with no reason to believe that his condition would likely worsen after separation. The prospect of redeployment to a combat environment was a major precipitating event for severe exacerbations of his PTSD symptoms. After separation that stressor would no longer apply. The best description of his functional status is “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)”, indicating a 30% impairment level. The Board also considered the Low Back Pain/Lumbar Strain, Hearing Loss, and Tinnitus conditions, unanimously determining that none of these conditions were unfitting at the time of separation from service and therefore no disability rating is applied. None of these conditions prevented performance of duties required of the CI’s rank or rating. The Right shoulder strain condition is not noted in the DES file and is therefore outside the scope of the Board. The CI retains the right to request his service Board for Correction of Naval Records (BCNR) to consider adding this condition as unfitting.

RECOMMENDATION: The Board recommends that the CI’s prior separation be recharacterized to reflect that rather than discharge with severance pay, the CI was placed on the TDRL at 50% for 6 months following CI’s prior medical separation (PTSD at minimum of 50% IAW §4.129 and DoD direction) and then permanently retired by reason of physical disability with a final combined 30% rating as indicated below.

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| --- | --- | --- | --- |
| **UNFITTING CONDITION** | **VASRD CODE** | **TDRL RATING** | **PERMANENT****RATING** |
| Post-Traumatic Stress Disorder | 9411 | 50% | 30% |
| **COMBINED** | **50%** | **30%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20100622, w/atchs.

Exhibit B. Service Treatment Record.

Exhibit C. Department of Veterans' Affairs Treatment Record.

 Deputy Director

 Physical Disability Board of Review

MEMORANDUM FOR DEPUTY COMMANDANT, MANPOWER & RESERVE AFFAIRS

Subj: PHYSICAL DISABILITY BOARD OF REVIEW (PDBR) RECOMMENDATION

Ref: (a) DoDI 6040.44

1. I have reviewed the subject case pursuant to reference (a). The subject member’s official records are to be corrected to reflect the following retroactive disposition:

 a. Separation from the naval service due to physical disability with placement on the Temporary Disability Retired List with a disability rating of 50 percent for the period February 28, 2001 thru August 31, 2007.

 b. Final separation from naval service due to physical disability effective September 1, 2007 with a disability rating of 10 percent and entitlement to disability severance pay.

2. Please ensure all necessary actions are taken to implement this decision, including the recoupment of previously paid funds if appropriate, and notification to the subject member once those actions are completed.

 Principal Deputy

 Assistant Secretary of the Navy

 (Manpower & Reserve Affairs)