Submission of Documents to Department Of Veterans Affairs

Board Of Veterans Appeals
Litigation & Support Division
P.O. Box 27063
Washington, D.C 20038

FAX: (844) 678-8979

Please index this submission as one .pdf

Veteran: [redacted]	**VSC:** VBASEA346
C-File or SSN: 17[redacted]	
Street Address: [redacted]	
City, State, Zip: [redacted]	

Date: May 21, 2021	**ATTN:** ***PLEASE FLASH VETERAN FOR OVER 75 ***

From: **Gordon A. Graham**	**Exclusive Contact Requested**
Title: Nonattorney Practitioner VA #39029 POA Code E1P	
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Type of Document Submitted:

☐	Request for Board Hearing at VA Central Office in D.C.
☒	Request for Advancement of the Docket (Rule 900)
☐	Request for Copy of Hearing Transcript
☐	Submission of New and Relevant Evidence associated with the instant Appeal
☒	VAF 10182 NOTICE OF DISAGREEMENT (BVA Review)
☐	Motion for Reconsideration (MFR)
☒	Other -Independent Medical Opinion with Curriculum Vitae (5 pages) -VA Form 21-4138 Statement in Support of Claim (3 pages) -Legal brief (17 pages)

Number of Pages Submitted (NOT including this cover sheet): Twenty six (26) pages

VA Directive 6609, NOVEMBER 9, 2007: NOTICE! Access to Veterans records is limited to Authorized Personnel Only. Information may not be disclosed unless permitted pursuant to 38 CFR 1.500-1.599. The Privacy Act contains provisions for criminal penalties for knowingly and willingly disclosing information from the file unless properly author

OMB Approved No. 2900-0674
Respondent Burden: 30 Minutes
Expiration Date: Feb. 28, 2022

Department of Veterans Affairs

DECISION REVIEW REQUEST: BOARD APPEAL (NOTICE OF DISAGREEMENT)

PART I - PERSONAL INFORMATION

1. VETERAN'S NAME *(First, middle initial, last)*
[redacted]

2. VETERAN'S SOCIAL SECURITY NUMBER	3. VETERAN'S VA FILE NUMBER *(if different than their SSN)*	4. VETERAN'S DATE OF BIRTH
[redacted]	C/CSS - 17[redacted]	[redacted]1933

5. IF I AM NOT THE VETERAN, MY NAME IS *(First, middle initial, last)*	6. MY DATE OF BIRTH *(If I am not the Veteran)*

7. MY PREFERRED MAILING ADDRESS *(Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)* ☐ I AM HOMELESS
[redacted]

8. MY PREFERRED TELEPHONE NUMBER *(Include Area Code)*	9. MY PREFERRED E-MAIL ADDRESS	10. MY REPRESENTATIVE'S NAME
(253) 313-5377	gagraham51@gmail.com	Gordon A. Graham VA #39029

PART II - BOARD REVIEW OPTION *(Check only one)*

11. A Veterans Law Judge will consider your appeal in the order in which it is received, depending on which of the following review options you select. *(For additional explanation of your options, please see the attached information and instructions.)*

☐ 11A. Direct Review by a Veterans Law Judge: I do not want a Board hearing, and will not submit any additional evidence in support of my appeal. *(Choosing this option often results in the Board issuing its decision most quickly.)*

☒ 11B. Evidence Submission Reviewed by a Veterans Law Judge: I have additional evidence in support of my appeal that I will provide within the next 90 days, but I do not want a Board hearing. *(Choosing this option may add delay to issuance of a Board decision.)*

☐ 11C. Hearing with a Veterans Law Judge: I want a Board hearing and the opportunity to submit additional evidence in support of my appeal that I will provide within 90 days after my hearing. *(Choosing this option may add delay to issuance of a Board decision.)*

PART III - SPECIFIC ISSUE(S) TO BE APPEALED TO A VETERANS LAW JUDGE AT THE BOARD

12. Please list each issue decided by VA that you would like to appeal. Please refer to your decision notice(s) for a list of adjudicated issues. For each issue, please identify the date of VA's decision and the area of disagreement.

☒ Check here if you attached additional sheets. Include the Veteran's last name and last 4-digits of the Social Security number. 25 pages

Check the SOC/SSOC Opt in box if any issue listed below is being withdrawn from the legacy appeals process. ☐ **Opt In from SOC/SSOC**

A. Specific Issue(s)	B. Date of Decision
Entitlement to an initial evaluation in excess of 10% for service connected status post encephalitis from November 16, 1953, to January 14, 1955, and from March 17, 1956, to September 29,2009.	2/09/2021
ATTENTION: PLEASE FLASH THE VETERAN FOR OVER 75 YEARS OLD	

PART IV - CERTIFICATION AND SIGNATURE

I CERTIFY THAT THE STATEMENTS ON THIS FORM ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

13. SIGNATURE *(Appellant or appointed representative) (Ink signature)*	14. DATE SIGNED
Gordon A. Graham VA #39029 POA Code E1P	5/21/2021

PENALTY: THE LAW PROVIDES SEVERE PENALTIES WHICH INCLUDE A FINE, IMPRISONMENT, OR BOTH, FOR THE WILLFUL SUBMISSION OF ANY STATEMENT OR EVIDENCE OF A MATERIAL FACT, KNOWING IT TO BE FALSE.

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Dept. Of Veterans Affairs
Board of Veterans Appeals
Litigation and Support Group
P.O. Box 27063
Washington DC 20038

May 21, 2021

Re: [redacted] C 17 [redacted]

In regard to: February 21,2021 Supplemental Claim Rating Decision

Extra Pages for VA Form 10182 Notice of Disagreement

Appellant, through counsel, now files his AMA Notice of Disagreement and submits new and relevant evidence in support of his claims for higher initial ratings subsequent to the July 30, 2016 award of entitlement to a compensable rating based on clear and unmistakable error.

As an aid to the Board chairman, a retrospective adjudicatory summary of facts is provided to understand the complex history of the claim and the numerous remands from the Board.

Facts

1. 11/18/1953--Veteran files original claim, inter alia, for status post (s/p) encephalitis. Claims file lost or destroyed.
2. 8/18/1965—Veteran reopens lost claim for s/p encephalitis.
3. 12/29/1965—Rating Decision (RD) grants service connection (SC) for s/p encephalitis at 0% from 8/18/1965.
4. 6/26/2008—Veteran files for increase of, inter alia, s/p encephalitis.
5. 8/28/2008—RD confirms and continues award of 0% for s/p encephalitis.
6. 6/03/2011—RD awards increase for s/p encephalitis of 100% effective 9/30/2009.
7. 6/21/2013—BVA Docket No. 12-16 582 denies earlier effective date (EED) for s/p encephalitis.
8. 8/15/2013—Veteran files Motion to revise the effective date of compensable entitlement to s/p encephalitis to 8/18/1965.
9. 8/06/2014—RD denies EED for compensable rating for s/p encephalitis.
10. 6/21/2016—BVA Docket No. 15-19-787 grants Motion to revise the effective date for s/p encephalitis to 11/16/1953 (CUE).
11. 7/30/2016—RD awards initial compensable rating of 10% for minimal residuals of s/p encephalitis effective 11/16/1953.
12. 12/04/2018—RD again denies EED of 11/16/1953 for higher initial compensation for s/p encephalitis.
13. 8/20/2020—BVA Docket No. 191121-49097 remands denial of an initial evaluation in excess of 10% for SC s/p encephalitis from 1953 to 1955 and from 1956 to 2009.
14. 2/09/2021—RD confirms and continues evaluation of 100% and denies EED for higher initial compensable rating.

Legal Standard of Review

The Appellant, a recognized combat Veteran, was injured in combat in Korea. He is entitled to the protection of 38 U.S.C. §1154(b). His lay testimony, from the events at the Chosin Reservoir massacre in December 1950 to his collapse into a coma on the battlefield four months later on April 12, 1951 must be accorded this consideration. See also §3.304(d)(2021).

When rating the Veteran's service-connected disability, the entire medical history must be borne in mind. ***Schafrath v. Derwinski***, 1 Vet. App. 589 (1991). Separate higher or lower compensable evaluations may be assigned for separate periods of time if such distinct periods are shown by the competent evidence of record during the appeal, a practice known as "staged" ratings. See ***Fenderson v. West***, 12 Vet. App. 119, 126 (1999) and affirmed more recently in ***Hart v. Mansfield***, 21 Vet. App. 505 (2007).

§4.2 states:

Different examiners, at different times, will not describe the same disability in the same language. Features of the disability which must have persisted unchanged may be overlooked or a change for the better or worse may not be accurately appreciated or described. **It is the responsibility of the rating specialist to interpret reports of examination in the light of the whole recorded history,** reconciling the various reports into a consistent picture so that the current rating may accurately reflect the elements of disability present. (emphasis added).

§ 4.3 Resolution of reasonable doubt states:

It is the defined and consistently applied policy of the Department of Veterans Affairs to administer the law under a broad interpretation, consistent, however, with the facts shown in every case. When after careful consideration **of all procurable and assembled data**, a reasonable doubt arises regarding the degree

of disability such doubt will be resolved in favor of the claimant. (emphasis added)

Except as otherwise provided by law, a claimant has the responsibility to present and support a claim for benefits under the laws administered by VA. VA shall consider all information and medical and lay evidence of record. Where there is an approximate balance of positive and negative evidence regarding any issue material to the determination of a matter, VA shall give the benefit of the doubt to the claimant. 38 U.S.C. §5107; 38 C.F.R. §3.102; see also ***Gilbert v. Derwinski***, 1 Vet. App. 49, 53 (1990).

VA is required to give due consideration to all pertinent medical and lay evidence in evaluating a claim for disability benefits. 38 U.S.C. § 1154(a). Lay evidence can be competent and sufficient to establish a diagnosis of a condition when (1) a layperson is competent to identify the medical condition, (2) the layperson is reporting a contemporaneous medical diagnosis, or (3) lay testimony describing symptoms at the time supports a later diagnosis by a medical professional. ***Jandreau v. Nicholson***, 492 F.3d 1372, 1377 (Fed. Cir. 2007).

In the instant appeal, it should be noted that the original claim filed in 1953 is now being evaluated for the proper, correct *initial* rating. This would, under normal circumstances, be done utilizing a staged rating procedure described in ***Fenderson*** *infra*. However, with the finding of fact that the medical evidence pertinent to the instant issue on appeal has been lost or destroyed, a different legal standard of review is for application. Where the Veteran's service records are lost or destroyed, there is a heightened obligation on the part of VA to explain findings and conclusions and to consider carefully whether reasonable doubt exists to resolve in favor of the Veteran. ***Cuevas v. Principi***, 3 Vet. App. 542 (1992); ***O'Hare v. Derwinski***, 1 Vet. App. 365 (1991).

The case law above does not lower the legal standard for proving a claim for service connection, but rather increases the Board's obligation to evaluate

and discuss in a decision all evidence that may be favorable to the claimant. ***Russo v. Brown***, 9 Vet. App. 46 (1996).

Up to the present date of this Notice of Disagreement, there has been an extreme degree of recalcitrance and a begrudging acceptance of the fact that the Appellant has been deprived of due process for over sixty eight years. This revelation has occurred in fits and spurts. This is Appellant's fourth appearance before the Board of Veterans Appeals in search of justice. At eighty seven years of age, it is highly unlikely Appellant will survive to return again. In this respect, Appellant begs the Board chairman to put an end to this endless litigation. He and his wife simply don't have the stamina to pursue this chimera forever. They feel the evidence more than supports his contentions.

The Veteran's s/p encephalitis is evaluated under 38 C.F.R. §4.124a, Diagnostic Code 8000, which remains unchanged since November 1953 and provides that epidemic and chronic encephalitis is rated at the 10 percent rate for minimum residuals and at 100 percent for an active febrile disease. The regulation also instructs that, aside from the exceptions noted, disability from organic diseases of the central nervous system and their residuals may be rated from 10 percent to 100 percent in proportion to the impairment of motor, sensory, or mental function. In doing so, the rater must consider psychotic manifestations, complete or partial loss of use of one or more extremities, speech disturbances, impairment of vision, disturbances of gait, tremors, visceral manifestations, etc., referring to the appropriate bodily system of the schedule. With partial loss of use of one or more extremities from neurological lesions, rate by comparison with the mild, moderate, severe, or complete paralysis of peripheral nerves. 38 C.F.R. §4.124a.

Most important to appellant's appeal, the note after DCs 8000- 8025 instructs that for the minimum ratings for residuals there must be "ascertainable" residuals. Notably, determinations as to the presence of residuals not capable of objective verification, i.e., headaches, dizziness, fatigability, must be approached on the basis of the diagnosis recorded; subjective residuals will be accepted when consistent with the disease and not more likely attributable to

other disease or no disease. It is of exceptional importance that when ratings in excess of the prescribed minimum ratings are assigned, the diagnostic codes utilized as bases of evaluation be cited, in addition to the codes identifying the diagnoses. 38 C.F.R. § 4.124a, Note (after Diagnostic Code 8025).

§4.25(b) states:

(b) Except as otherwise provided in this schedule, the disabilities arising from a single disease entity, e.g., arthritis, multiple sclerosis, **cerebrovascular accident**, etc., are to be rated separately as are all other disabling conditions, if any. (emphasis added).

Post-remand development by the Agency of Jurisdiction must comply with the dictates of the Board's remand instructions. See ***Correia v. McDonald***, 28 Vet. App. 158 (2016); ***Sharp v. Shulkin***, 29 Vet. App. 26 (2017). Such a practice hinders the decision-making process and raises the undesirable specter of piecemeal litigation. See ***Fugere v. Derwinski***, 1 Vet. App. 103, 105 (1990), aff'd 972 F.2d 331 (Fed. Cir. 1992).

In Monzingo v. Shinseki, the Court held : "Although "[t]here is no requirement that a medical examiner comment on every favorable piece of evidence in a claims file" to render an adequate opinion, a medical examination report or opinion must "sufficiently inform the Board of a medical expert's judgment on a medical question and the essential rationale for that opinion." ***Monzingo v. Shinseki***, 26 Vet. App. 97,105 (2012).

In Nieves-Rodriguez v. Peake, The Court held: "It should now be obvious that a review of the claims file cannot compensate for lack of the reasoned analysis required in a medical opinion. It is the factually accurate, fully articulated, sound reasoning for the conclusion, not the mere fact that the claims file was reviewed, that contributes probative value to a medical opinion." ***Nieves-Rodriguez v. Peake***, 22 Vet. App. 295, 301 (2008). "In other words, the examiner must provide not only clear conclusions with supporting data, but also a reasoned medical explanation connecting the two." ***Id.*** at 301.

Undoubtedly, further medical inquiry can be undertaken with a view towards further developing the claim. However, in this regard, the Court has cautioned VA against seeking an additional medical opinion where favorable evidence in the record is unrefuted, and indicated that it would not be permissible to undertake further development if the sole purpose was to obtain evidence against an appellant's claim. See ***Mariano v. Principi***, 17 Vet. App. 305, 312 (2003). See also ***Kahana v. Shinseki***, 24 Vet. App. 428 (2011); ***McLendon v. Nicholson***, 20 Vet. App. 79, 85 (2006) (In any event, the lack of medical evidence in service does not constitute substantive negative evidence).

§3.304(c) states:

(c) *Development.* The development of evidence in connection with claims for service connection will be accomplished when deemed necessary **but it should not be undertaken when evidence present is sufficient for this determination.** In initially rating disability of record at the time of discharge, the records of the service department, including the reports of examination at enlistment and the clinical records during service, will ordinarily suffice. Rating of combat injuries or other conditions which obviously had their inception in service may be accomplished pending receipt of copy of the examination at enlistment and all other service records. (emphasis added).

Relief Sought

1. Entitlement to a higher initial compensable rating under DC 8000 for cognitive impairments of moderate memory, attention, concentration and executive functions, moderately severely impaired judgement and fatigability.

2. Entitlement to an initial compensable rating of 50% for migraine headaches under DC 8000-8100 based on very frequent completely prostrating and prolonged attacks productive of severe economic inadaptability.

3. Entitlement to an initial compensable rating of 10% under §4.84b DC 8000-6204 (1953) for chronic moderate tinnitus and occasional dizziness.

4. Entitlement to an initial compensable rating under §4.130 DC 8000-9302 (1953) at 30% for chronic brain syndrome associated with intracranial infections other than syphilis (s/p encephalitis) with definite impairment of social and industrial adaptability.

Discussion

Appellant has consistently and credibly averred the evidence shows he submitted certain claims for his subjective residuals of his severe s/p encephalitis. Unfortunately, due to the racial atmosphere afoot in the early 1950s, until true integration occurred in 1954, his claims were destroyed or lost subsequent to filing upon separation. Additional attempts to file were equally downplayed or discarded outright. This was finally acknowledged in 2016- fully sixty three years later. Not until 1965 was the Veteran able to successfully sustain a claim for service connection for his disabilities. Even then, the decision failed to consider and rate his subjective residuals mentioned in the Note following DC 8000 in Part IV of the VASRD. This was resolved to some degree in 2016 with the BVA's conclusion of law agreeing a clear and unmistakable error occurred in 1953 when the claims file was either destroyed or probative records were lost.

1. The January 19, 2010 C & P Examination

Appellant attended a January 18, 2010 c&p examination conducted by M[redacted] E. M[redacted], M.D., Pediatrics, upon which the 100% evaluation for encephalitis from September 30, 2009, to the present was based. The clinician opined that the Veteran has carried a diagnosis of s/p encephalitis and the condition had existed since 1951. Appellant endorsed headaches occurring 3 times per day; dizziness as often as 3 times a day. Neurological deficits included moderate abnormality 2 to 3 of 5 of the Cranial nerve VII on the left side with facial paralysis/numbness of lower lip, complete loss of smell on the right side,

partial loss on the left with partial loss of taste. Dr. M[redacted]'s diagnoses are entitled to the presumption of regularity. See ***Sickels v. Shinseki,*** 643 F.3d, 1362, 1365-66 (Fed. Cir. 2011) (holding that the Board is "entitled to assume" the competency of a VA examiner and the adequacy of a VA opinion without "demonstrating why the medical examiners' reports were competent and sufficiently informed"). See also ***Ashley v. Derwinski***, 2 Vet. App. 307, 308 (1992) ("[t]here is a presumption of regularity under which it is presumed that government officials 'have properly discharged their official duties.") (quoting ***United States v. Chem. Found., Inc.***, 272 U.S. 1 (1926)). Dr. M[redacted] stated, however, that the headaches and dizziness were not related to the s/p encephalitis "per the patient". Appellant vehemently denies saying this. In any event, the point is moot because the Secretary later conceded in the July 30, 2016, rating decision that these diagnoses <u>were</u> symptomatic of his service connected s/p encephalitis.

The award of 100% for residuals of encephalitis is a favorable finding of fact and protected as a matter of law. See ***Medrano v. Nicholson***, 21 Vet. App. 165, 170 (2007) (The Court is not permitted to reverse findings of fact favorable to a claimant made by the Board pursuant to its statutory authority).

As can be ascertained, the Secretary freely concedes Appellant had active residuals of s/p encephalitis. Absent an act of omission or commission by the Appellant,the 100% award of entitlement for s/p encephalitis was, and is, protected as a matter of law.

<u>2. The July 30, 2016 Rating Decision</u>

The July 30, 2016, Decision Review Officer rating decision conceded the Movant had subjective, compensable residuals as early as the date of separation in 1953. The Secretary chose to rate him under the objective criteria- i.e., ascertainable residuals to include the impairment of motor, sensory, or mental functions. A minimum rating of 10% was assigned. The VA examiner opined further and cited to an internet article as a peer-reviewed citation -

https://www.encephalitis.info/images/iPdf/Research2/CONSEQUENCEs1.pdf. The link now appears to be inoperative but the VA examiner conceded residuals of s/p encephalitis to include, inter alia, problems such as headaches, balance issues and short-term memory problems were recognized symptomatology.

The rating decision went on to state the Appellant's lay testimony provided evidence of subjective residuals during and after the first period of service, during his second period of service and continuously to the 1965 c&p examination. The rating decision also confirmed and continued the 100% rating entitlement from 2009 to the present (2016) as being correct.

It would be clearly and unmistakably erroneous to rate the appellant under DC 8000 at 10% for "residuals, minimum" that encompass subjective residuals. §4.25(b) is explicit in its instructions as to how to rate disabilities arising from a single disease entity- e.g., a cerebrovascular accident such as encephalitis. The regulation instructs, as does the Note in §4.124a, to rate these other subjective disabling conditions separately under the proper diagnostic codes applicable.

Thus, by operation of law, Appellant's described subjective residuals of s/p encephalitis must be rated on the basis of the diagnosis(es) recorded. In addition, they must be rated according to the diagnostic codes applicable. See §§4.20; 4.21; 4.27; 4.124a DC 8100. DC 8000's note explicitly instructs that when ratings in excess of the prescribed minimum ratings are assigned, the diagnostic codes utilized as bases of evaluation be cited, in addition to the codes identifying the diagnoses. This requires the assignment of a "built up" rating code number employing the tenets of §4.27- e.g., DC 8000-8100 for headaches or DC 8000-6204 for Labyrinthitis, chronic (dizziness). DC 8000-9302 (1953) would be applicable to rate mental disorders associated with intracranial infections other than syphilis -e.g., s/p encephalitis. In the same vein, sensory impairment such as DC 8000-8209 loss of smell in cranial nerve IX (glossopharyngeal) would also be a subjective residual.

3. The 8/20/2020 BVA Remand Instructions

The dearth of evidence in the claims file prompted a finding of pre-decisional error and the remand from which this appeal is taken. The Board chairman specifically instructed the Secretary to obtain a retrospective, independent medical evaluation, preferably by a neurologist, of the Appellant to determine the nature and residuals of his service connected s/p encephalitis from his filing in November 1953 to September 2009.

Item b. on page 9 of the remanded August 2020 Docket No.191121-49097 was anally specific. The Veterans Law Judge asked the clinician to identify *all* the Appellant's subjective residuals and opine on their etiology. An asterisk below the remand instruction noted Appellant's prior, credible lay testimony concerning the presence of numerous chronic subjective symptoms which are covered under the combat presumption in §1154(b). The Board chairman further instructed that, in keeping with the clear and unmistakable language of §4.124a, that Appellant's subjective residuals must be accepted when consistent with the disease and not more likely attributable to other disease or no disease.

On page 11 under paragraph d. of the remand instructions, The Board stated:

" If the examiner cannot provide an opinion without resorting to mere speculation, this should be so stated along with supporting rationale. In so doing, the examiner shall explain whether the inability to provide a more definitive opinion is the result of a need for additional information, or that he or she has exhausted the limits of current medical knowledge in providing an answer to the particular question."

4. The 10/30/2020 C&P Examination

On October 28, 2020, post BVA remand, Appellant attended a c&p examination in person before S[redacted] L. G[redacted], M.D. General Medicine. Dr. G[redacted] has no neuropsychiatric training nor a specialty in psychology. Nevertheless, at the c&p examination, Dr. G[redacted] recorded:

"Veteran has no particular neuropsychiatric complaints at the present time other than an occasional headache.

Neurological examination is completely negative at this time.

Diagnosis: No neuropsychiatric disability evidenced at this time."

On the last page of the inwards-facing Central Nervous Symptoms DBQ, Dr. G[redacted] opined:

"The claimant left the hospital in 1951 symptom free other than an occasional headache which may or may not have been related to his diagnosis of encephalitis. On followup evaluations there were no residuals of the encephalitis identified. The encephalitis specifically has had no bearing on his employability. He has been unable to hold a steady job due to his anger management issues (according to his wife) possibly related to his PTSD. Currently he is aged (87) with a variety of medical issues which preclude employment."

Dr. G[redacted] neglected to explain what neuropsychiatric training Appellant's wife possessed which permitted her to opine on the etiology of his anger management issues and their relationship to his service connected PTSD. Dr. G[redacted] at no time stated he was unable to provide an opinion without resorting to speculation. Absent any contemporary records which are admittedly missing or destroyed, it is incomprehensible how Dr. G[redacted] could opine on a rationale for Appellant's unemployability sixty years ago.

Irrespective of the six pages of explicit remand instructions provided by the Board chairman, there appears to have been something lost in the transmittal. The numerous findings of fact and subsequent diagnoses of residuals in prior c&p examinations seem to have escaped the clinician. Worse, as Dr. G[redacted] has no neuropsychiatric training, his summary of lack of symptomatology and no residuals of s/p encephalitis merely amount to data and conclusions and are entitled to little or no probative value. ***Nieves-Rodriguez*** *supra*. Following the c&p examination, this representative informed the VA examiner of Dr. G[redacted]'s lack of neuropsychiatric credentials. The VA examiner agreed to provide a second examination with a board certified neurologist.

5. The January 26, 2021 C&P Examination

The Secretary elected to reconsider appellant's claim and conducted a new Independent Medical Evaluation (IME) of Appellant's contemporary records in lieu of an in-person c&p examination. P[redacted] R[redacted], M.D. Neurology, conducted an Acceptable Clinical Evidence (ACE) review of Appellant's medical records on January 4, 2021. Included in his review were records post-dating the 100% award of entitlement to s/p encephalitis after 2009 which have no bearing on the remand request for a survey of residuals from 1953 to 2009 nor any probative value. ***Mariano*** *supra*

Dr. R[redacted] noted that Appellant, on August 3, 2008, "reports he does not experience any functional impairment for this condition" (s/p encephalitis). Dr. Rossi failed to note what medical training Appellant possessed which would permit him to opine on his own neuropsychiatric symptomatology. ***Layno*** *supra*. ***Jandreau*** *supra*. See also ***Espiritu v. Derwinski,*** 2 Vet. App. 492, 494-95 (1992) (laypersons are not competent to render medical opinions, including etiology opinions). Considering Appellant can't remember what he had for breakfast yesterday morning, it would be ludicrous to attribute any probative value to his self-reported symptomatology.

Dr. R[redacted] further opined "It is unclear to the undersigned, a board-certified neurologist, as to how to otherwise answer the above noted medical opinion requested in VA form 2507 dated 11/09/2020." Dr. R[redacted] further stated:

"The undersigned therefore also resulted [sic] the following medical opinions: It is less likely as not that the Veteran has any residuals as a result of his in-service encephalitis condition. It is at least as likely as not that the Veteran's encephalitis condition is resolved as a result of his in-service treatment in April and May 1951."

"The available evidence of record and the weight of medical literature supports that the Veteran had no chronic and disabling conditions, to include any residuals of encephalitis, subsequent to his recovery in 1951."

"The undersigned reviewed and took into consideration the Veteran's lay testimony regarding his claimed residuals of encephalitis which is not congruent with the evidence of record and the weight of medical literature."

"Although this combat Veteran has reported his experiences and the undersigned believes these experiences occurred, the Veteran is not qualified to make a medical diagnosis as the result of those experiences. The diagnoses of encephalitis and residuals of encephalitis are MEDICAL diagnoses." (emphasis in original)

The credibility and weight to be attached to medical opinions is within the providence of the Board as adjudicators. ***Guerrieri v. Brown***, 4 Vet. App. 467, 470-71 (1993). Greater weight may be placed on one physician's opinion over another depending on factors such as reasoning employed by the physicians and the extent to which they reviewed prior clinical records and other evidence. ***Gabrielson v. Brown***, 7 Vet. App. 36, 40 (1994).

Nieves-Rodriguez *supra* held a medical examination report must contain not only clear conclusions with supporting data, but also a reasoned medical explanation connecting the two); see also ***Stefl v. Nicholson,*** 21 Vet. App. 120, 124 (2007) (stating that a medical opinion must support its conclusion with an analysis that the Board can consider and weigh against contrary opinions).

Dr. R[redacted] makes mention of "the weight of medical literature" in arriving at his medical opinion but woefully neglects to share or cite to this illuminating, peer-reviewed literature for the edification of the Board. In point of fact, the dearth of evidence, both medical and lay, forced Dr. Rossi to rely extensively on a decidedly defective history provided solely by the Appellant. See ***Reonal v. Brown***, 5 Vet. App.458, 460 (1993). "[The] Board [is] not bound to accept opinions of two physicians who made diagnoses . . . almost 20 years following appellant's separation from service and who necessarily relied on history as related by appellant." ***Reonal*** at 460. Dr. R[redacted] like Dr. G[redacted], at no time stated he was unable to provide an opinion without resorting to mere speculation. Nevertheless, it would appear from the record, or more specifically the lack of a record, that speculation was the operable metric employed here.

Further, Dr. R[redacted] seems to contend that, contrary to Layno, Appellant is not qualified to report that (subjective symptoms) which comes to him via his five senses. See ***Layno v. Brown***, 6 Vet. App. 465, 470 (1994)(a Veteran is competent to report on that of which he or she has personal knowledge).

Perhaps most disturbing is the post hoc rationalization put forth by both Dr. G[redacted] and Dr. R[redacted] that Appellant has never had any residuals of s/p encephalitis whatsoever; this in spite of the paradox of the Secretary's concession otherwise- both in the 2010 rating decision granting a 100% rating for the condition as well as a subsequent concession in 2016 of clear and unmistakable error in the 1953 decision resulting in an award of 10% for "minimal residuals". See ***Evans v. Shinseki,*** 25 Vet. App. 7, 16 (2011) (explaining that "it is the Board that is required to provide a complete statement of reasons or bases" for its decision and "the Secretary cannot make up for [the Board's] failure to do so" by providing his own reasons or bases on appeal).

Quite simply, an error either exists with Dr. R[redacted]'s and Dr. G[redacted]'s medical opinions or the Secretary erred in awarding a permanent and total disability rating of 100% for DC 8000 in 2010 and the additional retroactive award of 10% to November 1953. The Secretary cannot have his cake and eat it

too. See ***Russell v. Derwinski***, 3 Vet. App. 310, 313-14 (1992) ("an error either undebatably exists or there was no error within the meaning of §3.105).

Submission of New and Relevant Evidence

In the interests of dispelling ambiguity, Appellant has elected to obtain a truly unbiased Independent Medical Opinion (IMO) by a Board certified subject matter expert that comprehends the residuals of s/p encephalitis, enunciates clear conclusions with supportive data, while also proffering a reasoned medical explanation connecting the conclusions to peer-reviewed literature that can be weighed independently *de novo* by the Board itself. Most importantly, Appellant chose to provide the Board Chairman with a medical opinion which actually attempts to comply with the August 20, 2020, BVA remand request.

In addition, Appellant submits a VA Form 21-4138 Statement in Support of Claim, both notarized and sworn to, in an effort to collect all the contemporary history of his residuals and the nature of serving in a decidedly racist environment where Black servicemen were chosen over their white counterparts and ordered to march across fields as virtual minesweepers. Appellant did not have the luxury of deciding whether he was well or ill when it came time to go into battle. Not until the deactivation of the 94th Engineer Battalion on November 27, 1954, more than a year after his separation, did the U.S. Army become truly integrated. Nevertheless, it would be another decade until true equality was achieved. See https://www.digitalhistory.uh.edu/topic_display.cfm?tcid=100 (last visited May 20, 2021).

In summary, Appellant has attended five c&p exams over the last six decades-none of which have ever recorded all the symptomatology or etiology of the subjective residuals of his s/p encephalitis. Appellant has had a dizzying array of medical opinions, some pro but most con, regarding his disease. Now, following an award of initial compensable entitlement to s/p encephalitis retroactive to his lost 1953 filing, The Secretary proffers not one, but two IMO post

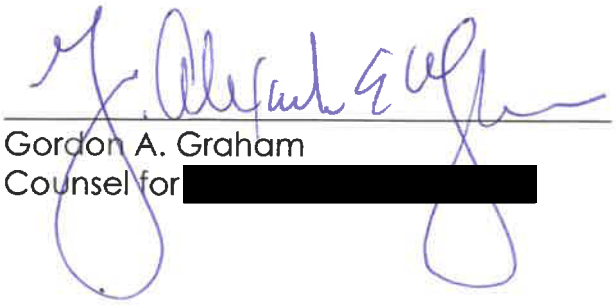
hoc rationalizations which completely contradict the prior awards. An error either undebatably exists or there was no error. This combat Veteran seeks the finality as envisioned in ***Mariano*** *supra*.

The pro-Veteran canon instructs that provisions providing benefits to veterans should be liberally construed in the veterans' favor, with any interpretative doubt resolved to their benefit. See, e.g., ***King v. St. Vincent's Hosp.***, 502 U.S. 215, 220 (1991).

Barrett v. Principi, 363 F.3d 1316, 1320 (Fed. Cir. 2004) ("[T]he veterans benefit system is designed to award entitlements to a special class of citizens, those who risked harm to serve and defend their country. This entire scheme is imbued with special beneficence from a grateful sovereign."

Wherefore Appellant begs the Board chairman to conclude this endless 68-year odyssey in search of equity and justice and grant him the benefit of the doubt enshrined in VA jurisprudence.

Respectfully submitted,



Gordon A. Graham
Counsel for [redacted]

Attachments:

Exhibit A- Independent Medical Opinion by D[redacted] P[redacted]k, M.D. Board-Certified Neurology with Curriculum Vitae

Exhibit B- VA Form 21-4138 Statement of Claim.

OMB Control No. 2900-0075
Respondent Burden: 15 minutes
Expiration Date: 12/31/2020

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

STATEMENT IN SUPPORT OF CLAIM

INSTRUCTIONS: Read the Privacy Act and Respondent Burden on Page 2 before completing the form. Complete as much of Section I as possible. The information requested will help process your claim for benefits. If you need any additional room, use the second page.

SECTION I: VETERAN/BENEFICIARY'S IDENTIFICATION INFORMATION

NOTE: You will *either* complete the form online or by hand. Please print the information request in ink, neatly, and legibly to help process the form.

1. VETERAN/BENEFICIARY'S NAME *(First, Middle Initial, Last)*

[redacted]

[redacted] | (253) 33-5377 law offices | gordon.graham@va.gov

8. MAILING ADDRESS *(Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)*

No. & Street

Apt./Unit Number | City

State/Province | Country | ZIP Code/Postal Code –

SECTION II: REMARKS

(The following statement is made in connection with a claim for benefits in the case of the above-named veteran/beneficiary.)

I, [redacted] a decorated combat Veteran of the Korean War and survivor of the Chosin Reservoir Battle in Winter,1950, swear that the following is true and correct. As no one has yet, to date, inventoried all my symptoms following my encephalitis infection, I will attempt to correct that now.

As a Negro infantryman serving in the U.S. Army in 1951, we were in a segregated unit. We obeyed orders until we dropped in our tracks. Which is where I was when I became unresponsive in battle somewhere on the Korean Peninsula on 4/14/1951. I regained consciousness from a coma on or about May 18th, 1951 and found myself at the 361st Station Hospital in Tokyo, Japan.

As no one recorded my subjective symptoms after regaining consciousness, I wish to do so now. The first thing amiss was my vision. At first, I could not see clearly or focus. I could not see "down" without tilting my body forward. I had frequent headaches (2-3 times daily), dizzy spells and couldn't remember how I arrived in Japan. I was weak, tired and suffered from insomnia. My facial muscles tingled and were sometimes numb to the touch. I had lost my sense of smell. I had loud ringing in my ears constantly. I was told these symptoms would go away as I recovered. My memory problems were apparent. I could not remember where my ward and bed were when I returned from a walk. I was finally discharged to light duty on 7/08/1951-2 months and 3 weeks after I fell ill in Korea. My personality had changed. I was sad, depressed and cried occasionally for no apparent reason. Some days I was angry and lashed out at others-again- for no apparent reason. My vision problems gradually resolved but my facial muscles around my mouth continued to feel numb to the touch.

I never did regain my sense of smell. My headaches never abated. I continued to suffer from dizzy spells several times a day. I had a hard time understanding people when told what to do. It felt like "brain fog" for lack of a better term. The tinnitus also never diminished or went away. I began to miss formations when I was supposed to be there. I began to get Article 15 non-judicial punishments for my infractions. It finally resulted in my receiving a General Discharge under Honorable Conditions rather than an Honorable Discharge.

There was no work to be had so I re-enlisted in January 1955. Shortly thereafter, my feet caused me so much pain from my frostbite injuries at the Chosin Reservoir battles that the Army decided to operate on them. My PUHLES L Score was reduced to a 3 due to my surgery. I continued to have mental problems with my sadness and anger and was eventually determined not to be Army material. My second three-year enlistment ended

VETERAN'S SOCIAL SECURITY NO. 5 1 2 – 2 8 – 2 5 5 0

SECTION II: REMARKS (Continued)
(The following statement is made in connection with a claim for benefits in the case of the above-named veteran/beneficiary.)

abruptly on 3/16/1956- 14 months after re-enlisting- with a second General Discharge after numerous non-judicial punishments for not following orders. It was not that I wanted to misbehave or disobey my superiors. It was an inability to remember when to be somewhere or to accomplish assigned tasks when ordered to do so. Additionally, my feet had become very painful after the August 1955 surgery to remove parts of four of my toes which were damaged by frostbite in Winter 1950. I tried to get a hardship discharge at the end of February 1956 but was refused.

Following military service, I found employment difficult. I found it very hard to stay on task. I found myself unable to recall things I had just done. I had exhibited poor judgement in the past after the coma but this problem seemed to only get worse. My first wife told me I jerked in my sleep a lot. She also noticed that I garbled my words or mispronounced them sometimes. Eventually, my wife and I divorced in 1974 due to my personality changes. By this time, my children were mortally afraid of me.

I do not pretend to be a doctor, I do, however, understand what comes to me via my five senses. What I do know is the symptoms I have described above have continued uninterrupted since awakening from the coma in May 1951. The symptoms have waxed and waned at times but never resolved. In the last thirty years, my speech has become occasionally slurred by what appears to be the numbness in my facial muscles.

Negro soldiers were "no deposit-no return" soldiers in the 1940s-1950s. We were not allowed to vote and were punished for even the slightest infraction. As soon as it became evident I was troublesome, I was separated from the Army in my second enlistment. We were forbidden to go on sick call unless we were deathly ill or incapable of work. This is one primary reason I was not allowed to report for medical attention in Korea until I had a high fever and became unresponsive.

My symptoms have impaired my ability to obtain good work over the last 50-60 years. Some employers fired me because they thought I had been drinking on the job due to my slurred speech. At other times, I was fired for being "untrainable" or too stupid to accomplish assigned tasks. I never had any problems with my personality before contracting the disease. I have never claimed that all the symptoms I suffer are related to encephalitis. I merely claim I never had any of these problems before 1951.

For the record, my claimed November 26, 1965 neuropsychiatric examination by John D. Morgan, M.D. never happened in person. I met on that day with Dr. G.L. Birnbaum M.D. who examined me for my foot conditions. This seems to be why none of my symptoms were ever recorded other than headaches, dizziness and memory problems. The VA recognizes that they have either lost or destroyed all my medical records during the time of the 1953 claim filing. As for recording my symptoms after awakening from the coma in May, 1951, I can only say that the doctors assured me that my symptoms were acute and would resolve in time. Being extremely poor, I was not financially able to seek medical help for decades and the disabilities were never noted.

SECTION III: DECLARATION OF INTENT

I CERTIFY THAT the statements on this form are true and correct to the best of my knowledge and belief.

9. [redacted] | 10. DATE SIGNED *(MM/DD/YYYY)* 1/11/21

PENALTY: The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement or evidence of a material fact, knowing it to be false.

PRIVACY ACT INFORMATION: The VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA Programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education, and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is required to obtain or retain benefits. VA uses your SSN to identify your claim file. Providing your SSN will help ensure that your records are properly associated with your claim file. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. The VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by Federal Statute of law in effect prior to January 1, 1975, and still in effect. The requested information is considered relevant and necessary to determine maximum benefits under the law. The responses you submit are considered confidential (38 U.S.C. 5701). Information submitted is subject to verification through computer matching programs with other agencies.

RESPONDENT BURDEN: We need this information to obtain evidence in support of your claim for benefits (38 U.S.C. 501(a) and (b)). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 15 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at www.reginfo.gov/public/do/PRAMain. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

NOTARY SEAL in the back Please.

State of Washington
County of King
I certify that I know or have satisfactory evidence that

[redacted]

is/are the person who appeared before me,
and signed and sworn on 02-11-2024 (date).

Chetna Maini 02-01-25
Signature Notary Public Commission Expires

Dr. D[redacted] P[redacted]
Board Certified, Neurology

April 27, 2021

[redacted]

Summary of Records Reviewed:

Complete VA claims file, Army service treatment records from 1951 relating to treatment for severe suppurative encephalitis with brain abscess. Multiple more recent compensation and pension examinations (clinical and forensic) regarding neurological and psychiatric conditions. Transcript of VA appeals hearings conducted on 05/25/2016 and 3/17/2020. Notarized statement from the applicant dated 02/11/2021.

OPINION

As to the question: "Is it at least as likely as not that the applicant's long-standing headaches, dizziness, insomnia, memory impairments, anxiety, and agitation are direct result of the prior, and already service-connected, condition of encephalitis?"

I believe that it IS as likely as not that the insomnia, memory difficulties, anxiety, agitation, headaches and dizziness, are related to the prior case of encephalitis, caused by his combat injuries during the Korean War in April of 1951.

RATIONALE

The applicant had a very severe case of encephalitis with brain abscess while in Army service in 1951. On or about 4/14/1951 Mr. [redacted] was in combat on the Korean Peninsula where he suffered high fever and pneumococcal infection of the right lung, became unresponsive and taken to an aid station in a coma. On or about 5/18/51, he regained consciousness when he awoke from his coma at the 361st Station Hospital (neuropsychiatric) in Tokyo, Japan. The VA has already ceded that Mr. [redacted] had encephalitis in service as a result of his combat operations. The question at hand is not whether Mr. [redacted] currently has encephalitis; he clearly does not. The question is whether the residuals of his previous diagnosis of encephalitis, to include insomnia, memory difficulties, anxiety, agitation, headaches and dizziness, warrant a service connection retroactive to his original VA disability claim, submitted in 1953.

In trying to determine this, a physician would rely on medical evidence and previous research to develop an opinion. Unfortunately, the VA admits that the medical records associated with Mr. [redacted] are missing and lost. Additionally, the medical records that do exist, from many years ago, did not paint a thorough picture of Mr. [redacted] conditions, relative to his sworn statement in support of his claim.

Given these facts, each piece of information that is available, including the known absence of medical records, the previous VA decisions, most notably the 7/30/16 decision granting 10% for residuals to service-connected encephalitis, statements from Mr. [redacted] and available medical research, each bear even more weight in this specific case.

The 7/30/2016 rating decision held Mr. [redacted]'s testimony was credible and he was competent to testify. Proceeding from there, the VA conceded he suffered "residual headaches, dizziness and memory issues" secondary to his now-service connected s/p encephalitis. The rating decision went on to note that "residuals associated with encephalitis include problems such as headaches, balance issues and shot-term [sic] memory problems.
See https://www.encephalitis.info/images/iPdf/Research2/CONSEQUENCES1.pdf

Mr. [redacted] currently, in his most recent sworn statement in support of his claim, outlined his previous and current residuals of his encephalitis diagnosis in 1951. Those include symptoms that have "waxed and waned" over the years but are still ever present. Mr. [redacted] specifically references chronic headaches, dizziness, tinnitus, personality changes (agitation), memory loss, anxiety and insomnia. He specifically states he did not experience any of these symptoms prior to his combat injuries and subsequent bout with encephalitis. Please see his sworn statement for the particulars on each residual.

Such a condition often results in substantial sequelae including, but not limited to, headaches, dizziness/vertigo, tinnitus, visual disturbances, insomnia, memory difficulties, impaired focus/concentration, seizures, paralysis, anosmia, dysgeusia, and behavioral abnormalities. There are numerous and credible references in the records to many of these ailments, and it is at least as likely as not that that the agitation, anxiety, insomnia, memory trouble, headaches and dizziness are directly attributable to the applicant's case of very severe encephalitis.

There are no studies documenting the frequency of the long-term and permanent sequelae of encephalitis - but then there are also no studies that rule out the long-term effects or if they can be permanent.

Complications of severe illness

Inflammation can injure the brain, possibly resulting in a coma or death.

Other complications — varying greatly in severity — may persist for months or be permanent. These complications can include:

- Persistent fatigue
- Weakness or lack of muscle coordination
- Personality changes

- Memory problems
- Paralysis
- Hearing or vision defects
- Speech impairments (1)

Additionally, there are multiple studies and research that associate long-term effects of encephalitis that show symptoms such as insomnia, memory difficulties, anxiety, agitation, headaches and dizziness, as part of the symptomology. These studies clearly show that it is at least as likely as not that there is a connection between Mr. [redacted] symptoms as it relates to his incident of encephalitis in 1951. (2,3,4,5,6)

Therefore, given the facts outlined above, it is medically reasonable and at least as likely as not, that Mr. [redacted]'s previous and current headaches, dizziness, insomnia, memory impairments, anxiety, and agitation are residuals of his encephalitis caused by his injuries incurred in combat in 1951.

Lastly, I note that the VA accords combat Veterans great leeway in the credibility of their statements under 38 U.S.C. §1154(b). Given this statute, Mr. [redacted]s testimony would appear to be unimpeachable based on the award of a Combat Infantryman Badge.

Debra Ann Pollack, MD
Board Certified-Neurology
Board Certified-Sleep Medicine

References*

(1) https://www.mayoclinic.org/diseases-conditions/encephalitis/symptoms-causes/syc-20356136
Encephalitis - Symptoms and causes - Mayo Clinic

(2) https://pubmed.ncbi.nlm.nih.gov/27422743/
Long-term outcomes of infective encephalitis in children: a systematic review and meta-analysis - PubMed (nih.gov)

(3) https://pubmed.ncbi.nlm.nih.gov/17676530/

Neuropsychological sequelae of acute-onset sporadic viral encephalitis - PubMed (nih.gov)

(4) https://pubmed.ncbi.nlm.nih.gov/10983899/
Cognitive outcome in acute sporadic encephalitis - PubMed (nih.gov)

(5) https://pubmed.ncbi.nlm.nih.gov/10983899/
Neuropsychological and psychiatric profiles in acute encephalitis in adults - PubMed (nih.gov)

(6) https://www.encephalitis.info/Pages/Category/after-effects-of-encephalitis

**All referenced links above are active and currently online as of 4/27/2021*

D[redacted] P[redacted], M.D.

BOARD CERTIFICATION:	**Neurology** American Board of Psychiatry and Neurology	1996, 2006, 2016, through 2026;
	Sleep Medicine (ABMS Subspecialty) American Board of Psychiatry and Neurology	2011, through 2021
	Sleep Medicine American Board of Sleep Medicine	1998, lifetime
LICENSURE:	Licensed in CT (through 4/2021), NY (through 3/2021), MA (through 4/2022)	
PROFESSIONAL EXPERIENCE:	Director of Neurology and Sleep Medicine Center for Comprehensive Care, LLC Danbury and Shelton, CT	2009-present
	Medical Director, Gaylord Sleep Medicine Gaylord Hospital Multiple locations in CT	2003-2009
	Director, Gaylord/New Haven Sleep Services Gaylord Hospital New Haven, CT	1998 – 2003
	Neurology and Sleep Medicine Associates and Attending Neurologist, St. Vincent's Medical Center, Bridgeport, CT	1996 – 1998
POST-GRADUATE TRAINING:	Fellowship in Sleep Medicine Medical College of Pennsylvania Philadelphia, PA	07/1995 -07/1996
	Neurology Residency Pennsylvania Hospital, Philadelphia, PA	07/1992 – 06/1995
	Internal Medicine Internship Graduate Hospital, Philadelphia, PA	07/1991 – 06/1992
EDUCATION:	Hahnemann University School of Medicine Philadelphia, PA Doctor of Medicine	05/1991
	Cornell University, Ithaca, NY Bachelor of Science	05/1987