Michael Joseph Little, ABH2 (AW/SW)
US Navy (Individual Ready Reserves)
US Coast Guard Auxiliary
Combat Disabled Navy Veteran

06 March 2019

Board for Corrections of Naval Records
701 S. Courthouse Road
Building 12, Suite 1001
Arlington, VA 22204-2490

Dear Members of the Board for Corrections of Naval Records:

Re: ABH2(AW/SW) Michael Joseph Little, USN (IRR S-2),
1.) Review of Findings of the Physical Evaluation Board Proceedings
2.) Review of Petition for Relief from the President of the PEB

I am writing this letter in support of my dispute with the Navy. The following is the history of this case.

A Physical Evaluation Board (PEB) was held on March 17, 2016. The findings of the board were that I was fit to continue naval service. This finding was clearly wrong based on the standards that must be followed and the evidence presented.

The PEB decision violated SECNAVINST 1850.4 series ,is 5001(a)(3) in that the decision is contrary to the great weight of evidence of record. Specifically the PEB erred in finding me fit for duty. Although a Petition for Relief was filed on May 31, 2016, the Director of the Navy Council of Personnel Boards (DCNPB) ignored the evidence and denied the petition.

Additionally, there is new evidence which directly affects the findings of the PEB and constitutes a basis for the relief pursuant to SECNAVINST 1850.4 series ,is 5001(a)(l). That new evidence was ignored by the DNCPB.

Both the PEB and the DNCPB ignored the threshold requirement that in interpreting and evaluating the injury and assigning disability percentages, all reasonable doubt must be resolved in favor of the petitioner. 38 C.F.R. ,i 4.3. See also, SECNAVINST 1850.4 series i)3804.

The PEB did concede the presence of PTSD[1], but it erred in weighing the evidence. The PEB rationale "cherry picked" the voluminous testimony to seize on the few points leaning in favor of a finding of fitness while ignoring the overwhelming evidence that I was was no longer fit for service.

[1] The Board made the common error of referring to the disability as Post Traumatic Stress Disorder. The modern and better approach is to refer to it as Post Traumatic Stress (PTS). The use of the word "Disorder" invokes negative implications of a mental defect or disease. The condition was caused by military service and is a direct result of service induced trauma. It does not reflect a psychological defect in the member. It is no more of a disorder than a physical wound. It is a psychological wound and should be referred to as such.

The PEB Rationale correctly identified the duties of an ABH2 as follows:

> The primary duties of an ABH2 are to direct the movement and spotting of aircraft ashore and afloat; operate, maintain, and perform organizational maintenance on ground handling equipment used for moving and hoisting of aircraft ashore and afloat; supervise securing of aircraft and equipment; perform crash rescue, firefighting, crash removal, and damage control duties; perform duties in connection with launching and recovery of aircraft. Navy Enlisted Classifications Manual (NAVPERS 18068F).

Placing a PTS/TBI victim in this environment is a recipe for disaster. This position requires intensive concentration and the ability to complete mental checklists without error or omission. I am incapable of remaining focused during the high tempo of aircraft operations. In my own testimony, I related an incident where my lack of concentration and focus put an aircraft in an unsafe condition that could have resulted in the loss of the aircraft and the death of the pilot. It was at this point that I began to seek help for my PTS wound. Returning a mentally wounded warrior to this situation would be an accident waiting to happen and the Navy would be hard pressed to justify their actions when an airplane was lost and various personnel in the plane and on the flight deck were hurt or killed. The gross negligence involved in placing a PTS/TBI sailor in this situation would result in heavy losses in people and equipment.

RADM G. E. Hall, USN (Retired) presented significant evidence at the hearing. RADM Hall was a designated aviator and a former Commanding Officer of an amphibous assualt ship. He is conversant with aircraft operations and opined that I would be potentially harmful to myself and others if I was engaging in these types of operations. The environment is noisy and even in low tempo operations I would not be able to perform to expected standards. This was confirmed by Captain Ken Ireland (USN Retired), my former Commanding Officer at NOSC North Island. Captain Ireland was a naval aviator also conversant with flight deck operations. Master Chief Niblach, a former Command Chief aboard several ships and a Command Master Chief at a NOSC agreed. Even Mrs. Little, a former ABH3 and current Coast Guard HS2, who valiantly defended me as her husband, agreed I was no longer fit for service on a flight deck afloat or ashore. Chris Slawinski, a retired air warfare petty officer and currently service officer for the Fleet Reserve Association, who coordinated Petty Officer Little's VA claim, also opined that he would be a danger to himself or others. The hearing was also observed by Thomas Snee, the National Executive Director of the Fleet Reserve Association, who was observing in that capacity.

The psychological evaluations confirm the fact that I am not fit for duty. On September 8, 2010, I was assigned a Global Assessment Factor of 75, which indicated transient symptoms. In June of 2015 the GAF had slipped to a score of 60-65. A score of 65 indicates mild symptoms such as depressed mood and insomnia with some difficulty with social or occupational functions. In the high pressure environment of a flight deck, this was potentially dangerous. At 60, however, the symptoms were moderate to include panic attacks, which were documented in my experience. More importantly, the score of 60 gives rise to potential conflicts with peers or co-workers. A flight deck must operate as a close knit team. Conflicts lead to potential fatal consequences. The score of 60 was a slight improvement of scores between 50 and 55 documented between 2011 and 2013 and may have been a result of treatment. This 50-55 range reflects serious symptoms including the inability to keep a job and suicidal ideations. The

fluctuations between 50 and 65 are indicative of a case in transition which is responding somewhat to treatment but has not been cured. The problem is that the flight deck is no place for a GAF less than 71 and I have been unable to attain that level since 2010.

The triggering stressors for the PTS occurred when I was assigned to detainee operations in Iraq in 2008-09. In their rationale, the PEB seems to emphasize that subsequent to the triggering stressors, I volunteered for an additional Individual Augmentee tour of duty in Afghanistan. The PEB did not contest the PTS diagnosis nor the substantiated stressors but instead inferred that they were not serious enough to prevent me from performing additional duties. Significant evidence was presented to confirm the stressors that I suffered during my deployments. Additionally, the second deployment aggravated my initial PTS.

The Diagnostic and Statistical Manual of Mental Disorders version IV and IV-TR and V recognize delayed onset PTS. In delayed onset PTS, at least six months pass before the symptoms manifest. In fact, the symptoms may not be evident for years. Yet all experts agree that the symptoms must be imputed back to the traumatic event or stressor.

In order to trigger PTS, there must be exposure to a traumatic event or intrusive recollection. I suffer from both. Additionally, I display the symptoms of PTS which have manifested themselves with increasing frequency until I began to undergo treatment. This was documented at the hearing. Witnesses painted a picture of a deteriorating individual who would perform admirably with periods of unreliability as he sought to withdraw from life while he fought his demons.

The fact that I volunteered for a follow on deployment while still in Iraq is of no moment. Given the delayed onset of PTS, the ramifications of the condition had not manifested itself. There is no evidence that I knew I had PTS when I volunteered.

The testimony of Sam Wilson, my friend and former employer, provided insight into the developing condition. He stated that I was a great employee but that things could quickly deteriorate. As a result, I actually was unable to report to assist with a "Relay for Life Event" due to a panic attack.

The testimony of Captain Ken Ireland offered further insight. Captain Ireland was familiar with PTS and saw indications of it in me. He recommended counseling and that I should not complete the second tour. I was still in the denial phase of PTS, which is common in the early stages. Accordingly, I did not attempt to cancel my orders. This is also consistent with the condition since most PTS victims are very patriotic. Failing to complete the mission, or even an inability to complete the mission, affects the victim' s self esteem. Indeed a sense of worthlessness is one of the features of PTS.

In their rationale the PEB notes that post-deployment, while on annual training, I had a panic attack because "billowing steam clouds" reminded me of sandstorms. What the rationale does not discuss, although clearly presented at the hearing, is that I lost focus and failed to ensure that the check list was properly completed. The failure to properly ensure all safety procedures were followed could have resulted in the loss of an aircraft and death of the pilot had a supervisor not caught the discrepancy. This tragedy was avoided solely by luck and not due to my abilities.

The PEB also relied upon the completion of a pre-deployment mental health psych survey. It is commonly accepted that these surveys are more form than substance and are completed as part of the myriad of pre-deployment paperwork. Additionally, as discussed above, given the delayed onset of PTS my answers are not surprising. Psychological counseling would have been very premature at that stage, at least in my mind. Given the suicide information classes presented over the past decade, I knew that even if I was having suicidal thoughts, which again would be premature in delayed onset PTS, my orders would be cancelled if I revealed them. As there was no indication that I had been prescribed mental health medications, my denial of their use would have been accurate and consistent with delayed onset PTS. The significance of this survey is not relevant to my condition in 2016.

The post deployment survey conducted in 2010 merely shows the progression of the PTS. Here I report the anxiety, nightmares and difficulty sleeping consistant with delayed onset PTS. The PEB rationale curiously dismisses the early factors because I did not report any stressors in the Afghanistan operation. While I underwent some stressors, the major occurrences happened in Iraq. The delay in the manifestation of the symptoms is consistent with the proven progression of PTS. The failure of the PEB to recognize this progression is clear error.

The PEB rationale infers that I was lying when I said that Abu Bahkr al-Baghdadi was a prisoner at Camp Bucca at the time of my Iraq deployment. In fact there is evidence that al-Baghdadi was held there from 2005-2009. See, Terrence McCoy, "How ISIS Leader Abu Bahkr al-Baghdadi became the world's most powerful jihadist leader," Washington Post 10 December 2014. The former Commander of Camp Bucca, Colonel Kenneth King confirmed the presence of al-Baghdadi during this time period. Michael Daly, "ISIS Leader: See you in New York," The Daily Beast, 14 June 2014. The PEB rationale further opined that there were no riots at Camp Bucca after November 2007 is disproven by the attached correspondence. While one might differ on the definition of the term riot there were certainly violent outbreaks.

Thus the Board should have had no difficulty in reconciling the events with my time line.

While RADM Hall and Master Chief Niblach testified to my excellent work performance, the rationale cherry picks from the testimony to accentuate the positive. Both testified that I often worked from home due to panic attacks and lack of sleep. Both testified that I would sometimes miss important events. The Blue Water Navy case was cited as an example and not the sole instance of absence. Master Chief Niblach testified that some of the civilians at my workplace were resentful because I often did not come to the office. RADM Hall testified that he purposely made accommodations because of his familiarity with PTS and his sympathy for the effects of the condition. This was not discussed in the rationale. The testimony indicated that while I would often perform at the highest levels, I would unpredictably withdraw from my responsibilities due to panic attacks and anxiety.

The PEB Rationale further notes that I created a non- profit entity where I work to counsel veterans. This was necessary due to my former role as a registered lobbyist. Counseling veterans as a registered lobbyist would have created a conflict of interest. More importantly, the counseling often consisted of shared experiences which is therapeutic for the counselor as well as the counselee. In other words, this counseling was part of my treatment for PTS.

Mrs. Little testified that she had seen significant changes in me since the time we had served together on a carrier flight deck. She was aware of my headaches and had administered shots for me, with medical approval, to treat them. She was also aware of my occasional bad temper and panic attacks. She notes that while I watched World War II movies on TV, I cannot watch anything dealing with the Middle East conflicts. She confirmed my pro bono work for veterans was therapeutic. Although the rationale says Mrs. Little did not remember me waking up from nightmares, that report is not consistent with her testimony. In fact she remembers some nightmares but confirmed she is a deep sleeper. She attempted to curtail any negative statements about her husband due to the obvious loyalty and love she feels for me. Other witnesses, including my co-workers, confirmed that I often hid my panic attacks, nightmares etc. from her because I did not want to worry her. Mrs. Little also testified that things had improved somewhat since I began the stellate ganglion block treatments, a regime that is only available at a few locations such as Bethesda.

The rationale seems designed to rely upon positive evidence while ignoring the negative. As in all cases there is a mixture of both. The correct standard is whether the PEB or the DNCPB ignored the weight of the evidence and in this case they did. Trained and experienced naval officers and petty officers all stated that I could not perform the duties of my rate. Nor could I be depended upon to perform the duties of a second class Petty Officer at the NOSC or even to attend drills.

The PEB completely ignored the findings of the MEB Limitations and Prognosis section about my PTS which stated:

> Despite intensive multi-modal therapies his PTSD and depression prevent him from performing the requirements of his rank and Service. These conditions do not meet retention standards IAW SECNAVINST 8450.4E.
>
> His prognosis is guarded. His psychiatric conditions may stabilize improve with ongoing psychotherapy and the use of psychotropic medications. Although his non-medical assessment (NAM) recommended retaining him in the Navy Reserve, because of the chronic recurrent nature of his symptoms, it is unlikely that the SM will improve sufficiently in the next 5 years to meet retention standards. It is almost certain that his PTSD and depression would worsen if exposed to the unique stressors of the military environment.

The picture of this dedicated petty officer and polished counselor and former lobbyist dissolved at the hearing as I deteriorated into a sobbing shell who was begging for help. My demeanor and body language were not reflected in the PEB rationale.

The findings of the Director, Secretary of the Navy Council of Review Boards, in his response to my petition for relief from the President of the Board, are clearly wrong because he used the Non Medical Assessement that was provided by my Commanding Officer. This NAM was provided by a CO who at that point had never even met me. My command was completely unaware of struggle with PTS, and after reviewing my service record, my CO was only aware that I was capable of being one of his top 2nd classes, and there was no reason I shouldn't be retained in the Navy.

After receiving a rave review of my service, I requested many times to meet with the CO to seek his support in changing my NMA. The CO was not interested in meeting with me. Instead, after I hired an attorney to help me prepare for my PEB, he added a cover letter that stated I no longer wished retention in the US Navy The reason this change of wanting to serve was requested was never explained, and the command showed zero interest in helping to advocate for me.

When I started to the process of having an LOD, I still was in denial that I had PTS, but after being treated at Walter Reed, I accepted the fact that I no longer was capable of continued naval service, and tried to work with my command to express this, but received no support. The Director failed to see that my command had not given me an evaluation in over 2 years, which further proved the lack of support I was getting from this while trying to address my PTS. Instead of cherry picking evaluations, they should have considered the MEB that stated continued Naval service would only worsen my mental state. A consistent Early Promote Sailor, does not just allow himself to go a few years without an evaluation unless he feels completely cut off from Command.

I have served my country well. Now it is time for my country to recognize my service, the wounds I suffered due to my service, and to serve me. The military has been taken to task by Congress for its refusal to aid its mentally wounded warriors. Several provisions of the 2010 and the 2017 National Defense Authorization Act have highlighted Congressional concerns. This included a requirement that appropriate discharge upgrade boards consider PTS/TBI as a cause of misconduct when there has been a diagnosis. As a sailor, a veteran's advocate and a human being I deserve to be placed on the Permanent Disability Retirement List (PDRL). A PDRL assignment is in alignment with the MEB findings that I am not likely to improve in the next 5 years, and further military service would worsen my disabilities. My PTS service wounds are as real as physical service wounds that cause destruction to a sailor’s body.

Very Respectfully,

ABH2(AW/SW) Michael Joseph Little
United States Navy (IRR S-2)