DEPARTMENT OF THE NAVY
NAVAL SEA SYSTEMS COMMAND
1333 ISAAC HULL AVE SE
WASHINGTON NAVY YARD DC 20376-0001

IN REPLY REFER TO
5800
Ser 00/190
2 May 23

FINAL ENDORSEMENT on (b) (6), (b) (7)(C) [redacted] ltr of 9 Feb 23

From: Commander, Naval Sea Systems Command
To: File

Subj: COMMAND INVESTIGATION INTO CAUSAL OR CONTRIBUTING FACTORS IN THE FOUR SAILOR DEATHS WITHIN 28 DAYS AT MID-ATLANTIC REGIONAL MAINTENANCE CENTER

1. I approve the findings of fact, opinions and recommendations as modified and commented upon in the first endorsement. I also concur with Commander, Navy Regional Maintenance Command, on the application of many of these recommendations to Mid-Atlantic Regional Maintenance Center (MARMC) and to all the Regional Maintenance Centers (RMCs). Many of the 25 recommendations can be shared with my partners across Navy leadership with the intention of fleet-wide impact and improvement and are forwarded to the Navy's Learning to Action Board to increase Navy-wide learning. We must do our best to learn from this in order to prevent similar tragedies in the future.

2. The goal of this report and the continued work to implement its recommendations is to ensure that the Sailors at MARMC and across the NAVSEA enterprise are safe and have access to the services they need. The report also examined MARMC's climate, including allegations of toxic individuals or workplaces, but did not corroborate these allegations based on a lack of supporting facts. I also relied on other input such as assessments, site visits, and inspections in reaching this conclusion.

3. There is no statement strong enough to convey the impact that these losses have had across the command and the Navy. To the surviving families, friends, and shipmates, I extend my sincere condolences.

4. By copy of this letter, I am inviting the attention of fellow leaders and superiors on the findings and recommendations in this case.

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5. My point of contact for this matter is (b) (7)(C), (b) (6), USN, available at (b) (7)(C), (b) (6) or (b) (6), (b) (7)(C) (b) (6), (b) (7)(C).

W. J. GALINIS

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5830
Ser 00/195
17 Mar 23

FIRST ENDORSEMENT on (b) (6), (b) (7)(C) ltr of 9 Feb 23

From: RDML E. H. Ver Hage, Commander, Navy Regional Maintenance Center (CNRMC)
To: Commander, Naval Sea Systems Command

Subj: COMMAND INVESTIGATION INTO CAUSAL OR CONTRIBUTING FACTORS IN THE FOUR SAILOR DEATHS WITHIN 28 DAYS AT MID-ATLANTIC REGIONAL MAINTENANCE CENTER

1. Forwarded, concurring with the findings, opinions, and recommendations of the investigating officer, as amplified below.

2. My deepest sympathy to each of the affected families who have lost a loved one, I regret their loss and their loss is felt deeply within the CNRMC and MARMC Navy family. I speak for the entire command in expressing my sympathy.

3. My highest priority following the four tragedies has been to ensure that the Sailors under my command are safe, supported and have access to vital resources including medical care, mental healthcare, Fleet and Family support services, chaplain services, legal services, proper pay and adequate housing. Consistent with the findings of this investigation, suicide is complex and rarely the result of a single stressor. It is often difficult to pinpoint the specific cause of suicide, but based on this investigation to understand the causal and contributing factors in these four cases, we have taken steps to effect positive lasting change within the MARMC and greater RMC populations to prevent similar tragedy in the future. I have also shared with the greater Tidewater Navy community the lessons learned and steps taken to prevent suicides.

4. To that end, I have worked with my subordinate commanders, Bureau of Medicine (BUMED) and Chaplain Corps to ensure that the Sailors, not only at MARMC, but at all the Regional Maintenance Commands (RMCs) have lasting access to counseling and mental health services, as well as a trained cadre of Deployability Coordinators. These Depoyability Coordinators will be able to assist in providing the limited duty Sailor the rapid access to the medical information that they require.

5. The investigation makes 25 discrete recommendations, 13 of which are within my authority for action. I have assessed that a majority of these recommendations should also be applied across all the RMCs, including requesting a Shore Manpower Requirements Determination study and industrial hygiene survey to inform decision-making on the resources and manpower required to effectively assign, manage, administer and provide oversight to the limited duty Sailor populations. Taking a deliberate approach to document and study this issue on a larger

scale across the RMCs has the potential to provide a data-supported model that could be more broadly applied Navy-wide in other commands with large limited duty or otherwise vulnerable populations.

6. In keeping with the investigation recommendations, I will also be requiring all RMCs to prioritize the oversight of the limited duty population by holding recurring sync meetings with their respective command Deployability Coordinators, increasing the number of personnel at the command with SMART database access, and having monthly meetings with the respective Medical Treatment Facility Deployability Coordinators. These actions, in addition to a thoughtful and intentional effort by each of my Triads to obtain vital information from newly reporting personnel regarding their support needs will undoubtedly improve each command's ability to lead in meaningful way.

7. I have ordered an assessment across all RMCs to ensure that Suicide Prevention Programs are in full compliance with OPNAVINST 1720.4, including the execution of the required crisis response drill, and a campaign to improve internal communications on suicide prevention within each command and the enterprise. In parallel, I will also be assessing the Fitness Enhancement Program and Command Indoctrination Program and instructions across all RMCs, as well as evaluating ways to increase participation and feedback in the Defense Organization Climate survey.

8. While the investigation identifies several areas for remedial action, which I intend to implement across the RMCs and share across the Tidewater region and beyond, there were no individual actions or inactions that caused or directly contributed to the tragic deaths in this case.

9. My point of contact for this matter is (b) (6), (b) (7)(C) , who can be reached at (b) (6), (b) (7)(C) .

E. H. VER HAGE

5830
9 Feb 23

From: (b) (6), (b) (7)(C)
To: Commander, Navy Regional Maintenance Center

Subj: COMMAND INVESTIGATION INTO CAUSAL OR CONTRIBUTING FACTORS IN THE FOUR SAILOR DEATHS WITHIN 28 DAYS AT MID-ATLANTIC REGIONAL MAINTENANCE CENTER

Ref: (a) JAGINST 5800.7G, Manual of the Judge Advocate General
(b) MILPERSMAN 1300-1400, Limited Duty
(c) OPNAVINST 1300.21, Enlisted Manning Policy and Procedures
(d) OPNAVINST 1300.20, Deployability Assessment and Assignment Program
(References continue at the end of the report)

Encl: (1) CNRMC ltr 5800 Ser 100/534 dtd 29 Nov 22
(2) CNRMC ltr 5800 Ser 100/593 dtd 19 Dec 22
(3) CNRMC ltr 5800 Ser 100/013 dtd 10 Jan 23
(4) CNRMC ltr 5800 Ser 100/083 dtd 31 Jan 23
(Enclosures continue at the end of the report)

Preliminary Statement

1. Pursuant to enclosure (1) and in accordance with reference (a), a command investigation (CI) was conducted to inquire into the facts and circumstances surrounding the tragic, suicide-related deaths of four service members assigned to the Mid-Atlantic Regional Maintenance Center (MARMC) that occurred over a 28-day period (29 Oct 22– 26 Nov 22). In chronological order, these Sailors are ET2(SW) Kody Decker, ETSN Cameron Armstrong, MMFN Deonte Autry, and FC2 Janelle Holder. Given the unique complexity, and the multitude of factors to be investigated in each case, three extensions of time were granted in order to allow the investigation team to complete this report (see Enclosures 2 through 4). The Command Investigation Team was directed to focus its efforts on identifying causal and contributing factors, as well as any commonalities, leading to each of the four deaths. Throughout this report, the Mid-Atlantic Regional Maintenance Center is referred to as "MARMC."

2. All reasonably available evidence and information has been collected, and all requirements of reference (a) and enclosure (1) have been satisfied. The following difficulties collecting relevant evidence were encountered during the investigation: (1) the autopsies and toxicology reports are not yet available for any of the four Sailors, (2) the Naval Criminal Investigative Service (NCIS) has not completed their forensic analyses of FC2 Holder's personal laptop and cell phone and (3) ET2(SW) Decker's mobile device(s) were unavailable for analysis by NCIS. Additionally, the CI Team did not interview immediate or extended family members, based largely on the advice of NCIS, who is conducting their own concurrent investigation into the four Sailor deaths. Despite these information shortfalls, based on the extensive amount of evidence obtained, the receipt of

this additional information is unlikely to alter the findings, opinions, and recommendations contained in this report.

3. The Investigating Officer (IO) and the CI Team reviewed every available medical and mental health record of the deceased in meticulous detail. This review yielded valuable insights into the complex medical history of each Sailor, and in some cases, provided helpful context regarding the state of mind of the Sailors near the time of their tragic deaths. These insights would not have been available from other forms of evidence or interviews. We discuss these insights in the report; however, medical and mental health records contain personal and private details pertaining to the individuals which were not intended for public disclosure. For that reason, we treat the medical records as a reference in this report, and do not include them in the accompanying enclosures. To the extent that we limit or broadly summarize our discussion of certain details contained in the medical records, we have done so out of an abundance of caution in order to protect the privacy of the deceased and the surviving family members, given our expectation that this report will be made available to the public. Additionally, the CI Team did not include any discussions or opinions related to the quality of medical care provided to the deceased Sailors, as this was not within the scope of the investigation, nor within the CI Team's area of expertise.

4. The NCIS Norfolk, Virginia Field Office provided close consultation and collaboration throughout this investigation, to include information/evidence sharing, and liaison with local law enforcement. Additionally, the CI team interviewed the Southwest Regional Maintenance Center (SWRMC) to draw a comparison of how LIMDU policies and processes are being implemented across similarly sized Navy Regional Maintenance Centers (RMCs).

5. (b) (6), (b) (7)(C), USN, served as legal advisor and was consulted in the preparation of this report.

6. Lastly, the CI Team wishes to extend its deepest condolences to all the families regarding the tragic loss of their respective service members, and our shipmates.

Executive Summary

1. This investigation probed into the causal and contributing factors involved in the tragic deaths of four Sailors assigned to MARMC over a 28-day period. Each of the four suicide-related deaths entailed unique causal and contributing factors. The Command Investigation (CI) Team performed an exhaustive and exacting review into each case and was unable to draw any direct correlation(s) between them. I can state with high confidence that any commonality amongst the cases is confined to the following: (1) each Sailor was in their first enlistment; (2) each Sailor had been placed in a Limited Duty (LIMDU) status at some point during their enlistment; (3) each Sailor had unrestricted access to personally-owned firearms (lethal means), which were used in each case; (4) each Sailor was suffering from a confluence of external stressors imposed

by a unique combination of personal and professional circumstances. However, each Sailor was in a different phase of the LIMDU and/or Disability Evaluation System (DES) process, and each was dealing with extenuating circumstances related to the disposition of their individual cases. These circumstances are covered in-depth in subsequent findings of fact pertaining to each Sailor.

2. While the CI Team identified common stressors amongst the four MARMC Sailors, to include family, financial, medical, and career-related factors, it is our opinion that the tragic, suicide-related deaths of ET2(SW) Decker, ETSN Armstrong, MMFN Autry, and FC2 Holder were neither related, nor connected.

3. All governing instructions - to include Local, Navy, and Department of Defense (DOD)-wide Policy - pertaining to the management, care, and disposition of LIMDU/DES Sailors were reviewed in depth in conjunction with this investigation. The CI Team found that the directions, guidance and recommendations contained therein exceeded the capacity of MARMC to effectively implement and enforce given the large and growing population of LIMDU Sailors placed under its cognizance. The CI Team assessed an imbalance and misalignment with respect to the requirements tied to Deployability/LIMDU Policy, and the resources available at MARMC to effectively execute to those requirements. Despite these obstacles, MARMC continued to meet its mission, and spared no effort to provide support to all Sailors assigned in accordance with applicable instructions, policies, and processes.

Findings of Fact

Facts Regarding Mid-Atlantic Regional Maintenance Center (MARMC)

1. MARMC is an Echelon Four command whose Immediate Superior in Command (ISIC) is the Commander, Navy Regional Maintenance Center (CNRMC), both of whom are part of Naval Sea Systems Command (NAVSEA). MARMC is comprised of military and civilian personnel and provides intermediate-level surface ship maintenance and management, as well as oversight of private sector depot-level maintenance and fleet technical assistance to ships in the Mid-Atlantic region of the United States. MARMC also provides support to the Fifth and Sixth Fleet Areas of Responsibility. Additionally, MARMC exercises ownership responsibility of the floating dry-dock “Dynamic” (AFDL-6). [Encl (5)]

2. MARMC provides core services to over 70 ships. Those services include Contract Management Oversight (CMO), Total Ship Readiness Assessments (TSRA), Fleet Technical Assist, as well as a dry-docking facility that supports Mine Counter Measure (MCM) vessels, Landing Craft Utility (LCU) platforms, Yard Tugs (YTB), and other vessels of similar size. [Encl (5)]

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3. MARMC's workforce is comprised of approximately 1,600 military personnel (which includes LIMDU/DES service members assigned), and approximately 1,600 civilian and contractor personnel. [Encl (5)]

4. MARMC has an annual budget of over one billion dollars, with 11 major maintenance availabilities (aka "Avails") in-progress at the time of this report. On average, MARMC provides support for 25 CNO Avails and 85 Continuous/Emergent Maintenance Availabilities (CMAV's/EMAV's) per-year. [Encl (5)]

5. MARMC Code 900 (Intermediate Maintenance Production Shop) annual workload includes: executing repairs on over 5,500 work item requests per year; sole provider for preventive and corrective maintenance on marine gas turbine engines; conducting approximately 4,500 diving operations per year providing underwater husbandry services; overhauling in excess of 125 pumps per year; and completing 75-100 Maintenance Assist Team (MAT) visits per year. [Encl (5)]

6. MARMC Code 200 (Fleet Technical Support) annual workload includes: executing approximately 75 shipboard assessments per year; executing approximately 12,000 shipboard technical assistance visits per year; and providing on-site maintenance training to shipboard Sailors. [Encl (5)]

7. As of 13 Dec 22, MARMC had 1,507 active-duty Sailors, 1,284 civilians and 300 contractors onboard for a total of 3,091 personnel. [Encl (6)]

8. MARMC's most recent Shore Manpower Requirement Determination (SMRD) Study was conducted in July 2014. The study was specific to the composition of RMC Project Teams and did not include MARMC military manpower. [Encl (7)]

9. MARMC receives Sailors placed in LIMDU, Reassignments for Humanitarian Reasons (HUMS), and Pregnant and Postpartum Sailors, many of which are assigned to the Code 1190 "HLPP" (HUMS/LIMDU/PREGNANT/POSTPARTUM) Branch. [Encl (8)]

10. At any single point in time, MARMC has between 450 and 550 Sailors assigned to the Code 1190 HLPP branch. MARMC's HLPP numbers fluctuate frequently. [Encl (8)]

11. As of 25 Jan 23, MARMC reported that they had a total of 464 HLPP billeted Sailors; this number included 200 LIMDU/DES Sailors, 213 Pregnant/Postpartum Sailors, 27 Sailors awaiting separation, 13 Sailors found fit for full duty and awaiting orders, and 11 on HUMS reassignment. [Encl (9)]

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Facts Regarding Limited Duty (LIMDU)

12. LIMDU is defined as the assignment of a service member with certain medical limitations or restrictions concerning the duties the service member may perform in a duty status for a specified time. LIMDU is divided into two separate categories: temporary limited duty (TLD) and permanent limited duty (PLD). [Ref (b)]

13. Assignment of LIMDU and pregnant/postpartum Sailors is governed by OPNAVINST 1300.21 Enlisted Manning Policy and Procedures, paragraph 13. [Ref (c)]

14. Policy pertaining to deployability assessments in order to determine service members' ability to perform military duties commensurate with their office, grade, or rank is governed by OPNAVINST 1300.20 Deployability, Assessment, and Assignment Program. [Ref (d)]

15. LIMDU Sailors are assigned per MILPERSMAN (MPM) Article 1300-1400, ref (b), as well as in accordance with guidelines established in OPNAVINST 1300.21, subparagraphs 13a(1) and 13a(2). [Ref (c)]

16. LIMDU requests are approved by the cognizant Medical Treatment Facility (MTF) Convening Authority (CA) if the LIMDU period will not result in an extension of LIMDU status beyond 12 consecutive months, **and** the Service member is expected to return to a medically unrestricted duty status at the completion of the LIMDU period. [Ref (b)]

17. If the medical community determines that a service member is unable to return to a medically un-restricted status at any point during the LIMDU period, the individual's case is either referred to the Disability Evaluation System (DES) for follow-on adjudication or is processed for administrative separation due to a condition not amounting to a disability (CnD). [Ref (b)]

18. As of 6 Dec 22, Navy-wide, there were 12,218 LIMDU cases closed in calendar year (CY) 2022. 37.2% of closed cases were "Return to Duty." [Encl (10)]

19. Whenever possible, LIMDU Sailors reassigned to shore from a sea duty command will be assigned to commands with valid billets authorized (BA) for their rating; however, these Sailors will be aligned as excess and not affect the generation of manning requisitions. [Ref (c)]

20. Navy Personnel Command (NAVPERSCOM) (PERS-4) assigns and defines personnel Accounting Category Codes (ACC) 104, 105, 354, and 355 as shown in Figure 1 below. [Ref (e)]

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ACC-CODE	ORDER PRODUCTION MODULE (OPM) PHRASES FOR ENLISTED ASSIGNMENT INFORMATION SYSTEM (EAIS) AND OFFICER ASSIGNMENT INFORMATION SYSTEM (OAIS) ORDERS
104	Humanitarian Duty (more than six months). Member assigned per MPM Article1300-50
105	LIMDU/Medically Restricted (more than six months). Members' assignment is restricted by a medical board for medical reasons, or at the direction of NAVPERSCOM (PERS-454). The activity to which members are assigned is considered a Permanent Duty Station (PDS)
354	Temporary Duty (TEMDU) for Humanitarian Assignment (HUMS) (6 months or less). Member assigned under M1300-500 while enroute to next PDS
355	TEMDU Awaiting Medical Board. Member awaiting formal medical board processing

Figure-1: ACC-CODE Definitions

21. With respect to quantity, the CI Team defines "LIMDU" as the total population of ACC 105 plus ACC 355 Sailors assigned to an activity (i.e., MARMC). [Ref (c)]

22. MPM Article 1300-1400 and OPNAVINST 1300.20 draw a clear distinction between different categories of LIMDU, including "Temporary Limited Duty (TLD)" and "Permanent Limited Duty (PLD)." OPNAVINST 1300.21 draws no such distinction. [Refs (b), (c), (d)]

23. BUMEDINST 6000.19, Medical Evaluation Board Composition, Function, Management, Staffing, and Standardization, defines the term TLD as synonymous/interchangeable with LIMDU. [Ref (h)]

24. The total number of LIMDU personnel assigned to an activity will normally not exceed established assignment caps based on the command's total prospective nine months billets authorized (P9BA) manning profile. [Ref (c)]

25. The Prospective 9 Months Billets Authorized Manning Profile (P9BA) assignment cap for a command with P9BA > 500 Sailors is 30%. [Ref (c)]

26. Pregnant/postpartum Sailors will be assigned per SECNAVINST 1000.10B, ref (f), and OPNAVINST 6000.1D, ref (g), and following guidelines in subparagraphs 13b(1) through 13b(4) of OPNAVINST 1300.21. [Ref (c)]

27. Assignment caps for LIMDU personnel (30%) and pregnant/postpartum Sailors (30%) are calculated separately from one another. [Ref (c)]

28. The number of LIMDU Sailors located in a major home port area may exceed the number that may be assigned to those local commands. In such cases, NAVPERSCOM Deployability Assessment and Assignment Branch (PERS-454) may authorize assignment of LIMDU Sailors beyond the established caps at a command with the cognizant Allocation Manager's (NAVPERSCOM) approval. [Ref (c)]

29. Commands are encouraged to use senior LIMDU and pregnant/postpartum Sailors to assist with the management of their LIMDU and pregnant/postpartum Sailor population; however, they must not be assigned as the command's Deployability Coordinator. [Refs (b), (c)]

30. Requests to exempt commands from assignment of LIMDU and pregnant/postpartum Sailors will not normally be approved; however, if a command has a valid justification such as workplace assignment restrictions determined by an industrial hygiene site survey, they may submit a request for exemption to the Allocation Manager (NAVPERSCOM) via respective fleet readiness integrators (FRIs). [Ref (c)]

31. While discussions have been ongoing to reduce the LIMDU/HLPP population(s) at the RMCs, no formal request for exemption has been submitted to the allocation manager via the FRI. [Encl (11)]

32. MARMC tracks the breakdown of Sailors within each of their HLPP accounting categories, which is shown in Figure-2 below, alongside the accompanying assignment caps. [Ref (c); Encls (6), (12)]

	Assignment Code (ACC) or Distribution Navy Enlisted Classification (DNEC)	**P9BA**	**Assignment CAP**	**CAP Number**	**MARMC Population**
LIMDU	ACC 105 (LIMDU/Medically Restricted) +	831	30% of P9BA	249	ACC 105 = 100
	ACC 355 (TEMDU Awaiting Medical Board)				ACC 355 = 100
	Total LIMDU Population				200 **<u>24.0%</u> of P9BA**

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Pregnant & Postpartum	DNEC 0054	831	30% of P9BA	249	213 **25.6% of P9BA**
HUMS	ACC 104 (Reassignment for Humanitarian Reasons)				11
SEPARATING	ACC 380 (Awaiting Separation)				27
ORDERS	ACC 100 (Awaiting Orders)				13
HLPP Total					**464**

Figure-2: MARMC LIMDU, Pregnant/Postpartum, HUMS, Awaiting Separation, and Awaiting Orders Sailor Population (as of 25 Jan 23)

33. Based on data obtained via MyNavy Assignment, MARMC has the largest number of LIMDU/HLPP Sailors assigned across the Budget Submission Office (BSO) 60/US Fleet Forces Command region. MARMC's LIMDU/HLPP population is 45% larger than Fleet Readiness Center Mid-Atlantic (FRCMA) DET Norfolk, which ranks second. [Encl (9)]

34. As a percentage of P9BA, FRCMA is at 28.2% of their LIMDU assignment cap, and 21.3% of their pregnant/postpartum assignment cap. [Encl (9)]

Facts Regarding the Disability Evaluation System (DES)

35. The Disability Evaluation System (DES) is a performance-based review of Service members' medical conditions to determine if a medical condition (or conditions) render a Sailor or Marine unfit to reasonably perform their duties. Most Sailors and Marines are initially referred into the DES for a single wound, illness, or injury. [Encl (13)]

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36. The DES consists of three phases: Medical Evaluation Board (MEB) phase, the Physical Evaluation Board (PEB) phase, and the Service Member Transition phase as shown in figure 3 below. [Encl (14)]

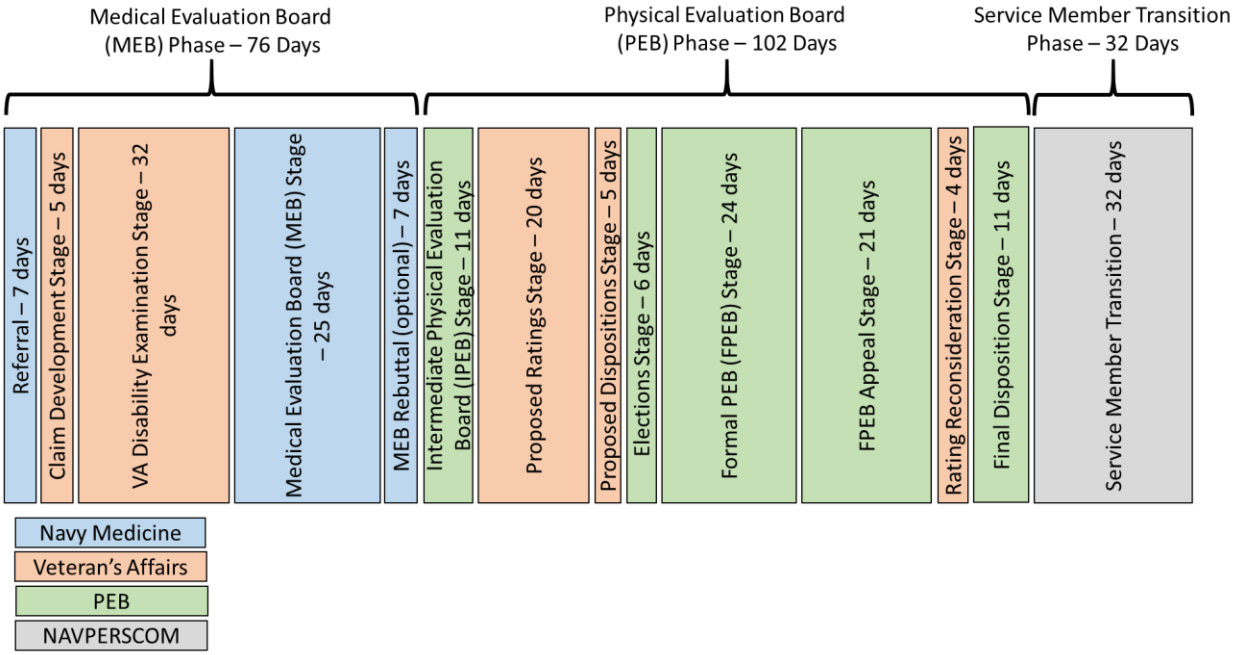

Figure-3: 230 Day Integrated Disability Evaluation System (IDES)

37. The total Integrated Disability Evaluation System (IDES) timeline goal is 230 days. Data presented to the DOD/Veterans Affairs (VA) Joint Executive Committee on 27 Sep 22 reported average Navy IDES timelines of 360 days. [Encls (10), (14)]

38. The Navy Bureau of Medicine and Surgery (BUMED) is responsible for 32 days of the MEB phase of the Integrated DES (IDES) (39 days if MEB rebuttal is chosen by the service member). The average days spent by Service members in the MEB phase owned by BUMED is 56 days. [Encls (10), (14)]

39. The average days spent by Service members in the PEB phase is 183 days. [Encl (10)]

Facts Regarding LIMDU Management

40. Every command and Military Treatment Facility (MTF) must appoint, in writing, a single point of contact to act as the Command Deployability Coordinator. Deployability coordinators must not be in a LIMDU status. [Ref (b)]

41. Close liaison between Deployability Coordinators at tenant commands and MTFs is critical to ensure accurate accounting, tracking, medical treatment, and expeditious movement of LIMDU personnel through the transient pipeline. [Refs (b), (d)]

42. The MTF is required to conduct monthly meetings with tenant Deployability Coordinators to review current cases, discuss potential problems, and analyze existing processes. The MTF has never conducted a meeting to discuss cases or potential problems with MARMC. [Ref (b); Encl (15)]

43. The MPM *encourages* commands with 50 or more LIMDU personnel to appoint a Command Deployability Coordinator as a primary duty and to assign collateral Deployability Coordinators on a 1:50 ratio to assist in the management of LIMDU personnel. [Ref (b)]

44. MPM Article 1300-1400 references MTF's and Command Deployability Coordinators but does not define what the individual's background should be, in contrast to BUMEDINST 6000.19 which stipulates that members with a clinical background are *preferred* in this role. [Refs (b), (h)]

45. MARMC has a Deployability Coordinator, (b) (6), (b) (7)(C) , assigned as his primary duty. While not a requirement, he does not possess a clinical background. [Ref (d); Encls (16), (17)]

46. (b) (6), (b) (7)(C) agreed that, as the single command appointee, he was overwhelmed with the LIMDU/Deployability program at MARMC given the significant number of LIMDU Sailors under his cognizance, the amount of work involved, and the breadth/scope of governing instructions requiring close compliance. [Encl (15)]

47. Applicable policy does not require commands to assign collateral deployability coordinators. Based on this, and a shortage of billeted manpower resources available, MARMC has not assigned any personnel as collateral deployability coordinators. [Encl (15)]

48. In response to MARMC Commanding Officer's (CO) request for HLPP staffing advice and recommendations, and to better understand LIMDU/DES policy requirements, Navy Medicine Fleet Liaison staff met virtually with MARMC Leadership and emailed them recommendations, to include copies of BUMED Instruction 6000.19 (ref (h)) and MILPERSMAN 1300-1400 (ref (b)). [Encl (18)]

49. BUMEDINST 6000.19 applies to all healthcare providers delivering care to Sailors or Marines in MTFs. It does not apply to non-MTFs like MARMC. [Ref (h)]

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Facts Regarding LIMDU Training

50. The MTF is required to provide training to tenant command deployability coordinators. [Ref (b)]

51. Training regarding the Deployability and LIMDU processes, to include accompanying Medical Evaluation Board/Disability Evaluation System (MEB/DES) policies, LIMDU Sailor and Marine Readiness Tracker (SMART) system, roles/responsibilities, etc. is covered in a 195-page Microsoft PowerPoint presentation that was sent to MARMC via Naval Medical Forces Atlantic (NAVMEDLANT). [Encl (18)]

52. Neither [redacted] (MARMC Deployability Coordinator), [redacted] (HLPP Division 1190 Admin Officer), nor the MARMC Command triad (CO/XO/CMC) had received this training as of 30 Dec 22. [Encl (18)]

Facts Regarding LIMDU Sailors at MARMC

53. MARMCINST 1300.1A, Humanitarian Reassignment, Limited Duty, Physical Evaluation Board, Pregnant, and Postpartum Personnel Management and Accountability, is the command's internal policy for the assignment, distribution, utilization, and specific responsibilities of personnel under the cognizance of the HUMS, LIMDU, PEB, and Pregnant/Post-partum (PP) personnel programs. This instruction is under revision. [Encl (19)]

54. MARMC requires all Sailors to conduct a check-in interview with the Command Master Chief (CMC). CMC does not probe into the specifics of why LIMDU Sailors were assigned LIMDU status, unless the member elects to volunteer that information. [Encl (20)]

55. The Deployability Coordinator does not have a recurring engagement scheduled with CMC to discuss potential issues with LIMDU Sailors. CMC is also not briefed on any specific, non-emergent medical issues or concerns related to individual LIMDU cases. [Encl (20)]

56. The MARMC triad does not receive information that details LIMDU Sailors' "issues and limitations." In contrast, the triad does receive documentation for Sexual Assault Prevention and Response (SAPR) cases. For example, when a Sailor that has been identified as the victim of sexual assault is transferred to MARMC, that individual arrives with a Sexual Assault Response Coordinator (SARC) point-of-contact, thorough paperwork/documentation, and other details that provide the command with a complete understanding of the Sailor's needs. [Encl (21)]

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Facts Regarding LIMDU Tracking

57. BUMED implemented the LIMDU SMART system in fiscal year (FY)17 in order to collect, maintain, and track basic demographics, military personnel, and LIMDU-specific medical information for its patient population. [Encl (22)]

58. LIMDU SMART is the definitive source for Navy Medicine's population-level LIMDU patient data. [Encl (22)]

59. The SMART database is designed to include primary diagnostic (Dx) codes, and primary Dx category for every [LIMDU] period. Supporting Dx codes can also be documented. All Dx codes are reported as International Classification of Diseases, Tenth Edition (ICD-10) codes. [Encl (22)]

60. Previous studies to analyze and assess the LIMDU Sailor and Marine population utilizing SMART have exposed a multitude of limitations with respect to raw SMART data. [Encl (22)]

61. For example, a study led by the Association of Military Surgeons of the United States found that the process of checking, correcting, and verifying raw SMART data has proven extremely time-consuming and labor intensive. [Encl (22)]

62. Per the above-referenced study, all consumers of information derived from SMART data (i.e., Command Deployability Coordinators) should be cautioned to critically evaluate the underlying processes used to generate results. Going forward, efforts to improve the accuracy, consistency, and reliability of new data collected by authorized SMART users will increase the system's value and capabilities for Navy Medicine. [Encl (22)]

63. These studies relied on SMART data extracted between 1 Oct 16 and 30 Sep 19. Efforts to optimize and refine the overall quality and fidelity of raw SMART data remain ongoing. [Encl (22)]

64. [redacted] is the only Sailor assigned to MARMC designated as an authorized user with access to the LIMDU SMART database. [Encl (15)]

Facts Regarding Health Insurance Portability and Accountability Act (HIPAA)

65. The DOD defines Personal Health Information (PHI) as: "Individually identifiable health information that is transmitted or maintained by electronic or any other form or medium. PHI excludes individually identifiable health information in employment records held by a DOD covered entity in its role as employer. Information which has been de-identified in accordance with Paragraph 4.5.a is not PHI. PHI is a subset of Personally Identifiable Information (PII), with respect to living persons." [Ref (i)]

66. Generally, PHI of individuals must not be used or disclosed by DOD covered entities or their business associates, except for specifically permitted or required purposes. [Ref (i)]

67. There is an exception to the general prohibition against use or disclosure of PHI for Special Government Functions for Military Personnel when authorized by an appropriate command authority. An appropriate command authority is defined as: "All commanders who exercise authority over an individual who is a Service member, or other person designated by such a commander to receive PHI in order to carry out an activity under the commander's authority." [Ref (i)]

68. There is a presumption against disclosure of PHI to command authorities involving mental health services or substance abuse. [Ref (i)]

69. While there is a presumption against disclosing mental health services or substance abuse PHI, it can be overcome. For example, healthcare providers *shall* notify command authorities about mental health or substance abuse services when the requirements of DODI 6490.08, Command Notification Requirements to Dispel Stigma in Providing Mental Health Care to Service Members. [Ref (j)]

70. PHI may be disclosed for special government functions for military personnel to determine "fitness to perform any particular mission, assignment, order, or duty, including compliance with any actions required as a precondition to performance of such mission, assignment, order, or duty" or "carry out any other activity necessary for the proper execution of the Military Service mission." [Ref (i)]

Facts Regarding Navy Suicide Prevention Policy and Resources

71. The Naval Audit Service recently determined that the Navy, writ large, has failed to fully implement the Suicide Prevention program in accordance with OPNAVINST 1720.4B. [Encl (23)]

72. Based on their assessment of selected commands, the Naval Audit Service determined that Crisis Response Plans had not been fully developed and annual crisis response drills involving Suicide Related Behavior (SRB) had not been conducted in accordance with OPNAVINST 1720.4B. [Encl (23)]

73. MARMCINST 1720.4 is the current command instruction for providing amplifying information to OPNAVINST 1720.4B, Suicide Prevention (ref (k)), tailored to the command for the handling and reporting of high-risk service members involving suicidal ideation, suicidal gesture, suicide attempts, and completed suicides. [Encl (24)]

74. MARMCINST 1720.4, does not contain guidance concerning the reintegration of personnel after demonstrating an SRB, nor does it contain guidance regarding postvention actions to be

taken in the aftermath of a suicide at the command, as directed in section 5.c. of OPNAVINST 1720.4B. [Ref (k); Encl (24)]

75. MARMC had not conducted an annual Suicide Prevention Drill as required by paragraph 6.j.(5) of OPNAVINST 1720.4B, ref (k), over the past three years. [Encl (25)]

76. [redacted] is MARMC's designated Suicide Prevention Coordinator (SPC). [Encl (26)]

77. Per NAVADMIN 201/22, annual Suicide Prevention training *should* be given via face-to-face, small group facilitated discussions, and should include a continuum of messaging, education and awareness throughout the year. [Ref (l)]

78. MARMC conducted the FY22 Department of the Navy (DON)-approved General Military Training (GMT) over the month of August. [Encl (27)]

79. FY22 DON-approved annual GMT pertaining to Suicide Prevention emphasized that "restricting access to lethal means is critical to saving lives." [Encl (28)]

80. FY22 DON-approved annual GMT stated that Commanding Officers and health professionals may ask Sailors, who are believed to be at risk for suicide or causing harm to others, to voluntarily allow their privately-owned firearms to be stored for safekeeping by the command. [Encl (28)]

81. Of the four deceased Sailors, the CI team could only validate that ETSN Armstrong and FC2 Holder had completed the FY22 Suicide Prevention GMT. Records for ET2(SW) Decker and MMFN Autry were removed from all Navy training databases following their deaths. [Encls (29), (30)]

82. As part of their Suicide Prevention program, MARMC has issued more than 300 gunlocks to assigned personnel since they first received the locks in November 2022. Approximately 100 gun locks were issued to MARMC personnel following the death of ETSN Armstrong, in conjunction with the Suicide Prevention Stand-down held between 14-16 Nov 22. To facilitate ease of access for individuals desiring gunlocks, MARMC maintains the gunlocks at locations accessible to all Sailors. [Encls (31), (32)]

83. OPNAVINST 1720.4B requires SPC's to ensure suicide prevention materials, resources, and leadership messages are accessible throughout the command. [Ref (k)]

84. MARMC did not have Suicide Prevention informational materials or resources available in MARMC headquarter building LF-18. [Encl (33)]

85. MARMC production building CEP-200 had Suicide Prevention informational materials and resources available at two bulletin board locations in the main production shop area, however there were no printed materials found in any of the other passageways or common areas contained in that facility. [Encl (34)]

86. MARMC military programs were reviewed as part of a Naval Sea Systems Command (NAVSEA) Inspector General (IG) assessment conducted on or about January 2022. MARMC's Suicide Prevention program was included in the assessment. [Encls (35), (36)]

87. No substantial discrepancies regarding the Suicide Prevention program were noted as part of the IG assessment. [Encls (35), (36)]

88. The Sailor Assistance and Intercept for Life (SAIL) program supplements mental health treatment by providing continuous contact throughout the critical first 90 days following an SRB. It is an intervention strategy that provides rapid assistance, ongoing risk management, care coordination, and reintegration assistance for Sailors identified with an SRB. [Encl (37)]

89. SRBs are actions such as expressed suicidal thoughts, suicide attempts, or other self-injurious behaviors. [Ref (k)]

90. Participation in the SAIL program is voluntary for Sailors that are referred, but Commanding Officers are required to ensure that SPCs refer all Sailors who experienced SRBs to the program. Command referrals are mandatory for Sailors that exhibit suicidal behavior or ideation. The referral is still required in cases where an MTF or Emergency Department determine that a Sailor is not a danger to self or others. [Encl (37)]

91. No criteria need to be met regarding the severity of a recent ideation or attempt in order to be eligible for SAIL services. Even if a Sailor declines outpatient treatment at an MTF, they may still obtain SAIL services. [Encl (37)]

92. Two of the four Sailors, ETSN Armstrong and FC2 Holder, despite experiencing SRBs, were not referred to the SAIL program. [Encls (38), (39), (40), (41)]

93. SAIL referrals were not made in either of the above cases due to a lack of clarity regarding the definition of an SRB. [Encls (38), (39), (40), (41)]

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Facts Regarding the Command Indoctrination (INDOC) Program

94. MARMCINST 1720.2C, Indoctrination Program (INDOC) provides newly reported personnel information regarding MARMC's mission, organizational structure, policy and routines. [Encl (42)]

95. MARMC conducts INDOC every two weeks. [Encl (43)]

96. MARMCINST 1720.2C did not list specific topics to be covered during INDOC, but did include, as Enclosure (1), a Program Critique form which contained three pages of presentation topics. Suicide prevention was not listed. [Encl (42)]

97. OPNAVINST 1740.3E, Command Sponsor and Indoctrination Program, does not list Suicide Prevention as a required topic for Command INDOC. [Ref (m)]

Facts Regarding Mental Health and Resiliency Resources Available at MARMC

98. MARMC is not billeted for a dedicated Navy Chaplain or embedded mental health support. [Encl (44)]

99. In response to these tragic events, interim Chaplain support and mental health counseling was implemented at MARMC in Building LF-18 beginning on 29 Nov 22 (Chaplain) and 30 Nov 22 (mental health counseling). [Encl (44)]

100. On-site mental health counseling has been available to MARMC Sailors and civilians on Mondays, Wednesdays, and Fridays (half-days) since 30 Nov 22. [Encl (44)]

101. A local Navy Chaplain was sourced via the Chaplains Religious Enrichment Development Operation (CREDO) and has provided counseling support to MARMC Sailors and civilians on Tuesdays and Thursdays (all-day). The Chaplain has also been made available to MARMC Sailors on a by-appointment basis via the CREDO or his personal cell phone. [Encl (44)]

102. MARMC has subsequently arranged for permanent, full-time mental health support utilizing the DOD Magellan Health System contract. A dedicated Military Family Life Counselor (MFLC) checked-in to MARMC on 11 Jan 22. [Encl (44)]

103. While neither the CREDO nor MARMC have identified an end-date with respect to interim Chaplain support, there is currently no plan in place regarding how to preserve this support long-term at MARMC. [Encl (44)]

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Facts Regarding MARMC Defense Equal Opportunity Climate Survey (DEOCS)

104. According to the Defense Equal Opportunity Management Institute (DEOMI), the DEOCS is an effective management tool that enables commanders to proactively assess critical organizational climate dimensions that can have an impact on effectiveness within the organization. It also provides them valuable information regarding individual members' perceptions of the organization's climate. [Encl (45)]

105. MARMC conducted a DEOCS in 2021. Despite a low overall response rate (16%), there were no findings in the survey to indicate the existence of a toxic command climate. [Encl (46)]

106. MARMC also conducted a DEOCS in 2022. The Survey was administered between 20 Sep 2022 and 11 Oct 2022. [Encl (47)]

107. The overall response rate to MARMC's 2022 DEOCS was 36% (62% Civilian employee response, and 18% Military employee response). [Encl (47)]

108. Higher Favorability Ratings were recorded for the following protective factors, which are associated with positive outcomes for organizations or units:

- Supportive Leadership/Ratings for all Immediate Supervisors: 81%
- High Connectedness: 79%
- Cohesive Organization: 74%
- Work-Life Balance: 74%
- Engaged and Committed: 71%

[Encl (47)]

109. DEOCS states that higher Favorability Ratings on these protective factors are linked to higher retention, improved readiness, and a lower likelihood of suicide. [Encl (47)]

110. Lower Unfavourability Ratings were recorded for the following factors. Higher unfavorable ratings on these factors are linked to a greater likelihood of negative outcomes for organizations or units:

- Frequent Workplace Hostility: 23%
- Toxic Leadership/Ratings for all Immediate Supervisors: 8%
- Toxic Leadership/Ratings for Senior NCO/SEL: 6%
- Passive Leadership/Ratings for Unit Leader: 3%

[Encl (47)]

111. One protective factor surveyed via the 2022 DEOCS measured respondents' attitudes, beliefs, and behaviors related to "Lethal Means Usually Safely Stored." This factor received a Favorable Rating of 58%. [Encl (47)]

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Facts Regarding the Comparison with Southwest Regional Maintenance Center (SWRMC)

112. SWRMC reported similar challenges with respect to LIMDU/HLPP resources and their assessment that existing manpower was inadequate to provide effective management, administration, and oversight of LIMDU/HLPP Sailors under its cognizance. [Encls (48), (49)]

113. MARMC and SWRMC have different organizational constructs, policies, and processes in place governing the management, administration, and oversight of their respective HLPP Sailor populations. [Encls (48), (49)]

114. SWRMC's LIMDU/HLPP Sailor population and assignment caps closely approximated MARMC's based on P9BA. [Encls (48), (49)]

115. SWRMC's appointed Deployability Coordinator is a civilian employee, which satisfies the requirement set forth in the governing instruction. [Ref (c); Encl (48)]

116. SWRMC is not billeted for dedicated Navy Chaplain or embedded mental health counseling support. These services are currently not available at SWRMC on an interim or full-time basis. [Encl (50)]

117. SWRMC conducted a DEOCS in 2022. The Survey was administered between 16 May 2022 and 20 Jun 2022. Overall, the results appeared similar to those reported in MARMC's 2022 DEOCS. One exception was that SWRMC reported a higher overall participation rate (58%) than MARMC (36%). [Encl (51)]

118. At the command's discretion, and as allowed by DEOMI, SWRMC chose to break out their DEOCS response rates by Code/Shop, as opposed to Civilian/Military. [Encl (51)]

119. Higher Favorability Ratings were recorded for the following protective factors:
- Supportive Leadership/Ratings for all Immediate Supervisors: 79%
- Cohesive Organization: 77%
- High Connectedness: 76%
- Work-Life Balance: 75%
- Engaged and Committed: 71% [Encl (51)]

120. Lower Unfavourability Ratings were recorded for the following factors:
- Frequent Workplace Hostility: 20%
- Toxic Leadership/Ratings for all Immediate Supervisors: 10%
- Toxic Leadership/Ratings for Senior NCO/SEL: 3%
- Passive Leadership/Ratings for Unit Leader: 3% [Encl (51)]

121. One protective factor surveyed via the 2022 DEOCS measured respondents' attitudes, beliefs, and behaviors related to "Lethal Means Usually Safely Stored." This factor received a Favorable Rating of 54%. [Encl (51)]

Facts Regarding Additional Concerns

122. Family members of the deceased Sailors have indicated via interviews conducted by the NCIS Norfolk, VA Field Office and local media that their service member(s) were the target of hazing behaviors and unfair treatment at MARMC. [Encls (52) - (55)]

123. The CI Team probed into these concerns via interviews conducted with various Command members (peers/supervisors) who worked in HLPP code 1190, the code 953/2M (Micro-Miniature) Repair Shop, and code 1170 Training Department and was unable to uncover any evidence corroborating these statements. [Encls (56) - (66)]

Facts Regarding ET2(SW) Kody L. Decker, USN

124. ET2(SW) Kody L. Decker, USN was a 22-year-old male at the time of his death. [Encl (67)]

125. ET2(SW) Decker enlisted in the Navy on 10 Sep 18 for six years. [Encl (67)]

126. ET2(SW) Decker's End of Active Obligated Service (EAOS) was 9 Sep 24. [Encl (67)]

127. After completing Electronics Technician (ET) "A" School, he reported to USS BATAAN (LHD 5) in Norfolk, VA on 7 Dec 19 and was assigned to Combat Electronics (CE) division as a Communications Technician. [Encl (68)]

128. The last performance evaluation ET2(SW) Decker signed on 22 Jun 22 contained an "Early Promote" (EP) recommendation, with the following comments: "MY NUMBER 2 OF 11 THIRD CLASS PETTY OFFICERS!!!", "OUTSTANDING PROFESSIONAL KNOWLEDGE, QUALITY OF WORK, AND PERSONAL INITIATIVE," and "ALREADY OPERATING AS A SECOND CLASS, HE HAS MY HIGHEST RECOMMENDATION FOR ET2!". [Encl (69)]

129. ET2(SW) Decker was well-liked on LHD 5, and colleagues/shipmates noted his outgoing personality and technical skills. [Encls (70) - (74)]

130. The environment onboard LHD 5 was characterized as "mission first," and personnel from LHD 5 described the command as high OPTEMPTO, even when the ship was in-port, with no time off. [Encls (70) - (74)]

131. ET2(SW) Decker married (b) (6), (b) (7)(C) (b) (7)(C), (b) (6) [Encl (75)]

132. On 1 Aug 22, ET2(SW) Decker requested a referral to seek mental health (MH) therapy from the LHD 5 Medical Department due to work stressors that had accumulated over the past several months. He denied any suicidal ideation or intent. [Ref (n)]

133. The LHD 5 Medical Officer planned to enter a referral for a MH network appointment on behalf of ET2(SW) Decker. [Ref (n)]

134. ET2(SW) Decker drove himself to the Naval Medical Center Portsmouth (NMCP) Emergency Room (ER) on 10 Aug 22 for MH concerns. ET2(SW) Decker called a shipmate, (b) (6), (b) (7)(C), on his way to the hospital. (b) (6), (b) (7)(C) met him at NMCP and he sat with ET2(SW) Decker in the ER until ET2(SW) Decker was admitted. [Ref (n); Encls (71), (74)]

135. On 11 Aug 22, ET2(SW) Decker agreed to be admitted to NMCP for in-patient mental health evaluation based on suicidal ideations and maladaptive coping through alcohol. He stated that he had experienced suicidal ideations for the past two months due to workplace stressors, and he used alcohol as a coping mechanism. ET2(SW) Decker stated that he was worried that his suicidal ideations might progress into actions in the future. He also admitted to keeping a loaded firearm at his bedside for protection and was resistant to having his personal firearms secured. [Ref (n)]

136. ET2(SW) Decker completed five days of inpatient treatment at NMCP, during which he participated in five group therapy sessions and created a safety plan. During one of his group therapy sessions, he stated that he had been thinking that he wanted to get out of the military. His plan, post-Navy, was to become a contract electrician. During his stay, ET2(SW) Decker had no further suicidal ideations or indications of alcohol withdrawal. He also declined psychotropic medications during his inpatient treatment. [Ref (n)]

137. ET2(SW) Decker's safety plan included three main tenets that he needed to codify: 1) people whom he could reach out to for help in a crisis, 2) people or places that he deemed safe, and 3) steps he could actively take to make his home and his life safe. He identified his wife and his mother as the individuals that he would turn to for help in a crisis. [Ref (n)]

138. Upon discharge from NMCP on 15 Aug 22, ET2(SW) Decker was denied access to personally owned firearms or other weapons/methods of self-harm, as confirmed by his spouse. [Ref (n)]

139. ET2(SW) Decker's treatment plan upon discharge involved being placed on Temporary Limited Duty (TLD) (ACC 105) for continued outpatient treatment, with intent to return to medically unrestricted service. [Ref (n)]

140. ET2(SW) Decker was officially placed on TLD on 15 Aug 22, based on Adjustment Disorder with Depressed Mood (IDC-10 code F4321) and Alcohol Abuse with Alcohol-induced Mood Disorder, which requires follow-up Substance Abuse Response and Prevention (SARP) screening. [Ref (n)]

141. ET2(SW) Decker's NMCP discharge orders stated he would be referred to the Sailor Assistance and Interception for Life (SAIL) program. [Ref (n)]

142. On 16 Aug 22, ET2(SW) Decker was referred to the SAIL program but declined program services the next day. [Encl (39)]

143. The Columbia Suicide Severity Rating Scale (C-SSRS) is a well validated screening measure for suicidal ideation/attempt risk in both active duty and veteran populations. The C-SSRS ranges from 0 (no suicidal ideation present) to 5 (active suicidal ideation with specific plan and intent). [Ref (n)]

144. The C-SSRS rating was annotated in ET2(SW) Decker's medical record each time he had an outpatient mental health care encounter or a Psychiatric Continuity and Transition (PCaT) phone call. [Ref (n)]

145. ET2(SW) Decker had two Bridging Group sessions in August at the NMCP Adult Mental Health Clinic. He indicated no suicidal ideations at either Bridging Group session. His evaluated C-SSRS was 0 at both encounters. [Ref (n)]

146. ET2(SW) Decker reported to MARMC in a TLD status on 31 Aug 22. [Encl (76)]

147. ET2(SW) Decker was assigned to Code 1190 (HLPP division) for initial check-in, INDOC, and "coding" (i.e., work center placement). [Encls (76) - (78)]

148. ET2(SW) Decker's NMCP discharge orders required him to report to the MARMC Drug and Alcohol Program Advisor (DAPA) for further evaluation, and to schedule Substance Abuse Response and Prevention (SARP) treatment as indicated. [Ref (n)]

149. ET2(SW) Decker did not report to the MARMC DAPA and thus was not reflected in the Alcohol Drug Management Information System (ADMITS). [Encl (79)]

150. No coworkers interviewed by the CI Team had smelled alcohol, or noted any alcohol-related performance issues, with respect to ET2(SW) Decker during the two months prior to his departure from LHD 5. [Encls (71), (72), (73)]

151. ET2(SW) Decker's outpatient treatment plan included assignment to the NMCP Psychiatric Continuity and Transition (PCaT) unit. The NMCP PCaT unit provides virtual patient encounters during the LIMDU period in order to ensure that service members are connected with necessary resources and have a complete understanding of their upcoming appointment schedule. [Ref (n)]

152. ET2(SW) Decker had three PCaT encounters (phone calls) between August and October 2022 to discuss his MH status, his upcoming appointments, and any need for additional resources. He indicated no suicidal ideations during any of his PCaT sessions. His evaluated C-SSRS was 0 for all three sessions. [Ref (n)]

153. ET2(SW) Decker had five individual therapy sessions with the same therapist every two weeks beginning in early September 2022. [Ref (n)]

154. During his 20 Sep 22 therapy session, ET2(SW) Decker stated to his therapist that he believed he would function better if he were discharged from the military. ET2(SW) Decker agreed to pursue a Condition not a Disability (CnD) letter in preparation for a referral to administrative separation (ADSEP). [Ref (n)]

155. On 21 Sep 22, the therapist conducted a review of ET2(SW) Decker's medical record and drafted the CnD letter in preparation for the referral to ADSEP. [Ref (n)]

156. CnD ADSEP is governed by MILPERSMAN (MPM) Article 1900-120 and pertains to Sailors with a medical condition that poses interference with their performance of duty, but not specifically listed as a compensable disability under the veteran affairs (VA) schedule for disabilities. In accordance with MPM Article 1900-120, a service member may be eligible for separation due to conditions not amounting to a disability. [Ref (o)]

157. ET2(SW) Decker's third (4 Oct 22) and fourth (11 Oct 22) individual therapy sessions focused on his current psychological functioning, problem-solving, any acute issues, and encouraged active, adaptive coping skills. Again, his evaluated C-SSRSs were 0. During both therapy sessions, ET2(SW) Decker continued to state that his psychological condition would deteriorate if he were to return to a ship. [Ref (n)]

158. ET2(SW) Decker took routine personal leave from 4 Oct 22 to 17 Oct 22. [Encl (80)]

159. By mid-October 2022, ET2(SW) Decker was in the process of being assigned to the Navy Marine Corps Relief Society by MARMC HLPP division leadership, which was considered an

independent duty assignment, due to his outgoing personality, infectious attitude, and strong communication skills. [Encl (81)]

160. MARMC assigns LIMDU/HLPP Sailors to various codes within MARMC, and also to several non-MARMC entities within close geographic proximity to the command. [Encl (15)]

161. On 26 Oct 22, ET2(SW) Decker had a phone interview with the PCaT unit and reported no suicidal ideations. [Ref (n)]

162. ET2(SW) Decker's fifth (and final) individual therapy session occurred on 27 Oct 22. He repeated his concern that a return to his ship would be detrimental to his psychological functioning. His evaluated C-SSRS was 0. He continued to state strong protective factors in the form(s) of his family, his spouse, and his eight-month-old son. [Ref (n)]

163. During every in-person therapy session and PCaT unit phone call, ET2(SW) Decker "agreed to contact the NMCP Psychiatry Clinic at 953-5269, the nearest ER, or call 911 should suicidal ideations occur, prior to acting on them." [Ref (n)]

164. ET2(SW) Decker was also instructed "that if his condition should worsen, or should he become actively suicidal or homicidal, to contact the nearest ER, 911, the Psychiatry clinic at 953-5269, Ward 5F at 953-4917, the National Suicide Crisis Hotline at 1-800-SUICIDE or Military One Source at 1-800-342-9647." [Ref (n)]

165. ET2(SW) Decker's spouse stated that he was acting like himself in the two days leading up to his death. [Encl (53)]

(b) (6) [redacted]

167. (b) (6) stated that ET2(SW) Decker had sent her a text message at 1800 (EST). At 1815 (b) (6) called 911. At the time of the call, (b) (6) was driving in her personally owned vehicle, actively searching for her husband. [Encls (82), (83)]

168. Virginia Beach Police Department (VBPD) pinged ET2(SW) Decker's cell phone and located him in the Kroger grocery store parking lot at 3901 Holland Road, Virginia Beach, VA. VBPD found ET2(SW) Decker in the driver's seat of his vehicle with a suspected gunshot wound to the left side of his head. A firearm was found in his left hand. [Encl (83)]

169. ET2(SW) Decker was pronounced deceased at 1952 (EST). [Encl (83)]

170. (b) (6) [Encl (83)]

171. ET2(SW) Decker was posthumously advanced to ET2 effective 29 Oct 22. [Encl (84)]

Facts Regarding ETSN Cameron E. Armstrong, USN

172. ETSN Cameron E. Armstrong, USN was a 22-year-old male at the time of his death. [Encl (85)]

173. ETSN Armstrong enlisted in the Navy on 14 Jun 18 for six years. [Encl (85)]

174. ETSN Armstrong's End of Active Obligated Service (EAOS) was 13 Jun 24. [Encl (85)]

175. Prior to his death, ETSN Armstrong lived in a private residence in Norfolk, Virginia. (b) (6) until approximately 6 weeks prior to his death. [Ref (p)]

176. ETSN Armstrong owned personal firearms and stored them at his residence. [Encl (86)]

177. ETSN Armstrong was described as a quiet individual who tended to "keep to himself". He would often sit in the corner of the Micro Miniature (2M) shop with headphones on while working. If there wasn't much work to do, he would sometimes sit with headphones on and watch "anime videos". Though quiet, he would sometimes participate in shop conversations and did share some personal information with some of the other Sailors in the shop from time to time, specifically, stories of his childhood influences and his admiration for his spouse. [Encls (56), (57)]

178. ETSN Armstrong did not have any social interactions outside of work with anyone within the 2M shop. [Encls (56) - (59)]

179. ETSN Armstrong graduated boot camp on 17 Aug 18; he was reported as weighing (b) (6), (b) pounds two weeks prior to graduating. [Ref (p); Encl (87)]

180. Following boot camp, ETSN Armstrong began to rapidly gain weight. Six months after boot camp graduation, he had gained (b) (6), (b) (7)(C). Approximately a year after boot camp graduation, he had gained a total of (b) (6), (b) (7)(C). Three months prior to his death, he was approximately (b) (6), (b) (7)(C) heavier than he was at boot camp graduation. [Ref (p)]

181. ETSN Armstrong only passed the 2018-2 Physical Fitness Assessment (PFA) during his nearly 4.5 years of active service. Every required PFA after 2018 was documented as a failure. [Encls (88) - (91)]

182. On 19 Feb 19, while attached to Center for Surface Combat Systems (CSCS) Unit in Great Lakes, IL, ETSN Armstrong reported to a Military Treatment Facility (MTF) seeking medical clearance to allow participation in the physical readiness test (PRT). During the visit, ETSN Armstrong was counseled on weight loss, healthy eating, sleep and exercise and diagnosed with unspecified obesity. He was also provided a consult for a dietician. [Ref (p)]

183. On 1 Mar 19, ETSN Armstrong participated in a nutrition consultation. He was counseled on proper nutrition, exercise, and educated on a pathway for weight loss. He was directed to schedule a follow-up appointment for continued tracking of progress. No evidence was discovered to show that he scheduled a follow-up appointment. [Ref (p)]

184. On 18 Mar 19, ETSN Armstrong reported to an MTF with knee pain across both knees. [Ref (p)]

185. On 3 May 19, ETSN Armstrong married (b) (6), (b) (7)(C) (previously (b) (6), (b) (7)(C)). [Encl (92)]

186. On 9 Jul 19, ETSN Armstrong reported to an MTF with complaints of chronic pain in both knees for three months following a fall that occurred during physical training. [Ref (p)]

187. On 12 Sep 19, ETSN Armstrong reported to an MTF for continued knee pain, as well as morbid obesity and other developed comorbidities associated with his morbid obesity. He was also scheduled for a nutritional consultation as one had not occurred since the first one in March 2019. [Ref (p)]

188. On 20 Sep 19, ETSN Armstrong reported to an MTF for his follow-up nutritional consultation. The provider noted that all the goals from the previous encounter in March were only partially met. Between nutritional consults, ETSN Armstrong gained an additional (b) (6) and BMI increased five points. He was directed to schedule a follow-up appointment to continue nutritional counseling and management. No evidence was discovered to show that he scheduled a follow-up appointment. [Ref (p)]

189. On 23 Sep 19, ETSN Armstrong reported to an MTF for a consultation with an orthopedic surgeon due to his knee pain. The surgeon treated the knee pain with corticosteroid injection and advised against surgery due to ETSN Armstrong's weight and recommended that he continue with physical therapy. [Ref (p)]

Subj: COMMAND INVESTIGATION INTO CAUSAL OR CONTRIBUTING FACTORS IN THE FOUR SAILOR DEATHS WITHIN 28 DAYS AT MID-ATLANTIC REGIONAL MAINTENANCE CENTER

190. On 2 Oct 19, ETSN Armstrong was placed on Temporary Limited Duty (TLD) due to his continued knee pain without resolution. [Ref (p)]

191. Navy Personnel Command (NAVPERSCOM) is required to ensure that enlisted service members assigned to shore duty in a TLD status remain at their current shore duty station(s). No PCS (permanent change of station) orders are authorized. [Ref (b)]

192. On 20 Oct 19, ETSN Armstrong received PCS orders to MARMC Norfolk, VA with a report no later than date of 12 Nov 19; "FOR DUTY – LIMITED DUTY, ACC-105". [Encl (93)]

193. On 12 Nov 19, ETSN Armstrong reported to MARMC, Norfolk, VA for duty. [Encl (88)]

194. On 05 Dec 19, ETSN Armstrong reported to Naval Medical Center Portsmouth (NMCP) for a "PRT Waiver Renewal" and received a PRT waiver after being found unfit to participate. However, he was cleared to participate in command physical training at his own pace. He also received a referral to a nutritionist. [Encl (94)]

195. The PRT waiver received indicated that it was the second waiver for PRT that ETSN Armstrong received in 2019. [Encl (94)]

196. Individuals who receive a Body Composition Assessment (BCA) or PRT medical waiver for two consecutive PFA cycles or three waivers in the most recent 4-year period must be referred to an MTF for a Medical Evaluation Board (MEB). The MEB findings must be referred to NAVPERSCOM (PERS-454) for disposition. [Encl (95)]

197. A MEB referral was not initiated following ETSN Armstrong's second consecutive PRT medical waiver. [Ref (p)]

198. Though waived from participation in the PRT portion of the PFA, ETSN Armstrong was still required to participate in the BCA. [Encl (94)]

199. ETSN Armstrong was not assigned to MARMC's Fitness Enhancement Program (FEP) following his 2019-2 PFA failure. [Encls (96) - (98)]

200. On 3 Dec 19, ETSN Armstrong participated in a pre-diabetes nutrition class at NMCP. [Ref (p)]

201. On 18 Dec 19, ETSN Armstrong reported to NMCP for a follow-up for his knee pain. During the visit, his knee-pain was classified as resolved. His provider told ETSN Armstrong that he may "ride out this LIMDU period or return to full duty if he would like." His provider noted in the record, "If pain returns and LIMDU expires, I would recommend PEB for a condition not rating a disability." [Ref (p)]

202. During the same visit, ETSN Armstrong was referred to endocrinology and a full metabolic workup was ordered to understand any additional causal factors for his morbid obesity. [Ref (p)]

203. On 19 Dec 19, ETSN Armstrong reported to NMCP for a follow-up from a previous appointment to review his sleeping habits and assist him in gaining more productive sleep. During a previous visit, he was instructed to document his sleep habits and to get certain labs completed prior to arrival. He failed to bring those required materials to this appointment and he did not complete his labs. [Ref (p)]

204. ETSN Armstrong did report that he was feeling anxiety over going home to Florida because of the weight he had gained. He also reported financial stress. ETSN Armstrong stated that he "stress eats and worries frequently." ETSN Armstrong was administered the Physical Health Questionnaire 9 (PHQ-9) test as well as the General Anxiety Disorder 7 (GAD-7) test. He scored a 10 (moderate depression) on the PHQ-9 test and a 12 (moderate anxiety) on the GAD-7 test. [Ref (p)]

205. PHQ-9 is a series of questions designed as a quick depression test. [Encl (99)]

206. PHQ-9 scores are labeled with a description of "Depression Severity" and coupled with "Proposed Treatment Actions" as listed in figure 4. [Encl (100)]

PHQ-9 Score	*Depression Severity*	*Proposed Treatment Action*
0-4	None-Minimal	None
5-9	Mild	Watchful waiting; Repeat PHQ-9 at follow-up
10-14	Moderate	Treatment Plan, consider counseling, follow-up and/or pharmacotherapy
15-19	Moderately Severe	Active treatment with pharmacotherapy and/or psychotherapy
20-27	Severe	Immediate initiation of pharmacotherapy and, if severe impairment with poor response to therapy, expedited referral to a mental health specialist for psychotherapy and/or collaborative management

Figure-4: PHQ-9 Scores and Proposed Treatment Actions

207. The GAD-7 is a brief exam to measure the presence of general anxiety. [Encl (101)]

208. GAD-7 scores are labeled with a description of "Anxiety Severity" and described in figure 5. [Encl (102)]

GAD-7 Score	*Anxiety Severity*
0-4	Minimal Anxiety
5-9	Mild Anxiety
10-14	Moderate Anxiety
15-21	Severe Anxiety

Figure-5: GAD-7 Scores

209. On 19 Dec 19, ETSN Armstrong was referred to the Mental Health Department and stated he desired a Case Manager (CM) to aid in obtaining appointments. [Ref (p)]

210. On 23 Jan 20, ETSN Armstrong reported to NMCP for a consult with an endocrinologist to determine if there was a potential hormonal connection behind his weight gain. While numerous comorbidities were realized through the workups, including hypertension, hyperlipidemia, and pre-diabetes, the endocrinologist determined that there was no hormonal connection to his weight gain. ETSN Armstrong was diagnosed with morbid obesity due to excessive calorie consumption. He discussed with the provider that he had lost a significant amount of weight during his senior year of high school, going from greater than (b) (6) pounds to (b) (6) pounds in order to join the Navy. [Ref (p)]

211. Medical research shows an extremely high likelihood of returning to previous weight for people who have lost substantial weight. [Encls (103), (104)]

212. ETSN Armstrong stated that he believed his weight gain was due to a sedentary lifestyle and a bad diet. The provider discussed bariatric surgery as the most impactful intervention for his weight gain but acknowledged that bariatric surgery was not authorized for active-duty service members. The provider noted, regarding endocrinology, that ETSN Armstrong was fit for full duty. [Ref (p)]

213. On 25 Feb 20, ETSN Armstrong reported to NMCP for an initial Mental Health (MH) screening related to "…moderate symptoms of anxiety and depression due to weight gained physical health issues. Patient would like to learn new coping skills." ETSN Armstrong reported that he would have Suicidal Ideation (SI) thoughts when he was feeling overwhelmed. He was assessed as a low risk for suicide. He denied any history of self-harm or suicide attempts. He was referred to the network for therapy (out-in-town therapist) and scheduled for a follow-up on 30 Jun 20. ETSN Armstrong has now been morbidly obese for greater than 12 consecutive months and should have been evaluated for DES or administrative separation. [Refs (p), (q)]

214. On 25 Feb 20, the Office of Under Secretary of Defense for Personnel and Readiness issued Force Health Protection (Supplement 2) which directed Commanders to maximize the proportion of the workforce that can perform their duties via telework. [Encl (105)]

215. On or about March 2020, ETSN Armstrong was directed by MARMC to stay home based on being categorized as high-risk for COVID-19 infection due to comorbidities tied to morbid obesity. He was initially directed to muster via phone call on each workday. [Ref (p)]

216. On 18 Mar 20, PFA Cycle 2020-1 was suspended, excusing all personnel from participation in the PFA, as part of the Chief of Naval Operations (OPNAV's) response to the COVID-19 pandemic. [Ref (r)]

217. On 20 Apr 20, ETSN Armstrong's LIMDU period ended. From his telephonic consult on the same day, "patient [ETSN Armstrong] was previously seeing Endo [Endocrinologist] and his January note says the member can return to full duty after having a full evaluation for underlying endocrine conditions and that was all negative. Patient understands that I will be putting him back to Full Duty today." [Ref (p)]

218. On 14 May 20, during a telephonic follow-up with his Case Manager, it is noted that ETSN Armstrong had been receiving network MH care out in town. [Ref (p)]

219. On 11 Jun 20, ETSN Armstrong received PCS orders to detach MARMC in July 2020 and report to the USS WASP (LHD 1) no later than 13 Jul 20. [Encl (106)]

220. On or about 26 Jun 20, MARMC leadership directed ETSN Armstrong to begin "drive-in musters." Those Sailors considered high-risk for COVID-19 infection were required to drive to a muster point near MARMC in order to conduct in-person musters each workday. [Encl (107), (108)]

221. On 30 Jun 20, during his scheduled follow-up from his initial MH screening of 25 Feb 20, ETSN Armstrong reported that he had not obtained care from an off-base provider due to COVID and that, "it just ended up not happening." He also reported that he was feeling better and did not want to continue mental health care. He answered "no" to all questions pertaining to Suicidal Ideation definitions and prompts during the encounter. [Ref (p)]

222. On 7 Jul 20, PFA Cycle 2020-2 was suspended, excusing all personnel from participation in the PFA, as part of OPNAV's response to the COVID-19 pandemic. [Ref (s)]

223. On 16 Jul 20, ETSN Armstrong began his Sea Duty Screening in order to report to the USS WASP (LHD 1). [Ref (p)]

224. On 10 Sep 20, ETSN Armstrong was found unfit for sea duty due to his (then) current medical condition(s) ICD 10 CM Codes: I10 (Essential [Primary] Hypertension [High Blood Pressure]), E78.2 (Mixed Hyperlipidemia [High Cholesterol]), E66.07 (Obesity Due to Excess Calories), R73.03 (Prediabetes), R06.83 (Snoring), S83.207D (Unspecified Tear of Unspecified Meniscus, Current Injury, Unspecified Knee, Subsequent Encounter), F43.22 (Adjustment Disorder with Anxiety) and WASP's inability to sustain medical care. [Encl (109)]

225. When an enlisted Sailor fails a sea duty screening, the transferring command is required to notify NAVPERSCOM (PERS-40BB). The message must contain a recommended plan from the servicing MTF, such as LIMDU or PEB, and NAVPERSCOM will then recommend if Sailor is a fit for continued service. [Ref (t)]

226. Following the 10 Sep 20 failed sea duty screening, MARMC did not notify NAVPERSCOM of ETSN Armstrong's unsuitability screening. [Encl (110)]

227. On 29 Oct 20, ETSN Armstrong reported to NMCP for a scheduled appointment. A consult request was entered for a sleep study review and a nutritionist. He scored a 16 on the PHQ-9 test (moderately severe depression) and a 14 on the GAD-7 test (Moderate Anxiety). [Ref (p)]

228. On 16 Mar 21, ETSN Armstrong conducted a virtual Physical Health Assessment (PHA) (electronic PHA (ePHA) and telephonic follow-up). During the consultation, ETSN Armstrong reported a Suicide Ideation (SI) in 2020 but stated he had none since then. He scored a 15 on the PHQ-9 test (Moderately Severe Depression) and told the provider that he had been trying to get an appointment with MH and that he needed to talk to someone. [Ref (p)]

229. On 22 Mar 21, ETSN Armstrong conducted a virtual (telephonic) consultation with NMCP Mental Health. He told his provider that the military was a major stressor to him, that he wanted to get out of the Navy, and that he often does not want to get out of bed. The provider stated that further evaluation was necessary to determine suitability for continued military service. [Ref (p)]

230. On 31 Mar 21, ETSN Armstrong conducted a follow-up from the previous mental health consult. Clinician notes state that ETSN Armstrong's, "onset of depressive symptoms and anxiety is associated with adjusting to military service and feeling ashamed and ridiculed after he began gaining weight after experiencing knee pain." ETSN Armstrong told the provider that the "Navy is holding his life back" and reported that he continues to only phone muster for work because of COVID. The provider noted that, "prognosis for treatment through the network and continued service are poor based on distrust of the Navy and non-compliance with treatment." During that same visit the provider noted previous sleep study findings and that ETSN Armstrong had yet to follow-up. [Ref (p)]

231. On 20 Apr 21, ETSN Armstrong reported to NMCP and participated in his first scheduled therapy session with a Licensed Clinical Social Worker (therapist). The therapist's diagnosis was documented as "adjustment disorder with mixed anxiety and depressed mood." ETSN Armstrong was prescribed an anti-depressant medication. [Ref (p)]

232. On 21 Apr 21, during a telephonic medical consultation, ETSN Armstrong scored 19 on the PHQ-9 test (Moderately Severe Depression) and a 17 on the GAD-7 test (Severe Anxiety). [Ref (p)]

233. On 29 Apr 21, ETSN Armstrong participated in a telephonic consultation with, and was introduced to a Behavioral Health Care Facilitator (BHCF). The BHCF explained that there would be monthly follow-ups while ETSN Armstrong was undergoing mental health treatment. [Ref (p)]

234. A BHCF provides services that reinforce, encourage, check, and support the patient's adherence to the Primary Care Manager's (PCM's) treatment plan. [Ref (u)]

235. On 17 May 21, ETSN Armstrong participated in a scheduled virtual appointment with his mental health therapist. ETSN Armstrong's second appointment with his therapist, held on 17 May 21, was noted in his medical record as his third appointment. Every therapist appointment afterwards continued the misnumbering. He discussed feelings of anxiety associated with work. Specifically, he had recently begun coming to work in-person, and he discussed how he would sit in his car each morning to work up the courage to enter MARMC. His therapist noted that they discussed voluntary administrative separation (ADSEP) as an option. [Ref (p)]

236. On 20 May 21, ETSN Armstrong participated in a telephonic BHCF consultation. During the consultation, he discussed in more detail the previously reported SI from 2020. ETSN Armstrong stated that the SI that occurred in 2020 involved a firearm. When the BHCF suggested removing his personally owned firearms from his house, he said that he wasn't interested in doing that. ETSN Armstrong scored a 16 on the PHQ-9 test (Moderately Severe Depression) and an 18 on the GAD-7 test (Severe Anxiety). [Ref (p)]

237. On 26 May 21, ETSN Armstrong reported to NMCP for a follow-up as part of his ongoing MH treatment. During that visit ETSN Armstrong was prescribed medication to help with his anxiety and his anti-depressant medication dosage was increased. [Ref (p)]

238. On 2 Jun 21, ETSN Armstrong reported to NMCP for a scheduled appointment with his MH therapist. He reported that he felt that his depression and anxiety were improving. ETSN Armstrong stated that he and his wife had a system whereby she would take his guns and lock them up if he were experiencing suicidal thoughts. [Ref (p)]

239. The provider's notes associated with his 3 Jun 21 visit read as follows: "20 y/o AD [year old active duty] service member (3 years) PT [patient] was placed on limited duty in Oct 2019 to April 2020 for morbid obesity. At this time patients wt [weight] was (b) (6) and BMI [body mass index] was (b) (6). PT [Patient] was tx [treated] with nutrition counseling and FEP [fitness enhancement program]. I am unsure why patient was returned to full duty. Currently patient's wt [weight] is (b) (6) and BMI [body mass index] is (b) (6) I have initiated a MEB [medical evaluation board] on patient. I have seen AD [active duty] service members approved for bariatric surgery at other commands. I would like patient to be screened or counseled for possible bariatric surgery. Please authorize for evaluation and treatment." This was the MEB1 signature for entry into the DES. [Ref (p)]

240. On 10 Jun 21, ETSN Armstrong participated in a virtual appointment with NMCP Health Promotions for nutrition and weight management counseling. The provider's notes from 10 Jun 21 read as follows: "[Patient] presented to clinic and seemed very lethargic with little interest in the training. When I asked [patient] how I could help him or if he had any willingness to learn about nutrition [patient] stated he was already eating healthy, had done this training before, and that he works out. I referred him to the nutritionist, to which patient responded he didn't think they could help him because he knows how to eat healthy but that he would contact them and schedule an appointment." Additionally, the referral for gastroenterology was sent back and closed as, "Bariatric Surgery is not authorized for ADSM [Active-Duty Service Members]." [Ref (p)]

241. On 16 Jun 21, ETSN Armstrong reported to NMCP for a scheduled appointment with his MH therapist. He reported that he still had high anxiety from going to work, but didn't believe it was the job itself, as he felt he did a good job. He reported that he felt the medications were helping. [Ref (p)]

242. On 17 Jun 21, ETSN Armstrong participated in a telephonic BHCF consult. He reported that he felt that the medications were helping with his depression, but not his anxiety. He described his anxiety as increasing since returning to in-person work. He scored a 10 on the PHQ-9 test (Moderate Depression) and an 18 on the GAD-7 test (Severe Anxiety). [Ref (p)]

243. On 24 Jun 21, ETSN Armstrong reported to NMCP for a medical prescription review follow-up as part of his ongoing MH treatment. His dosage for his prescribed anti-anxiety medication was increased. [Ref (p)]

244. On 30 Jun 21, ETSN Armstrong reported to NMCP for a scheduled appointment with his MH therapist. He reported that his anxiety was increasing every day. His therapist, during a past session, had asked him to write down his thoughts to better benefit from the counseling. The therapist's notes describe that the journal was minimally done. [Ref (p)]

245. On 12 Jul 21, ETSN Armstrong reported to NMCP for a scheduled appointment with his MH therapist. He reportedly had lost (b) (6) pounds after going back to the gym and watching what he ate. He reported continued high anxiety but felt that it was improving. [Ref (p)]

246. On 16 Jul 21, ETSN Armstrong participated in a telephonic BHCF consultation. Based on reported non-mental side-effects from one of his medications, BHCF discussed potential options for other medications. BHCF reported that ETSN Armstrong had lost around (b) (6) pounds in the previous month and that he congratulated him on this accomplishment. [Ref (p)]

247. On 18 Aug 21, ETSN Armstrong reported to NMCP for a scheduled appointment with his MH therapist. He was reportedly tearful throughout the session and reported that he did not understand why his depression was getting bad again. When he described how he felt that his depression was better before, his therapist wrote that she felt that she never noted much

improvement in his depression. ETSN Armstrong reportedly endorsed feeling suicidal, but he did not endorse that he would ever follow through with committing a suicidal act. He thought he may need something like hospitalization but "does not have suicidal intentions or plans." During the visit he scored a 23 on the PHQ-9 test (Severe Depression) and a 17 on the GAD-7 (Severe Anxiety). [Ref (p)]

248. On 20 Aug 21, ETSN Armstrong participated in a telephonic BHCF consultation. ETSN Armstrong told the BHCF that he felt that his MH concerns should be added to his ongoing Medical Evaluation Board (MEB) processes. He stated that he felt the Navy was causing most of his stress. When asked if he felt the medications were helping, he stated that they were making it easier to function. ETSN Armstrong scored a 19 on the PHQ-9 test (Moderately Severe Depression) and an 18 on the GAD-7 test (Severe Anxiety). [Ref (p)]

249. On 31 Aug 21, ETSN Armstrong reported to NMCP for a scheduled review by the Medical Examination Board Approval Authority (MEBAA) based on morbid obesity due to excessive calories. The MEBAA noted, "SMs [ETSN Armstrong's] condition is considered to be a great risk to his metabolic and cardiovascular health, which would be incompatible with continuing military service." After reviewing ETSN Armstrong's case, the MEBAA's disposition notes read, "Continue current treatment and [follow-up] visits with PCM, nutritionist, and mental health." [Ref (p)]

250. On 07 Sep 21, ETSN Armstrong's assigned MEBAA endorsed a recommendation for entry into the Disability Evaluation System (DES). This was the MEB2 signature for entry into the DES. [Ref (p)]

251. On 15 Sep 21, ETSN Armstrong reported to NMCP for a scheduled appointment with his MH therapist. During the visit, he scored a 20 on the PHQ-9 test (Severe Depression) and an 18 on the GAD-7 test (Severe Anxiety). [Ref (p)]

252. On 17 Sep 21, ETSN Armstrong participated in a telephonic BHCF consultation. During the consultation, he scored a 22 on the PHQ-9 test (Severe Depression) and a 17 on the GAD-7 test (Severe Anxiety). Based on ETSN Armstrong's feelings of little improvement, coupled with the PHQ-9 and GAD-7 scores not improving, the BHCF placed a consult for a psychiatric medication management review. ETSN Armstrong was given the phone number to schedule an appointment with a psychiatrist, and the BHCF noted that once that appointment was scheduled, the BHCF would be closed out. [Ref (p)]

253. On 28 Sep 21, ETSN Armstrong reported to NMCP for a scheduled appointment with his MH therapist. He was told that he would be referred to the network for ongoing therapy since he "is stable at the moment and needs more frequent sessions." His therapist also informed him that she would be leaving her current position and that he would need to follow-up in order to continue to receive therapy from a new provider. She noted that ETSN Armstrong did not like the idea of changing therapists. The therapist noted, "he is doing well this week with his mood,

but it does tend to go in cycles. He seems to get lost in his negative thinking and it is 'sort of a security blanket for me'." She educated ETSN Armstrong on Cognitive Behavioral Therapy techniques that she felt could help him if he did them. ETSN Armstrong's therapist also noted that he tended to dwell on his negative thoughts and avoided the interventions and strategies that had been consistently recommended to him. His therapist continued, "…although he is reluctant to change therapists he was highly encouraged if not told to continue therapy." [Ref (p)]

254. On 29 Sep 21, ETSN Armstrong received a PRT Waiver for "back pain" waiving participation in the 2021-1 PRT. He was medically cleared for participation in the FEP and was cleared to participate in individual physical training. [Encl (111)]

255. On 4 Oct 21, ETSN Armstrong's therapist placed a psychiatry referral for a provisional diagnosis of "other reactions to severe stress." [Ref (p)]

256. On 15 Oct 21, ETSN Armstrong failed to show for a scheduled MH appointment at NMCP. The provider called and left a voicemail with a callback number, "should he like to reschedule this appointment." [Ref (p)]

257. On 21 Oct 21, ETSN Armstrong reported to NMCP for a Transcranial Magnetic Stimulation (TMS) screening. The screening found that he did not have a major depressive disorder, which is a requirement to be deemed a candidate for TMS treatment. [Ref (p)]

258. TMS is a noninvasive procedure that uses magnetic fields to stimulate nerve cells in the brain to improve symptoms of depression [Encl (112)]

259. On 21 Oct 21, ETSN Armstrong was notified by his Leading Petty Officer (LPO) that due to a change in MARMC policy, he would need to report back to MARMC for in-person work beginning on 25 Oct 21. [Encls (107), (113)]

260. On 25 Oct 21, ETSN Armstrong reported to NMCP for a medical prescription review as part of his on-going MH treatment. Per the provider notes, "pt [ETSN Armstrong] has been referred to Psychiatry as our attempts to tx [treat] him here in the clinic have been unsuccessful.", and "pt [ETSN Armstrong] relates that he does have an appointment pending and that he does not need any refills on his medications at this time." He scored a 20 on the PHQ-9 test (Severe Depression) and a 15 on the GAD-7 test (Severe Anxiety). [Ref (p)]

261. On 29 Oct 21, ETSN Armstrong failed to show for a scheduled MH appointment at NMCP. When contacted by NMCP, ETSN Armstrong reported that he wasn't able to make the appointment due to traffic. He was provided the clinic number to reschedule his appointment. [Ref (p)]

262. On 16 Nov 21, ETSN Armstrong failed to show for a scheduled physical therapy appointment. NMCP contacted ETSN Armstrong, notified him of their no-show policy, and informed him of his new appointment time. [Ref (p)]

263. On 4 Jan 22, ETSN Armstrong was referred to IDES for morbid obesity due to excessive calories. This completed the "referral" stage of the MEB Phase of the DES. [Ref (p)]

264. On 5 Jan 22, ETSN Armstrong failed to show for a scheduled physical therapy appointment. When contacted by NMCP, ETSN Armstrong reported that he was a close contact of someone who had tested positive for COVID-19. His appointment was rescheduled. [Ref (p)]

265. Between 26 Jan 22 and 16 Feb 22, ETSN Armstrong completed all required Veteran's Affairs (VA) Disability Benefits Questionnaires (DBQs). [Ref (p)]

266. On 2 Feb 22, ETSN Armstrong failed to show for a scheduled physical therapy appointment. NMCP contacted him and he agreed to reschedule the appointment for a later date. [Ref (p)]

267. On 14 Feb 22, ETSN Armstrong was issued a PFA Administrative Counseling/Warning (Page 13) and assigned to MARMC's Fitness Enhancement Program (FEP) based on a BCA failure of 31 Aug 21. [Encl (90)]

268. On 23 Mar 22, ETSN Armstrong reported to NMCP seeking a PRT waiver based on MARMC executing mock-PRTs and his stated reasoning of not being able to complete all required PRT events. He was given a light limited duty (LLD) chit for 30 days and told to seek a waiver once the official PRT season began. [Ref (p)]

269. On 11 May 22, ETSN Armstrong reported to NMCP Mental Health, referred during his previous PHA seeking an evaluation to address sadness. He reported that his sadness had been in place for three years and that his symptoms had remained unchanged and unresolved. He also noted sleep disturbance, lack of appetite, anhedonia (lack of pleasure), isolative habits, hopelessness, fatigue, difficulty with concentration, and feelings of frustration. [Ref (p)]

270. On 11 May 22, the Psychiatrist noted that ETSN Armstrong was open to medical counseling and medication management to help alleviate his sadness. In describing his history of sadness, ETSN Armstrong alluded to his weight management struggles prior to joining the Navy, and the return of his weight gain post-enlistment. He also alluded to his negative self-image and guilt based on re-gaining the weight he had previously lost. During the appointment, ETSN Armstrong attributed the source of his sadness to joining the Navy and negative childhood experiences. He "vehemently denied SI [suicide ideation] and HI [homicidal ideation], and contracted for safety." [Ref (p)]

271. ETSN Armstrong discussed his safety plans and protective factors, which included going to medical at MARMC, going to the nearest ER if away from MARMC, calling 911, or calling his friends or his spouse. He also discussed his alcohol consumption habits and the psychiatrist determined that his habits constituted "Alcohol Use Disorder, Mild". In his summary and in describing his impression of ETSN Armstrong, the psychiatrist wrote, "The service member meets criteria for Anxiety Disorder, Unspecified and Alcohol Use Disorder, Mild. The patient vehemently denied suicidal or homicidal ideations and contracted for safety. There are currently no acute safety concerns or issues identified, and the patient will be closely monitored by his command leadership and the providers overseeing his case during his treatment course. There are no indicators that the patient is dealing with a GMC [General Medical Condition] that may be contributing to their current pathology. The patient is open to engaging in psychotherapy treatment and medication management in order to be able to better cope with the emotional response to his stressors. The patient agreed to communicate with his providers concerning progression to be proactive in his healthcare and overall wellness plan. The patient reported hope for the future and willingness to follow-up with the undersigned provider for future treatment. The patient reported good social support." [Ref (p)]

272. During the same appointment, the psychiatrist defined ETSN Armstrong's prognosis as, "Given the patient's history of anxiety and depression in the context of identified stressor[s] his long-term prognosis is good. Given the reported history of functioning within the military and current situation their prognosis for long term successful functioning in the military and civilian setting is good." In describing ETSN Armstrong's fitness/suitability disposition, the psychiatrist wrote, "The patient is fit for full duty from a psychiatric perspective. However, he is on LIMDU for Morbid Obesity. He cannot carry a weapon until he is stable and recommended for waiver by a MH provider. The patient is responsible for his actions and based upon today's assessment he does not currently represent a significant acute risk to himself or others." "Patient agreed to follow-up with (doctor) for follow-up mental health care in 2-3 weeks or earlier if needed." Additionally, the psychiatrist wrote that a consult was placed for therapy and wrote for further follow-up, "Patient directed to follow-up with PCM [Primary Care Manager] as indicated to be closely monitored for management of primary care concerns and overall general well-being." [Ref (p)]

273. Additionally, under "substance abuse" the psychiatrist noted, "Recommend that the patient abstain from alcohol. The undersigned Psychiatrist spent time to educate the patient that alcohol consumption will likely worsen mood and sleep/wake cycle disturbances, as well as sound judgements and compromise good decision-making capacity. The patient was reminded to never mix prescribed medications with unauthorized prescription medications, illicit drugs or alcohol use." Relative to ETSN Armstrong's Alcohol Use Disorder, the psychiatrist wrote, "Referral to SARP [Substance Abuse Rehabilitation Program] level One through his command DAPA [Drug and Alcohol Program Advisor] is indicated. [Ref (p)]

274. ETSN Armstrong did not report to the MARMC DAPA and thus was not in the Alcohol Drug Management Information System (ADMITS). [Encl (79)]

275. On 10 Jun 22, ETSN Armstrong reported to NMCP seeking a PRT waiver. During the visit the provider wrote, "Medical Evaluation Board (MEB) for severe obesity, but exercise also causes severe knee and back pain. Still waiting for packet to be sent to DC, advised to f/u [follow-up] with Physical Evaluation Board Liaison Officer (PEBLO). Needs monthly f/u [follow-up] in clinic while on MEB. MEB recommended exercise at own pace but not to participate in PRT. Will waive full PRT, no BCA waiver. Didn't do PRT last cycle. Pt [ETSN Armstrong] interested in bariatric surgery if covered benefit. Will check with Health Benefits Advisor (HBA)." ETSN Armstrong received a PRT waiver and was not cleared to participate in FEP but was cleared to participate in individual physical training. [Ref (p)]

276. On 29 Jun 22, ETSN Armstrong was issued a PFA Administrative Counseling/Warning (Page 13) and assigned to MARMC's Fitness Enhancement Program (FEP) based on a BCA failure of 16 Jun 22. [Encl (91)]

277. On 23 Sep 22, ETSN Armstrong sent a text message to (b) (6), (b) (7)(C), ETSN Armstrong's supervisor, asking to have the next day off and informing ET1 that he was distraught over marital distress. [Encl (61)]

278. ETSN Armstrong texted his supervisor and reported, "I'm Baker acting myself", and added that he was on his way to the hospital. His supervisor replied that it was a good decision to seek help and asked if ETSN Armstrong desired to go on leave to get away for a bit and be with friends and family. ETSN Armstrong texted in response, "That would help a lot. I gotta get away from here." [Encl (41)]

279. ETSN Armstrong had approved leave to begin in mid-October. His supervisor thought that starting his leave sooner would help ETSN Armstrong cope. [Encl (61)]

280. When his supervisor asked him if was going to kill himself, ETSN Armstrong said "yes". His supervisor provided ETSN Armstrong with the MARMC Suicide Prevention Coordinator's contact information and told ETSN Armstrong that he would meet him at the ER. [Encl (61)]

281. ETSN Armstrong was waiting for his supervisor in the NMCP parking lot. ETSN Armstrong told him that he no longer wanted to kill himself, and instead just wanted to go on leave. [Encl (61)]

282. ETSN Armstrong reported to NMCP ER on 23 Sep 22 with complaints of depression, anger, and to seek a medical "clearance" to go on leave. The ER provider noted that his symptoms were a "grief reaction" and that he displayed "no current SI/HI" and that he did not meet the criteria for involuntary admission to the hospital. He received the "clearance" he was seeking to go on leave and was discharged from the ER that same day. [Ref (p)]

283. A SAIL referral was not made for ETSN Armstrong's SRB above. While MARMCs SPC was aware of ETSN Armstrong's visit to the ER, because he was released and "cleared" to go on leave, the SPC interpreted that a SAIL referral was not necessary. [Encl (38)]

284. On 23 Sep 22, the National Hurricane Center reported the formation of Tropical Storm Ian in the Caribbean Sea with its track projected towards Florida. In the five days following, the storm progressed into a Category 4 hurricane and made landfall on the west coast of Florida on 28 Sep 22, crossed Florida on 29 Sep 22, and made landfall again in South Carolina on 30 Sep 22. [Encl (114)]

285. After meeting with the 2M Shop Leading Chief Petty Officer (LCPO), ETSN Armstrong was informed that he would not be able to start leave until after Tropical Storm Ian passed Florida. [Encl (61)]

286. On 23 Sep 22, in the afternoon, his supervisor texted ETSN Armstrong apologizing that he wasn't able to get him on leave that day due to the storm. ETSN Armstrong acknowledged via text. [Encl (41)]

287. Though his leadership was able to obtain a barracks room for ETSN Armstrong to stay in, he desired to stay off-base for personal reasons. [Encl (41)]

288. On 23 Sep 22, during a follow-up conversation that afternoon, ETSN Armstrong told his supervisor that his dad would cover the costs of a hotel room so that he wouldn't have to go back to the apartment that evening. [Encl (61)]

289. On 23 Sep 22, his supervisor told ETSN Armstrong to submit his leave chit for as much time as he wanted, and to start his leave on 30 Sep 22. [Encl (41)]

290. On 26 Sep 22, ETSN Armstrong reported to work and his supervisor asked him how he was doing. ETSN Armstrong reported that he had not eaten in three days. He added that he ended staying at his apartment over the weekend. [Encl (61)]

291. On or about 26 Sep 22, his supervisor asked for ETSN Armstrong's details regarding when he was planning to drive down to Florida and notified him that Hurricane Ian was projected to hit Florida on "Friday" [30th]. [Encl (61)]

292. ETSN Armstrong and his supervisor discussed his travel plans and his plan for safely making it to Florida given the status of the storm. ETSN Armstrong told his supervisor that he wanted to stick "to the Friday plan" and his supervisor supported his decision. [Encl (61)]

293. On 29 Sep 22, ETSN Armstrong was auto-checked out on leave beginning at 0600. [Encl (115)]

294. On 29 Oct 22, ETSN Armstrong was auto-checked in from leave at 0600. [Encl (115)]

295. Multiple individuals assigned to the 2M Shop, including those that worked with ETSN Armstrong on a daily basis, stated that they did not notice any change in behavior following his return from leave. [Encl (56), (57), (59)]

296. NMCP and other medical providers for ETSN Armstrong never communicated any medical concerns or other patient information with MARMC. [Encl (15)]

297. ETSN Armstrong's timeline inside the LIMDU and DES process was as follows:

a. LIMDU for bi-lateral knee pain: 02 Oct 19 – 02 Apr 20
b. Referral into MEB for Morbid Obesity (MEB1): 03 Jun 21
c. MEBAA Interview for Morbid Obesity: 31 Aug 21
d. MEBAA Approved for Morbid Obesity (MEB2): 07 Sep 21
e. Referred into IDES for Morbid Obesity: 4 Jan 22
f. Completed Veteran's Affairs DBQs for seven identified potential disabilities: 26 Jan 22 – 16 Feb 22. [Ref (p)]

298. The referral to DES should take seven days. ETSN Armstrong's referral into DES took 216 days. [Ref (p); Encl (14)]

299. In total, ETSN Armstrong had 130 documented medical encounters during his enlistment period, with 20 of those encounters being specific to mental health. [Ref (p)]

300. On 5 Nov 22, a civilian friend of ETSN Armstrong's came to his apartment to check on him after she received an alarming text from him around 1030 (EST). She forced entry into the apartment and discovered ETSN Armstrong lying face-down on the floor. She contacted 911 Emergency Response and waited at the scene for their arrival. [Encl (86)]

301. On 5 Nov 22, Norfolk Police Officers, along with Norfolk Emergency Medical Services (EMS) responded to 6115 Tidewater Drive, Apartment 254, for a report of a gunshot victim who was located near the kitchen area of the apartment with a gunshot wound to the head. [Encl (86)]

302. ETSN Armstrong was pronounced deceased at 1922 (EST). A 5.56 caliber rifle was located under his body. [Encl (86)]

303. On 5 Nov 22, the civilian friend notified Norfolk Police during her initial interview that she knew ETSN Armstrong was battling depression but wasn't sure if he was diagnosed. She also notified Armstrong's (b) (6), (b) (7)(C)

304. ETSN Armstrong (b) (6), (b) (7)(C)

Subj: COMMAND INVESTIGATION INTO CAUSAL OR CONTRIBUTING FACTORS IN THE FOUR SAILOR DEATHS WITHIN 28 DAYS AT MID-ATLANTIC REGIONAL MAINTENANCE CENTER

Facts Regarding MMFN Deonte A. Autry, USN

305. MMFN Deonte A. Autry, USN was a 22-year-old male at the time of his death. [Encl (116)]

306. MMFN Autry enlisted in the Navy on 26 Nov 19 for five years. ([Encl (116)]

307. MMFN Autry's End of Active Obligated Service (EAOS) was 25 Nov 24. [Encl (116)]

308. MMFN Autry completed Recruit Training and Machinist Mate "A" School and reported to USS GEORGE WASHINGTON (CVN 73) on 5 May 20 while the ship was undergoing Refueling and Complex Overhaul (RCOH) and was assigned to Reactor Department. [Encl (117)]

309. Prior to his death, MMFN Autry lived in Schamberger Hall R-61 (Barracks) on Naval Station Norfolk and leased an apartment in Newport News, Virginia. He would often sleep in the barracks during the work week and then stay at his apartment on the weekends. [Encl (116)]

310. MMFN Autry owned at least one firearm and stored it at his personal residence. [Encl (119)]

311. At the apartment, MMFN Autry had two roommates: [redacted]. Both roommates served aboard CVN 73 and had known MMFN Autry and lived in the apartment together since their time together on CVN 73. [Encls (120), (121)]

312. MMFN Autry was described as a caring individual that made sure everyone around him was good. He loved playing basketball and was always positive. He could draw a crowd with his sense of humor. He was an optimistic, bubbly guy that loved to joke around. He talked about his family and visiting them. He was the same positive person at MARMC as he was when he was on CVN 73. [Encls (116), (120), (121)]

313. In late October 2021 or early November 2021, while on watch aboard CVN 73, MMFN Autry fell out of his chair and suffered a loss of consciousness (LOC). [redacted] on duty and near MMFN Autry at the time, reported seeing MMFN Autry shaking and his eyes fluttering immediately after falling. [Ref (v)]

314. MMFN Autry was evaluated by medical, given the rest of the day off, and no further action was taken. [Ref (v)]

315. On 18 Nov 21, MMFN Autry reported to the Langley Air Force Base (AFB) Hospital Emergency Room (ER) after experiencing another LOC shortly after waking up in the morning when he fell unconscious in his bedroom. [Ref (v); Encl (121)]

316. A computerized tomography (CT) scan was obtained and identified a cystic lesion on his brain, and this was followed up with a Magnetic Resonance Imaging (MRI) scan. MMFN Autry was prescribed levetiracetam, commonly called "Keppra", and referred to Neurosurgery for a follow-up. [Ref (v)]

317. On 10 Dec 21, MMFN Autry reported to Naval Medical Center Portsmouth (NMCP) Neurology for a follow-up and to review the MRI findings from his previous ER visit. The doctor explained to MMFN Autry that they found a 1.3cm cyst on his right frontal cortex on the surface of his brain. He explained that it could be a tumor, or it could be a cyst. The doctor further explained that his first LOC was suspicious for a seizure, but that his second event was not. For the LOC episodes, he recommended a follow-up with a neurosurgery provider to determine if it was necessary to remain on Keppra. For the cyst, the provider noted that he intended to follow-up with serial MRIs to determine if the cyst is growing or not and that based on future findings, he would determine if surgery was necessary or not. The provider noted that he would order a follow-up MRI in three months. [Ref (v)]

318. On or about 20 Jan 22, while aboard CVN 73, MMFN Autry had a third LOC episode. While standing at morning muster, he became light-headed and passed out. A nearby corpsman caught him and prevented him from hitting the ground. [Ref (v)]

319. On 3 Feb 22, MMFN Autry reported to NMCP Neurology for follow-up on the three LOC episodes consistent with generalized epilepsy. The provider felt that based on the MRI findings of a cyst-appearing lesion coupled with the LOC episodes, an increase in Keppra was warranted. Additionally, two electroencephalogram (EEG) tests were ordered - routine, and sleep-deprived. [Ref (v)]

320. Based on the work-up needed, the provider noted on 3 Feb 22 that Limited Duty (LIMDU) orders would be initiated for MMFN Autry and that his case would likely "refer to PEB [Physical Evaluation Board]." [Ref (v)]

321. The provider explained to MMFN Autry that he was to refrain from driving for six months, curb alcohol use, and take his medications as prescribed. [Ref (v)]

322. On 3 Feb 22, a Medical Evaluation Board (MEB) was convened and recommended a period of LIMDU for MMFN Autry. [Ref (v)]

323. On 14 Feb 22, MMFN Autry received Permanent Change of Station (PCS) orders to detach CVN 73 in FEB 22 and report to MARMC "FOR DUTY – LIMITED DUTY ACC 105", "no later than 23 FEB 22". [Encl (122)]

324. On 1 Mar 22, MMFN Autry reported to NMCP Neurology for the first of two electroencephalogram (EEG) tests. Abnormalities were found. [Ref (v)]

325. On 8 Mar 22, MMFN Autry reported to NMCP Neurology for the second of two EEG tests. Abnormalities were found. [Ref (v)]

326. On 24 Mar 22, MMFN Autry departed CVN 73 and reported to MARMC code 1190 HLPP division and assigned to First Division. [Encls (122), (123)]

327. On 26 Apr 22, MMFN Autry reported to NMCP Neurology for a follow-up and to discuss the findings from the previously conducted EEG tests. His provider noted that the workup had yielded several concerning findings. These, along with the cyst, highly increases likelihood of localization-related epilepsy. Based on likelihood of increased seizures, provider noted that MMFN Autry's case would be referred "for PEB". This was the MEB1 signature for entry into the Disability Evaluation System (DES). An order was also placed for an MRI. [Ref (v)]

328. On 18 Jul 22, MMFN Autry had a fourth seizure. He returned from work that day and went to sit down when he suddenly had an LOC and fell to the ground. Witnesses reportedly saw MMFN Autry with seizure activity for an unknown period. MMFN Autry later awoke with post-event confusion and tiredness for approximately one hour and reported to the NMCP ER for evaluation. While at the ER, blood was drawn for various labs including a test of the levels of Keppra in his body. [Ref (v)]

329. On 23 Aug 22, MMFN Autry reported to NMCP Neurology for epilepsy follow-up. Based on the lab results from 18 Jul 22 which showed his Keppra levels to be low, the provider suspected that the seizure that occurred on 18 Jul 22 was due to variable compliance with MMFN Autry taking his prescribed medication. The provider reiterated to MMFN Autry the importance of proper medication compliance as well as continuing not to drive and continuing to refrain from alcohol consumption. [Ref (v)]

330. During that visit on 23 Aug 22, MMFN Autry's provider ordered another lab to check the Keppra levels. His provider also re-ordered the MRIs and directed MMFN Autry to go to the PEB office to initiate the PEB process as nothing had happened since the initial referral from 26 Apr 22. [Ref (v)]

331. On 28 Aug 22, MMFN Autry had a fifth seizure. MMFN Autry was hanging out with friends when he got up from a couch to get water when he suddenly experienced a LOC, fell to the ground and had whole-body convulsions. Once MMFN Autry regained consciousness, one of his friends brought him to Langley AFB Hospital ER. [Ref (v)]

332. On 29 Aug 22, a telephonic consult was conducted between NMCP Neurology staff and MMFN Autry's provider to discuss the seizure from the previous day. MMFN Autry's provider noted that the breakthrough seizure was likely due to ineffective Keppra dose and increased his dosage. He also noted the upcoming MRI and PEB interviews. [Ref (v)]

333. On 13 Sep 22, MMFN Autry reported to NMCP Neurology for his scheduled MRI scans. [Ref (v)]

334. On 14 Sep 22, MMFN Autry reported to NMCP Neurology for a review of his MRI scans from the previous day. His provider compared his previous MRI from 18 Nov 21 to the most recent of 13 Sep 22 and determined that the notable changes in the cyst were indicative of an infectious lesion vice a neoplastic lesion (an abnormal mass of tissue that forms when cells grow and divide more than they should or do not die when they should). MMFN Autry's provider noted that they would re-consult the neurosurgical provider on the case given the cyst change as well as consult Infectious Disease experts to see if there are any other recommendations for treatment. [Ref (v)]

335. On 23 Sep 22, MMFN Autry participated in a telephonic virtual Medical Evaluation Board Approval Authority (MEBAA) interview. The provider captured a history of the seizures during the call and evaluated MMFN Autry as being at a higher risk of seizures over the next 12 months compared to the general population. This was the necessary review (MEB2) for entry into the DES. [Ref (v)]

336. On 24 Sep 22, MMFN Autry was referred to the Integrated Disability Evaluation System (IDES). This completed the "referral stage" of the MEB Phase of the DES. [Ref (v)]

337. The referral into DES should take seven days. [Encl (14)]

338. On 11 Oct 22, MMFN Autry had a sixth seizure. He went to the NMCP ER. [Ref (v)]

339. Later that day, NMCP staff consulted with MMFN Autry's provider to discuss treatment actions following the seizure. His provider discussed that he would increase Keppra to the maximum dosage and advised to continue to follow the no driving and no alcohol restrictions. A planned follow-up between MMFN Autry and a neurosurgeon was confirmed to be scheduled for 27 Oct 22. [Ref (v)]

340. On 20 Oct 22, MMFN Autry's prescription for the maximum dosage of Keppra was filled. [Ref (v)]

341. On 27 Oct 22, MMFN Autry reported to NMCP Infectious Disease for a scheduled follow-up based on the previously placed consult of 14 Sep 22. The provider gathered details from MMFN Autry about where he lived and traveled during his upbringing and noted that MMFN Autry consumed alcohol three times per week. [Ref (v)]

342. MMFN Autry was scheduled for an appointment with a psychologist as part of the Veterans Benefits Administration (VBA) Medical Disability Examination (MDE) on 8 Nov 22. MMFN Autry's medical records do not reveal if he attended this appointment. [Ref (v)]

343. MMFN Autry's timeline inside the LIMDU and DES processes were as follows:

a. LIMDU for Epilepsy: 03 Feb 22
b. Referral into MEB for Epilepsy (MEB1): 26 Apr 22
c. MEBAA Interview and Approval for Epilepsy (MEB2): 23 Sep 22
d. Referred into IDES for Epilepsy: 24 Sep 22. [Encl (v)]

344. The referral to DES should take seven days. MMFN Autry's referral into DES took 151 days. [Ref (v); Encl (14)]

345. NMCP and other medical providers for MMFN Autry never communicated any medical concerns or other patient information with MARMC. [Encl (15)]

346. On 10 Nov 22, after being placed in a liberty status, MMFN Autry returned to work to notify his Leading Petty Officer (LPO) that he would be having many more medical appointments beginning the next week. His LPO recalls him seeming excited and happy about his upcoming appointments. [Encl (123)]

347. On 10 Nov 22, a Sailor friend of MMFN Autry drove him to the barracks and dropped him off. They said goodbye "as they usually did". This Sailor friend did not see any difference in behavior from MMFN Autry. This was the last time this Sailor friend saw MMFN Autry. [Encl (116)]

348. On 14 Nov 22, MMFN Autry did not show up for muster at MARMC at 0600 (EST). His division called and texted multiple times without response or answer. [Encl (124)]

349. After MMFN Autry missed morning muster, two Sailors went to his barracks room on Naval Station Norfolk and reported he wasn't there. [Encl (124)]

350. MMFN Autry's Leading Chief Petty Officer (LCPO) went back to the barracks and gained entry into the room. His LCPO noticed MMFN Autry's uniform items in the room but did not find him. MMFN Autry's barracks roommate told his LCPO that he had not seen MMFN Autry in about a week. [Encl (124)]

351. MMFN Autry's LCPO and his LPO traveled together to Newport News to go to MMFN Autry's apartment. They arrived and banged on the door for a while without answer. [Encl (124)]

352. His LCPO called MMFN Autry's father to inquire if he had heard from or knew of MMFN Autry's whereabouts. MMFN Autry's father had not heard from him and did not know where he was. [Encl (124)]

353. After the phone call, MMFN Autry's LCPO and his LPO came back to MARMC and marked MMFN Autry as "UA" (unauthorized absence). [Encl (124)]

354. On 14 Nov 22, MMFN Bemis, MMFN Autry's first roommate, was heading out of the apartment in the late morning/early afternoon on his way to stop at a store prior to heading into work on CVN 73. Prior to leaving, he went upstairs to MMFN Autry's room to check and see if he needed anything. [Encl (121)]

355. MMFN Autry's first roommate witnessed MMFN Autry sitting on his bed playing video games and he asked him why he wasn't at work. MMFN Autry replied that he called out sick for the day. His first roommate found MMFN Autry's actions to be "odd," but left the apartment to head to the store and then the ship. [Encl (121)]

356. On the afternoon of 14 Nov 22, MMFN Autry's first roommate received calls and texts from multiple mutual friends asking about MMFN Autry as he was not responding to calls or texts. MMFN Autry's first roommate explained that he saw him playing video games earlier that day and that he thought MMFN Autry was fine. [Encl (121)]

357. On 14 Nov 22, at approximately 1454 (EST), Newport News Police Department (NNPD) received a call from a civilian identified as MMFN Autry's civilian friend asking for a wellness check based on him sending a strange text to family/friends just saying, "I love you". [Encl (119)]

358. On 14 Nov 22, the civilian friend also informed the police that MMFN Autry did not show up for work and that he also suffered from seizures and his family was concerned that he may have had a seizure and may be in need of help. [Encl (119)]

359. NNPD, accompanied by Emergency Medical Services (EMS), arrived at MMFN Autry's apartment. After knocking and announcing themselves multiple times, NNPD and EMS found the front door unlocked and entered the apartment. NNPD and EMS discovered MMFN Autry's body lying on his bed with an apparent gunshot wound to the head and a 9MM handgun in MMFN Autry's right hand. MMFN Autry was pronounced deceased at approximately 1505 (EST). [Encl (119)]

360. On 14 Nov 22, at approximately 1600 (EST), MMFN Autry's second roommate arrived at the Newport News apartment, having had duty on Sunday aboard CVN 73. Upon arrival, he witnessed multiple police officers and detectives in and around his apartment. [Encl (120)]

361. An NNPD detective asked MMFN Autry's second roommate to provide positive identification of MMFN Autry which he did. The second roommate called his LCPO aboard CVN 73 and notified him and then called MMFN Autry's first roommate and notified him. [Encl (120)]

362. MMFN Autry's second roommate was shocked by the news and cannot recall any signs of distress and remembered MMFN Autry acting normal on Saturday night, which was the last time he saw him. [Encl (120)]

363. On 26 Nov 22, funeral services were held for MMFN Autry at the Greater Grace Community Missionary Baptist Church in Marshville, NC. Approximately 20 Sailors attended MMFN Autry's funeral services, including his Sailor friend from MARMC and his first roommate, and the remaining group being former shipmates serving aboard CVN 73. [Encls (116), (121), (125)]

Facts Regarding FC2 Janelle N. Holder, USN

364. FC2 Janelle N. Holder, USN was a 39-year-old female at the time of her death. [Encl (126)]

365. FC2 Holder enlisted in the Navy on 15 Nov 18 for six years. [Encl (126)]

366. FC2 Holder's End of Active Obligated Service (EAOS) was 14 Nov 24. [Encl (126)]

367. FC2 Holder was married to [redacted] They were [redacted]. [Encl (127)]

368. [redacted] stated that FC2 Holder decided to enter the Navy at a relatively late age because she always maintained a fascination with the military and always wanted to serve, but issues with body weight prevented her from joining earlier in life. [Encl (52)]

369. As FC2 Holder approached the military's established age limit for enlisting, she lost over [redacted] and ultimately became eligible to join the Navy. [Encl (52)]

370. After completing boot camp and Fire Controlman (FC) "A" School, FC2 Holder graduated from Tactical TOMAHAWK Weapons Control System Operation & Maintenance School on 18 Nov 19. [Encl (128)]

371. FC2 Holder reported to USS GONZALES (DDG 66) in Norfolk, VA on 23 Nov 19. She was assigned as a TOMAHAWK Technician in Weapons Department. [Encl (129)]

372. FC2 Holder was viewed as a key contributor to the Combat Systems Missile (CM) division. [Encl (129)]

373. On 23 Mar 20, FC2 Holder reported to Naval Medical Center Portsmouth (NMCP) Emergency Room (ER) claiming suicidal ideation and seeking mental health treatment after discussing her thoughts with DDG 66 shipmates. FC2 Holder described stressors related to COVID-19, her job, and her home life, which included geographical separation from her immediate family, who resided [redacted]. FC2 Holder also reported depressive symptoms of poor/interrupted sleep, decreased appetite, fatigue, guilt related to family

separation, and isolative behavior. FC2 Holder's initial diagnosis was unspecified mood [affective] disorder with a suicide risk assessment of "low acute risk," which qualified her as a candidate for outpatient mental health care. FC2 Holder's Columbia – Suicide Severity Rating Scale (C-SSRS) was assessed as a 4. [Ref (w)]

374. The C-SSRS is a well validated screening measure for suicidal ideation/attempt risk in both active duty and veteran populations. The C-SSRS ranges from 0 (no suicidal ideation present) to 5 (active suicidal ideation with specific plan and intent) and is annotated in the medical record each time the service member has an in-person outpatient mental health (MH) care session or a PCaT phone call. The NMCP PCaT unit provides virtual patient encounters during the LIMDU period in order to ensure that service members are connected with necessary resources and have a complete understanding of their upcoming appointment schedule. [Ref (w)]

375. FC2 Holder received a follow-up mental health assessment on 24 Mar 20 at NMCP during which she denied suicidal ideation, including any passive thoughts regarding death. She was prescribed medication for anxiety and her provider discussed the possibility of LIMDU assignment if MH treatment proved ineffective. [Ref (w)]

376. In March of 2020, FC2 Holder did not have access to a firearm in the home, as a friend had taken possession. She was prescribed Lexapro for anxiety. Her provider discussed the possibility of LIMDU assignment if MH treatment proved ineffective. [Ref (w)]

377. On 30 Mar 20, FC2 Holder received a primary diagnosis of adjustment order, with mixed anxiety and depressed mood. She expressed worry regarding [redacted] and financial concerns. Her evaluated C-SSRS was 1 (low-grade suicidal thoughts) and was cleared for full duty with continued outpatient care. [Ref (w)]

378. FC2 Holder's follow-up MH assessment at NMCP on 30 Jun 20 showed overall improvement due to command-granted personal leave. She reported success on all levels with the stressors she had cited during her 30 Mar 20 MH assessment. [Ref (w)]

379. In the summer of 2020, FC2 Holder's (b) (6), (b) (7)(C) [redacted]

380. FC2 Holder's last full evaluation period prior to her Medical Board Evaluation, signed on 18 Jun 21, contained an "Early Promote" recommendation as the CM Division Leading Petty Officer (LPO) with the following comments: "#1 of 17 3rd Class Petty Officers", "Only 3rd Class Petty Officer to be an LPO on DDG 66", and "Strong leader, Top notch operator, Already operates at a First-Class level". [Encl (130)]

381. On 6 Jul 21, FC2 Holder reported to the DDG 66 medical department that she had recently been experiencing suicidal thoughts. She did not indicate any suicidal plans or intent. FC2 Holder received a diagnosis of anxiety and depression in the workplace setting. DDG 66's Independent Duty Corpsman (IDC) confirmed that her C-SSRS score indicated low risk for suicide, although, she still had suicidal thoughts. The DDG 66 IDC confiscated FC2 Holder's medication, which she thought about using during her suicidal thoughts. FC2 Holder cited (b) (6) [redacted] as protective factors and her reason for not following through with reported suicidal thoughts. [Ref (w)]

382. On 13 Jul 21, FC2 Holder completed a MH assessment with a provider at NMCP Medical Readiness SURFLANT. Her C-SSRS remained at 3 (intermittent suicidal thoughts), with frequent Suicidal Ideation (SI) absent intent or plan. Her stressors (work, financial, and family), remained the same. The provider restarted her Lexapro prescription and placed FC2 Holder on the "do not carry" (DNC) list with respect to small arms issuance until stable on medication for a period of 90 days. [Ref (w)]

383. The provider at NMCP Medical Readiness SURFLANT created and reviewed a safety plan with FC2 Holder. FC2 Holder's safety plan included three main tenets that she needed to identify: 1) people who she would ask for help in a crisis, 2) people or places that are safe for her, and 3) steps she could take to make her home and life safe. FC2 Holder identified her husband and two friends as the individuals that she would turn to for help in a crisis. [Ref (w)]

384. FC2 Holder was assigned temporary Additional duty (TAD) to Surface Combat Systems Training Command - Great Lakes for the month of August 2021. [Ref (w)]

385. On 27 Aug 21, FC2 Holder reported to the local military treatment facility (MTF) after suffering a syncopal episode (fainting) at approximately 0300. FC2 Holder reported that she had lost consciousness. She was transported to the ER and diagnosed with a broken nose and sciatica left hip pain. [Ref (w)]

386. On 8 Sep 21, FC2 Holder had an appointment with a MH provider at NMCP. FC2 Holder stated that she had no current suicidal or homicidal ideations (SI/HI), but that she had experienced anxiety, depressed mood, irritability and felt overwhelmed since her ship's operational tempo began to increase about eight months prior. FC2 Holder was motivated to remain in service and hoped to receive treatment for stress management. Her evaluated C-SSRS was 1. [Ref (w)]

387. FC2 Holder requested a new NMCP MH provider on 9 Sep 21. She stated that she wanted a new MH provider because she felt that the encounter on 8 Sep 21 didn't go well. Specifically, because the provider had informed her that she was a potential candidate for condition not a

disability (CnD) administrative separation (ADSEP). FC2 Holder was upset because she desired to remain in the Navy. [Ref (w)]

388. CnD ADSEP is governed by MILPERSMAN (MPM) Article 1900-120 and pertains to Sailors with a medical condition that poses interference with their performance of duty, but not specifically listed as a compensable disability under the veteran affairs (VA) schedule for disabilities. In accordance with MPM 1900-120, a service member may be eligible for separation due to conditions not amounting to a disability. [Ref (o)]

389. On 28 Sep 21, FC2 Holder reported to the DDG 66 IDC that her left hip and leg pain persisted with an assessed pain level of 4-5 out of 10. She claimed that stretching exercises had failed to relieve the pain. The IDC prescribed her Naproxen (anti-inflammatory) for pain management. [Ref (w)]

390. On 3 Nov 21, FC2 Holder had a MH appointment with a new provider at NMCP Medical Readiness SURFLANT. She indicated difficulty adjusting to life in the operational Navy. She reported recent suicidal ideations, though denied thoughts of method, intent, or preparatory acts. Her evaluated C-SSRS was 2. [Ref (w)]

391. FC2 Holder was unable to complete the cardio portion of the Physical Readiness Test (PRT) on 17 Nov 21 due to left hip pain. She was able to complete the plank and pushup portions of the PRT. [Ref (w)]

392. The DDG 66 IDC submitted a physical therapy (PT) consult on 18 Nov 21 and a magnetic resonance imaging (MRI) exam and the following medications for FC2 Holder: meloxicam (arthritis), and acetaminophen (pain relief). [Ref (w)]

393. FC2 Holder attended a PT evaluation for left hip pain on 29 Nov 21 at NMCP. Her cited pain level was a 4 (average) and a 6-7 (peak) out of 10. [Ref (w)]

394. On 29 Nov 21, during her MH appointment with her provider at NMCP Medical Readiness SURFLANT, FC2 Holder indicated that she continued to struggle with the stressors in her life. She had begun PT but stated that she was not optimistic about identifying the cause of her pain. FC2 Holder reported suicidal ideations involving a personally owned firearm. She stated that this was the only time she had experienced an active thought of suicide. She reported that there were pistols, shotguns, and a rifle in her home, and that they were all kept loaded and unsecured. She declined an offer of gun locks. She reiterated to her MH provider that she desired to complete her obligated service and continue her career in the Navy. [Ref (w)]

395. Based on her 29 Nov 21 MH appointment, FC2 Holder was found not fit for full duty. Her diagnosis was affirmed as adjustment disorder with mixed anxiety and depressed mood. Her evaluated C-SSRS was a 3. [Ref (w)]

396. FC2 Holder was placed on Temporary Limited Duty (TLD) on 30 Nov 21 for a period of six months. [Ref (w)]

397. On 1 Dec 21, FC2 Holder had an MRI exam performed on her left hip. [Ref (w)]

398. On 8 Dec 21, a Medical Evaluation Board (MEB) Convening Authority (CA) concurred that FC2 Holder was not currently fit for full duty and would be granted a period of TLD. [Ref (w)]

399. On 10 Dec 21, DDG 66 received the MEBs recommendation FC2 Holder be placed on LIMDU. [Ref (w)]

400. FC2 Holder had five PT sessions between 10 Dec 21 and 28 Jan 22. These sessions resulted in little-to-no improvement in her symptoms. [Ref (w)]

401. On 20 Dec 21, FC2 Holder attended a PT re-evaluation where they discussed her left hip MRI results, which indicated a possible labral tear. An orthopedic referral was entered and she was advised to continue with PT. [Ref (w)]

402. On 29 Dec 21, FC2 Holder attended her first network MH session. During this session with her network provider, she reported that she has been experiencing suicidal thoughts regularly since boot camp. She also reported previous self-harming acts and indicated that the most recent episode had occurred about a year ago. [Ref (w)]

403. FC2 Holder reported to MARMC in a TLD (ACC 105) status on 7 Jan 22. She was assigned to MARMC Code 1140 Training Department as a Team lead and watchbill coordinator. FC2 Holder enjoyed her work in training department, but her leadership and shipmates were worried about her back pain. [Encls (62), (131), (132)]

404. On 3 Feb 22, FC2 Holder had a PT re-evaluation that recommended she stop further PT pending the completion of an Orthopedic evaluation. [Ref (w)]

405. During FC2 Holder's 9 Feb 22 NMCP MH therapy session, she discussed her continued occupational stress. She requested different medication, citing concerns regarding weight gain and the potential for her to lose her advancement/promotion if she failed to comply with Navy body composition standards. Her evaluated C-SSRS was 0. [Ref (w)]

406. On 10 Feb 22, FC2 Holder received an Orthopedic evaluation for her hip joint at NMCP Sports Orthopedic Clinic. The doctor indicated that she had no signs or symptoms referable to her hip joints. The doctor stated that FC2 Holder's examination was consistent with primary lumbar pathology with possible sciatica/radiculopathy. The doctor stated she needed an MRI exam of her lower back. [Ref (w)]

407. On 18 Feb 22, FC2 Holder attended a PT re-evaluation following the receipt of her orthopedic evaluation results. Her PT was placed on hold until her lower back MRI was completed. [Ref (w)]

408. On 23 Feb 22, during her network MH encounter, FC2 Holder indicated feelings of hopelessness regarding her lack of physical and MH progress. [Ref (w)]

409. On 8 Mar 22, FC2 Holder's anxiety medication was changed from Lexapro to Zoloft. [Ref (w)]

410. During her 8 Mar 22 NMCP MH therapy encounter, FC2 Holder's claimed stressors related to family and finances remained unchanged. Her evaluated C-SSRS was 1. Her therapist discussed the potential for CnD ADSEP with FC2 Holder. FC2 expressed guarded interest in this path, citing concerns about potentially having to pay back enlistment monetary bonuses. FC2 Holder also admitted to feeling anxiety regarding the prospect of potentially reporting to a new ship. The therapist ordered a sleep study and offered trial of Atarax for insomnia. [Ref (w)]

411. On 30 Mar 22, FC2 Holder attended her initial sleep study appointment to discuss her insomnia and poor sleep quality. [Ref (w)]

412. On 31 Mar 22, FC2 Holder received the results of her lower back MRI exam, which revealed multiple findings pertaining to her lower back, some of which were deemed to be degenerative. [Ref (w)]

413. In April 22, FC2 Holder's spouse (b) (6) [redacted]. [Encl (52)]

414. On 14 Apr 22, FC2 Holder received a neurosurgery evaluation which concluded that she was not a candidate for surgery. The neurosurgeon recommended that FC2 Holder schedule PT and pain management appointments to address her lower back condition. [Ref (w)]

415. On 19 Apr 22, FC2, Holder requested a second opinion regarding her neurosurgery evaluation. She also requested a Physical Fitness Assessment (PFA) Medical/Clearance Waiver due to her back issues. Her waiver was approved not to participate in the PRT or Fitness Enhancement Program (FEP). However, FC2 was still required to comply with Navy Body

Composition Assessment (BCA) standards. FC2 Holder was not in compliance with the established BCA standards as of 19 Apr 22. [Ref (w)]

416. On 20 Apr 22, FC2 Holder had an appointment at the NMCP Pain Management Clinic to discuss her lower back pain. The Doctor discussed FC2's lower back condition with her and reviewed the findings from her MRI exam. The doctor explained to her that this could be very irritating to the surrounding nerves, potentially causing her leg symptoms. The doctor expressed to FC2 Holder his hope that she would focus on decreasing muscle spasms and be able to increase her cardiovascular routine. He also discussed the correlation between elevated Body Mass Index (BMI) and lower back pain and stated that the Epidural Steroid Injection (ESI) should help her rehabilitate and rebuild her strength. [Ref (w)]

417. On 22 Apr 22, FC2 Holder started her second round of PT sessions. The goal was to reduce the level of pain and strengthen her lower back and core. Four additional PT sessions were conducted between 29 Apr 22 and 18 May 22. [Ref (w)]

418. During her 22 Apr 22 MH therapy session, FC2 Holder provided an example of how she was previously stressed in the work environment by feeling that she had to live up to the expectations and reputation of a highly regarded FC who had been previously stationed there. While the command felt that stating their belief in FC2 Holder's ability to perform on-par with her predecessor was a potential confidence builder, FC2 Holder viewed the comparisons as negative. The doctor noted that although she had readily identifiable strengths, her distorted beliefs about herself significantly undermined her achievements. [Ref (w)]

419. On 26 Apr 22, FC2 Holder received an Epidural Steroid Injection (ESI) for her lower back pain. She later reported that the ESI did nothing to reduce her back pain. [Ref (w)]

420. On 29 Apr 22, during an NMCP MH therapy session, FC2 Holder's C-SSRS was evaluated as 3. Her primary stressor cited was her back pain. Her suicidal risk remained low. [Ref (w)]

421. On 5 May 22, FC2 Holder received a second neurosurgery evaluation which also concluded that she was not a candidate for surgery. [Ref (w)]

422. On 10 May 22, FC2 Holder completed her overnight sleep study. [Ref (w)]

423. On 16 May 22, FC2 Holder was diagnosed with Obstructive Sleep Apnea (OSA). She chose to use Continuous Positive Airway Pressure (CPAP) treatment to help improve her sleep quality. [Ref (w)]

424. On 24 May 22, FC2 Holder had a PT re-evaluation. She had not noticed any substantial changes in her symptoms by attending PT and/or doing her prescribed exercises at home. Since PT alone was deemed ineffective in addressing her pain, FC2 Holder was referred to her primary care team to help mitigate her symptoms. [Ref (w)]

425. FC2 Holder's back issues continued to be a source of significant, often debilitating pain. [Encls (40), (62) - (66)]

426. FC2 Holder scheduled no additional pain management appointments for her lower back, even though she was reminded to do so during all four of her PCaT encounters between 31 May 22 and 2 Aug 22. [Ref (w)]

427. On 13 Jun 22, during an NMCP MH therapy session, FC2 Holder disclosed that she had not increased her Zoloft dosage as planned but stated that she was likely to do so the next day. Her C-SSRS was evaluated as 0. FC2 Holder's therapist notified her that he was referring her case to the Disability Evaluation System (DES). [Ref (w)]

428. FC2 Holder went on leave from 13 Jun 22 to 11 Jul 22 in order to move (b) (6) while she completed the DES process. [Ref (w)]

429. FC2 Holder visited her family most weekends following (b) (6) . [Encls (40), (64) - (66)]

430. FC2 Holder was promoted to FC2 on 16 Jun 22. [Ref (w)]

431. There is no record of FC2 Holder meeting BCA standards prior to her promotion. [Refs (w), (y); Encl (133)]

432. On 15 Jul 22, FC2 Holder failed her Cycle 1 2022 BCA. [Encl (133)]

433. FC2 Holder was not placed in the MARMC FEP. [Encl (134)]

434. FC2 Holder's ACC transitioned from TLD (ACC 105) to temporary duty (TEMDU) Awaiting Medical Board (ACC 355) on 19 Jul 22. [Encl (135)]

435. FC2 Holder was referred to the DES on 25 Jul 22. [Ref (w)]

436. On 4 Aug 22, during an NMCP MH appointment, FC2 Holder reported low motivation to participate in activities. She attributed this lack of motivation to chronic back pain. Her evaluated C-SSRS was 2. FC2 Holder was prescribed Cymbalta. She was briefed on the risks, benefits, and

side effects including elevated risk of anti-depressant discontinuation syndrome if she suddenly stopped taking the medication. [Ref (w)]

437. On 23 Aug 22, FC2 Holder signed her DES paperwork and elected to remain in the Integrated Disability Evaluation System (IDES). FC2 Holder's IDES listed two disabilities: adjustment disorder with mixed anxiety (ICD-10 Code F4323) and lower back pain, unspecified (ICD-10 Code M5450). A third disability for Radiculopathy, Lumbar region (ICD-10 Code M5416) was not initially approved. [Ref (w)]

438. On 20 Sep 22, FC2 Holder failed to report to her NMCP MH Clinic appointment. She stated on 7 Oct 22 that she forgot about the appointment. [Ref (w)]

439. FC2 Holder's last MH therapy encounter at NMCP occurred on 7 Oct 22. She indicated to her provider that Cymbalta appeared to have a positive impact on her mood. However, she denied any positive impact with respect to her chronic back pain. Her evaluated C-SSRS was 1. She continued to report issues with insomnia, which was only partially managed since beginning CPAP treatment. She reported that her sleep was good whenever she was (b) (6) [redacted]. However, she had significant issues with falling and staying asleep when separated from her family, which her CPAP machine did not resolve. Her doctor discussed options for sleep aids, including Remeron, Seroquel, and Ambien. After extensive discussion of the risks and benefits associated with these options, she agreed to a trial of Remeron. [Ref (w)]

440. On 4 Nov 22, FC2 Holder requested an impartial medical review of the Radiculopathy, Lumbar region (ICD-10 Code M5416) disability in order to claim it in her DES package. [Ref (w)]

441. In her DES personal impact statement FC2 Holder stated "prior to the adjustment disorder and herniated disc, I was very active. I enjoyed hiking, playing sports, and being physically active with my family. This is much more difficult if not impossible due to these conditions. My husband or children usually make sure someone is by my side when we have to walk great distances in the event that I need to physically lean on them for support while walking. These conditions have greatly decreased my quality of life and has impacted how my family interacts. Prior to joining the Navy, I worked as a mail carrier with the United States Postal Service. It was a possibility that I could return to work there once separated from service, but since I'm limited to lifting light weight, I would no longer be able to return to that line of work. I have mostly worked in physically demanding jobs and due to my conditions, I would need to find less physical work". [Ref (w)]

442. On 7 Nov 22, FC2 Holder was notified that her request to add the Radiculopathy, Lumbar region (ICD-10 Code M5416) diagnosis to her DES package was approved, and that her file had been forwarded to the PEB. [Ref (w)]

443. FC2 Holder's timeline inside the LIMDU and DES process was as follows:

a. LIMDU for adjustment disorder with mixed anxiety: 30 Nov 21 – 29 May 22
b. 2nd LIMDU period: 29 May 22 – 24 Jul 22
c. MEB1 Interview for adjustment disorder with mixed anxiety and lower back pain: 27 Jun 22
d. MEB2 Interview for adjustment disorder with mixed anxiety and lower back pain: 25 Jul 22
e. DOD Referral to IDES: 10 Aug 22
f. VA Compensation and Pension (C&P) Reconciliation: 15 Aug 22 – 22 Sep 22
g. Radiculopathy, Lumbar region added to her disabilities: 18 Oct 22
h. MEB Complete, sent to PEB 7 Nov 22. [Ref (w)]

444. FC2 Holder's MEB phase of the IDES process took 134 days which was 58 days longer than the stated BUMED goal of 76 days. The referral stage took 45 days instead of the stated 7-day goal which was the greatest contributor to exceeding the MEB phase completion goal. [Ref (w)]

445. FC2 Holder stated that she was "happy and excited about being separated from the Navy and her next steps in life" after receiving the DES notification. [Encl (62)]

446. During her last PCaT encounter on 10 Nov 22, FC2 Holder reported that everything was going well since their last appointment. She reported her MEB Case File had been submitted and she was awaiting formal findings. [Ref (w)]

447. FC2 Holder had 14 encounters with the NMCP Mental Health Clinic while on LIMDU. [Ref (w)]

448. FC2 Holder had 13 Psychiatric Continuity and Transition (PCaT) encounters while on LIMDU. [Ref (w)]

449. FC2 Holder had 28 encounters with MH network providers while on LIMDU. [Ref (w)]

450. FC2 Holder had 18 encounters with back and pain management specialists, as well as physical therapists, while on LIMDU. [Ref (w)]

451. After the MARMC Suicide Prevention stand-down was held on 16 Nov 22, FC2 Holder confided in a colleague, (b) (6), that "she wasn't sure why she was alive, and that she couldn't

handle being alive with so much pain." (b) (6) did not interpret FC2 Holder's comments as a Suicide Related Behavior (SRB) and didn't report her comment to the Command Suicide Prevention Coordinator (SPC) or his supervisor. [Encls (40), (136)]

452. FC2 Holder's 16 Nov 22 MH appointment was cancelled due to the provider being out of the clinic. [Ref (w)]

453. FC2 Holder had approved leave in North Carolina from 21 Nov 22 to 28 Nov 22. [Encl (137)]

454. Several friends/colleagues reached out to FC2 Holder while she was on leave to see how she was doing. FC2 Holder consistently responded that everything was good. [Encls (40), (64)]

455. During the evening of 24 Nov 22, FC2 Holder's spouse described FC2 Holder as extremely depressed because she had to stay in bed and was unable to join the family. [Encl (52)]

456. On 26 Nov 22, around 1830 (EST) FC2 Holder (b) (6), (b) (7)(C) FC2 Holder (b) (6), (b) (7)(C) FC2 Holder's (b) (6), (b) (7)(C) FC2 Holder (b) (6), (b) (7)(C)

457. FC2 Holder exited the residence at 2104 (EST) and shot herself with a handgun that belonged to her spouse. The incident was recorded on the residence's security camera. [Encl (138)]

458. Approximately two hours later, her spouse found FC2 Holder lying outside near their front porch and immediately contacted 911. [Encl (138)]

459. The EMT declared FC2 Holder deceased at approximately 2330 (EST). [Encl (138)]

Opinions

General Opinions

1. The Command Investigation (CI) Team did identify common stressors amongst the four MARMC Sailors, to include family, financial, medical, and career-related factors. However, it is the opinion of the investigation team that there was no direct correlation or connection between the tragic, suicide-related deaths of ET2(SW) Kody Decker, ETSN Cameron Armstrong, MMFN Deonte Autry, and FC2 Janelle Holder. [FF 132, 135, 170, 269-273, 275, 277-278, 298, 309, 316, 317, 319, 328-330, 332, 339-340, 343, 373, 377, 382, 390, 384, 405, 408, 410, 420, 436, 441, 451, 455]

2. The CI Team assesses that access to personally owned firearms, and unwillingness to surrender access to lethal means, to include the use of gun locks, was a causal factor in the deaths of all four Sailors. [FF 135, 138, 166, 168, 176, 236, 302, 310, 359, 394, 457]

3. The CI Team assesses a general absence of communication between the MTF and the MARMC Deployability Coordinator with respect to all four Sailors. As a result, we assess that the communications path between MTFs and commands like MARMC is fractured, particularly with regard to LIMDU patients being treated for Mental/Behavioral Health-related concerns. The resultant information gaps led to blind spots with respect to individual LIMDU Sailors which the CI Team characterizes as a contributing factor. [FF 42, 135, 210, 213, 227-230, 232, 235-236, 238-239, 242, 247-248, 251-253, 256, 261-262, 264, 266, 271-273, 275, 394, 402, 420, 436]

4. The CI Team assesses that one of the contributing factors related to this fractured communications path is the scarcity of billeted manpower resources at MARMC with respect to the effective management, administration, and oversight of LIMDU/HLPP Sailors assigned. [FF 8, 13, 19, 24-28, 43, 46-47, 61]

5. The CI Team assesses that the lack of an embedded medical department at MARMC exacerbates the fractured communications between MTF's and the Command, which we have characterized as a contributing factor in the four Sailor deaths. A properly staffed medical department, to include an individual with a clinical (i.e., Independent Duty Corpsman/IDC-like) background, could promote improved continuity of care and serve as a central POC to facilitate the monthly meetings between the MTF and the Command to review LIMDU cases and discuss issues or concerns related to patient care. [FF 8, 13, 19, 24-28, 42-43, 46-47, 61, 373, 377-378, 381]

6. The CI Team assesses a broad misinterpretation of HIPAA/PHI at MARMC, which results in self-censorship that the CI Team has characterized as a contributing factor. [FF 54, 65-70]

7. The CI Team assesses an imbalance with respect to the requirements tied to Deployability/LIMDU Policy, and the resources available at Navy Regional Maintenance Centers, like MARMC, to effectively execute to those requirements. The CI Team assesses that this imbalance was a contributing factor to the deaths of these four Sailors. [FF 8, 13, 19, 24-28, 43, 46-47, 61]

8. The CI Team assesses that access to medical services (i.e., Mental/Behavioral Health support, counseling, Primary Care Provider appointments) did not serve as a barrier, nor was it a causal or contributing factor in any of the four deaths. Extensive reviews of individual Medical Records indicated that each Sailor was a high utilizer of Navy Health Care services and appeared to be receiving timely and dedicated medical care for their respective condition(s). [FF 132-145, 148, 151-154, 157, 161-164, 299, 314-319, 322, 324-325, 328-334, 338-339, 341, 373, 375, 378, 381-383, 385-387, 389-390, 392-395, 397, 400-402, 404-412, 414-424, 426-427, 436-440, 446-450]

9. The CI Team assesses that a toxic Command Climate did not exist at MARMC, nor does it assess that it was a causal or contributing factor to any of the four deaths. Extensive interviews were conducted with both MARMC civilian employees and Sailors assigned, across multiple grades/ranks, LIMDU and non-LIMDU members alike to augment our review of the 2021 and 2022 DEOCS results. No evidence or trend that Command Climate played any role whatsoever in these four tragic deaths was revealed. [FF 104-111, 122-123]

10. The CI Team assesses that neither the 2021 nor 2022 DEOCS results, alone, constitute a statistically viable data sample by which to draw definitive conclusions with respect to organizational perceptions amongst military members assigned to MARMC. This assessment is based on the low survey participation rates reported within this demographic. [FF 104-111]

11. The CI Team assesses that the addition of on-site mental health/resiliency counselors and Chaplain services at MARMC has addressed a need that was unfilled prior to the four deaths. [FF 98-103]

12. The CI Team was unable to locate any evidence indicating that the absence of meaningful work at MARMC was a causal or contributing factor to any of the four deaths. [FF 9, 147, 159, 160, 241, 312, 326, 403]

Opinions Regarding LIMDU Policy

13. The CI Team assesses that - due to the industrial environment, fast-paced work tempo, and the focus of the organic workforce - the large RMCs are not well-suited to the role of providing effective management, administration, and oversight to LIMDU/HLPP Sailors. [FF 8, 13, 19, 24-28, 43, 46-47, 61]

14. If the practice of assigning LIMDU/HLPP Sailors to large RMCs (i.e., MARMC and SWRMC) is continued, then additional manpower resources, with the appropriate backgrounds/skillsets, will need to be billeted in order to address shortfalls identified by the CI Team related to the effective management, administration, and oversight of the LIMDU/HLPP population. [FF 8, 13, 19, 24-28, 43, 46-47, 61]

15. The CI Team has identified ambiguity and an absence of definitive guidance regarding Deployability/LIMDU staffing. The governing instructions, i.e., the MILPERSMAN and BUMED Instruction 6000.19, do not provide clear and articulable guidance and trigger points for when validation or allocation of additional Deployability/LIMDU staffing resources *shall* be made available to commands. [FF 19, 40-49]

16. The CI Team assesses that data pertaining to LIMDU Sailors needs to be more granular, and more easily updateable, in order to permit more timely and accurate assessments regarding details pertaining to individual LIMDU cases, how the DES system is performing with respect to goals/timelines, and where the investment of additional resources should be targeted for

maximum effect. While the creation of the LIMDU SMART database has shown value and promise with respect to centralizing and tracking LIMDU patient progress and outcomes, there are still gaps in data completeness and overall fidelity that need to be resolved. [FF 35-39, 57-63, 297-298, 342-343, 443-444]

17. Poor data quality leads to poor analytics, which suboptimizes any efforts undertaken to improve the efficiency and functioning of the LIMDU and/or DES system(s). Inaccurate or fragmented data is inconsistent with a performance-to-plan mindset, nor will it help drive a Get Real, Get Better approach towards solving the complex challenges associated with maximizing outcomes for individual Sailors and the Navy. [FF 57-63]

18. The CI Team assesses that, as an Enterprise, the Navy is not currently postured to achieve the overarching expectation of the LIMDU Policy in accordance with MPM Article 1300-1400, namely, to return Sailors to medically unrestricted status following their LIMDU period. An overall return rate of approximately 37% to ACC 100 status in CY 2022 suggests that the Navy is underperforming relative to this inferred policy goal. [FF 14, 18]

19. The CI Team assesses that the training available to Deployability Coordinators at Commands like MARMC is inadequate. The accompanying breadth and scope of their responsibilities is expansive, and the DES process is complex to navigate. The CI Team assesses that for Deployability Coordinators to be effective they must function as process masters and subject matter experts in support of LIMDU/DES Sailors. Additionally, they should come from a clinical background, receive focused training beyond a PowerPoint presentation, and be thoroughly trained in all aspects of the policies, programs, and processes tied to LIMDU/DES (i.e., IDES, MEB, PEB, CnD ADSEP, LIMDU SMART, etc.). [FF 50-52]

20. The CI Team assesses that the requirement to train Command Deployability Coordinators should extend to Command Leadership as well, in order to ensure those accountable individuals are knowledgeable regarding the LIMDU/DES processes, they are fully aware of all the resources available and are postured effectively to support their LIMDU/DES Sailors. [FF 48, 50-52]

21. Higher-echelon instructions regarding Deployability/LIMDU Policy (i.e., BUMEDINST 6000.19) are not written for commands like MARMC. The actual, or intended, target audience is often unclear, as is the applicability of guidance contained therein to entities like MARMC. [FF 49]

22. The CI Team assesses a lack of continuity and consistency with respect to higher-echelon instructions pertaining to deployability assessments and assignments of LIMDU Sailors. Mixed terminology, conflicting definitions, and inconsistent reference(s) made regarding LIMDU, Temporary/Permanent LIMDU, etc. exist in multiple instances upon review of MPM Article 1300-1400, OPNAVINST 1300.20, and BUMEDINST 6000.19. The CI Team assesses that this

ambiguity leads to program execution challenges at commands like MARMC, which hinders their ability to provide effective support to LIMDU Sailors under their cognizance. [FF 22-23, 43, 44, 49]

Opinions Regarding Suicide Prevention and INDOC Programs

23. The CI Team assesses that the Navy's Suicide Prevention program is encountering challenges with respect to implementation, interpretation, and enforcement, and that any shortcomings in MARMC's program reflect broader issues that have been documented across the Navy regarding the effectiveness of its Suicide Prevention program. [FF 71-72, 74-75, 91-93]

24. The CI Team assesses that the suicide prevention program, HLPP program, and command INDOC program need to be reviewed by MARMC leadership in order to ensure compliance with governing instructions. [FF 53, 73, 74, 83-85, 91-97]

25. The CI Team assesses that the SAIL program is not being fully utilized at MARMC. If SAIL were implemented effectively, it could provide potential intervention opportunities that might disrupt the chain of destructive behavior and possibly prevent suicide. [FF 91-93, 278, 280, 283, 451]

Opinions Regarding MARMC Practices

26. The CI Team assesses that greater scrutiny and more intrusive leadership needs to be applied at the MARMC supervisory level when Sailors who are experiencing personal/professional crisis request to take leave. In the absence of previously agreed-upon periodic check-ins by the Command member, or the availability of mental health resources at the chosen destination, the practice of placing a Sailor on leave known to be suffering a personal or professional crisis can deprive key parties (i.e., leadership, shipmates/colleagues, medical professionals/counselors, family/relatives, etc.) of the opportunity to intervene at critical points and break the chain of destructive behavior that, in some cases, leads Sailors to tragically take their own lives. [FF 278-282, 284-286, 289, 293-294, 451, 453-454]

27. The absence of a thorough or thoughtful turnover/transfer (aka "a warm hand off") of LIMDU Sailors from their previous commands to MARMC is creating blind spots with respect to individual LIMDU Sailor needs, risks, and support requirements. These blind spots are exacerbated by the large influx and fluctuation of LIMDU Sailor arrivals to MARMC and are compounded by the lack of billeted HLPP Division manpower resources at the Command. [FF 10, 53-56, 139, 140, 148, 149, 381-382, 390, 394, 402, 420, 436]

28. The CI Team assesses that MARMC key principals (i.e., members of the Command Triad, Deployability Coordinator, and HLPP Division leadership) are self-censoring with respect to

obtaining details upon LIMDU Sailor check-in, due to a misunderstanding of the rules pertaining to HIPAA/PHI. This practice is creating knowledge gaps that could inform risk assessments, leadership engagement, and the allocation of support services at the command. [FF 54-55]

Opinions Regarding ET2(SW) Decker

29. The CI Team assesses that access to medical care was not a causal or contributing factor in the death of ET2(SW) Decker. [FF 132-136, 139-142, 145, 151-154, 157, 161-162]

30. The CI Team assesses that the climate within LHD 5 combat systems department was a contributing factor to ET2(SW) Decker's mental health stressors. [FF 127, 130, 132, 135]

31. ET2(SW) Decker's medical file indicated steady improvement in his mental health following his removal from sea duty. As a result, the CI Team assesses ET2(SW) Decker's workplace stressors were not causal or contributing factors to his suicide at the time of his death. [FF 135-136, 143-145, 152, 157, 159, 161-162]

32. The CI Team assesses that while ET2(SW) Decker's mental health appeared to be improving, a holistic review of evidence collected indicated that he had not completely disclosed the full spectrum of stressors he was dealing with to all concerned parties (i.e., Doctors, Mental Health Counselors, family/spouse, friends/colleagues). The confluence of these unresolved stressors was a contributing factor to his death. [FF 135-138, 154-157, 162, 166-167, 170]

33. The CI Team assesses a potential intervention opportunity was missed when the Command DAPA was not informed of ET2(SW) Decker's diagnosis of Alcohol Abuse. [FF 42, 135, 140, 148-150]

Opinions Regarding ETSN Armstrong

34. The CI Team assesses that access to medical care was not a causal or contributing factor in the death of ETSN Armstrong. [FF 299]

35. The CI Team assesses that continuity of care was a contributing factor in ETSN Armstrong's death. [FF 178-180, 182, 186-189, 200-204, 209-210, 212-213, 217-218, 221, 227-233, 235-249, 251-253, 256-257, 260-264, 266, 269-273, 282, 293-294, 296]

36. ETSN Armstrong was occasionally a non-compliant or uncooperative medical patient. His actions likely contributed to the delays in improvement in most of his diagnoses. [FF 180, 183, 187-188, 203, 218, 221, 240, 244, 252-253, 256, 261-262, 264, 266, 274]

37. While the delay in ETSN Armstrong's DES processing was inexplicable, it was not a contributing factor to his death. [FF 239, 248-250, 263, 265, 275, 297-298]

38. COVID-19 and its restrictive policies were a detriment to ETSN Armstrong's physical and mental well-being and was a contributing factor to his death. [FF 214-216, 220-222, 230, 235, 242, 259]

39. The change brought on by the marital stress altered ETSN Armstrong's strongest critical protective factor and was a contributing factor in his death. [FF 175, 185, 238, 271, 277]

40. The CI Team assesses that potential intervention opportunities were missed when ETSN Armstrong was not provided the full range of support during periods of crisis. For example, the lack of SAIL program referral or screening for alcohol dependency removed potential paths that could have provided key principals with a better understanding of the stressors and triggers in ETSN Armstrong's life. [FF – 271, 273-274, 278, 280, 283].

41. The CI Team assesses that additional intervention opportunities were missed at the following points: ETSN Armstrong's transfer to MARMC from Great Lakes while in a LIMDU status, consecutive PFAs waivers without follow-on action, non-deployable for greater than 12 consecutive months without required administrative action, a lack of referral to FEP earlier in his morbid obesity cycle, and adherence to BCA requirements when he was assigned to FEP. [FF – 180-182, 190-199, 212-213, 217, 224-226, 229, 235, 239, 254, 263, 267-268, 275-276, 278].

Opinions Regarding MMFN Autry

42. The CI Team assesses that access to medical care was not a causal or contributing factor in the death of MMFN Autry. [FF 314-319, 324-325, 327-335, 338-339, 341]

43. The CI Team assesses that continuity of care was not a causal or contributing factor to his death. [FF 314-319, 324-325, 327-335, 338-339, 341]

44. While the delay in ETSN Autry's DES processing was inexplicable, it was not a contributing factor to his death. [FF 322-323, 327, 330, 335-337, 342-344]

45. The CI Team is unable to determine whether or not MMFN Autry's medical condition and his prescribed medication were casual or contributing factors to his death. [FF 316-317, 319, 327-330, 332, 334, 339-340]

46. No evidence was discovered that revealed any connection between MMFN Autry's suicide and his previous service aboard USS GEORGE WASHINGTON (CVN 73). [FF 308, 311-312, 363]

47. Leading up to the day of his suicide, there were no findings that point to a reason or crisis event in MMFN Autry's life that would create a concern for or suspicion of suicide. [FF 346-347, 350, 352, 355-356, 358, 362]

Opinions Regarding FC2 Holder

48. The CI Team assesses that access to medical care was not a causal or contributing factor in FC2 Holder's death. [FF 373, 375, 378, 381-382, 385-387, 389-390, 392-395, 397, 400-402, 404-412, 414-424, 427, 436-440, 446-450]

49. The CI Team assesses that continuity of care was a not causal or contributing factor in FC2 Holder's death. [FF 373, 375, 378, 381-383, 385-387, 389-390, 392-395, 397, 400-402, 404-412, 414-424, 426-427, 436-440, 446-450, 452]

50. The CI Team is unable to determine whether or not FC2 Holder's medical condition and her prescribed medications were causal or contributing factors to her death. [FF 382, 389, 392, 409, 419, 427, 436, 439]

51. The CI Team assesses that, following FC2 Holder's placement on LIMDU, her workplace stressors were reduced. However, her frequent suicidal ideations persisted due to external stressors. This, combined with her debilitating back pain, and the realization that it could constitute a permanent disability, significantly increased her stress and anxiety regarding her future quality of life. The CI Team assesses that this confluence of stressors was a contributing factor to her death. [FF 395-397, 400-408, 410-412, 414-417, 419-421, 424-425, 436, 439, 441, 450-451, 455]

52. The CI Team assesses that the MARMC Command Fitness Leader (CFL) missed a potential intervention opportunity by not placing FC2 Holder in FEP and providing guidance/resources with respect to her weight management difficulties, which appeared connected to her mental health. [FF 405, 415, 430-433]

53. The CI Team assesses that potential intervention opportunities were missed due to a lack of communication between the MTF and MARMC regarding FC2 Holder's documented history of frequent suicidal ideations. [FF 42, 420, 436]

54. The CI Team assesses that an additional intervention opportunity was missed due to ambiguity regarding the definition of SRB and uncertainty regarding how command members should respond. [FF 451]

Recommendations

General Recommendations

1. At the earliest opportunity, recommend the Navy Manpower Analysis Center (NAVMAC) conduct a Shore Manpower Requirements Determination (SMRD) study of MARMC and SWRMC in order to account for additional manpower requirements associated with the effective management, administration, and oversight of their LIMDU/HLPP Sailor populations. These

additional requirements should be captured in appropriate manning documents, validated via N83, and resourced via the Navy Manpower Program Objective Memorandum (POM) process.

2. If not already complete, recommend MARMC and SWRMC work with their respective navy Medicine (NAVMED) Fleet Liaisons to conduct an industrial hygiene survey that can serve as objective quality evidence (OQE) in support of a formal request to the fleet readiness integrator (FRI) regarding exemption from LIMDU/HLPP assignment caps.

3. Recommend OPNAV promulgate a definitive LIMDU/HLPP policy document (i.e., Standard Organization and Regulations Manual (SORM)) that can codify missions/functions/tasks applicable directly to individual commands, particularly those with large population(s) of LIMDU Sailors (i.e. MARMC and SWRMC).

4. Recommend CNRMC publish and promulgate detailed, overarching LIMDU/HLPP guidance that can drive standardization and commonality across individual RMCs with respect to policy, process, and structure.

5. Recommend MTFs and NAVMED Fleet Liaisons develop a formal training curriculum and provide to all LIMDU/HLPP commands to ensure that Deployability Coordinators and Command leadership are knowledgeable with respect to the LIMDU/DES processes, and fully aware of all requirements, resources, and best-practices.

6. Recommend BUMED continue efforts to optimize the LIMDU Sailor and Marine Readiness Tracker System (SMART) to enable more accurate data analytics, less labor-intensive updates, fewer data gaps, and ease of usability.

7. Recommend BUMED conduct an annual survey and solicit feedback via all end users of LIMDU SMART in order to inform targeted improvements that would enable greater utility.

8. Recommend MTF's and/or NAVMED Fleet Liaisons provide dedicated training on the SMART database to all authorized users (i.e., Deployability Coordinators and HLPP division leadership).

9. Recommend MARMC designate additional authorized users, beyond [redacted], for access to the SMART database.

10. Recommend the MARMC Command triad implement a recurring sync meeting with the Command Deployabiltiy Coordinator, in order to maintain awareness of challenges or issues pertaining to their LIMDU/HLPP Sailor population.

11. Recommend NAVPERSCOM and BUMED work with the Fleet Manning Control Authorities (MCA's) to explore the feasibility of establishing a dedicated medical department at

RMCs with large HLPP Sailor populations like MARMC and SWRMC. Recommend the assessment include billeted mental health and resiliency counselors.

12. Recommend CNRMC conduct a comparative assessment across all RMC's regarding military member participation rates for DEOCS and develop an action plan to promote awareness and remove barriers to maximize participation in the survey.

Recommendations Regarding LIMDU Policies

13. Recommend OPNAV and NAVPERSCOM strengthen the language contained in governing policy instructions pertaining to Deployability/LIMDU assessments and assignments, specifically with respect to the assignment of Deployability Coordinators and collateral support at non-MTF's like MARMC. Example: Personnel assigned or detailed into the billet/position of Deployability Coordinator at MTF's or commands *shall possess* a clinical background.

14. Recommend BUMED and NAVPERSCOM explore the development of a "LIMDU package", similar to the SARC package that accompanies victims of sexual assault to their next Command and provides useful background information regarding the victim's case. The "LIMDU package" would be required for all LIMDU Sailors and enable a more thorough turnover between commands.

15. Recommend NAVMED Fleet Liaison(s) or MTF's provide interactive or in person training to RMC's regarding the proper interpretation and application of HIPAA/PHI with HLPP division leadership and Command triads.

16. Recommend MARMC LIMDU/HLPP division leadership, as well as the Command triad, refrain from self-censoring as it relates to obtaining details regarding newly reported LIMDU Sailors, and the specifics pertaining to their limiting condition(s) and accompanying medical/mental health support needs.

17. Recommend MARMC and the local MTF Deployability Coordinators conduct monthly meetings to review current cases, discuss potential problems, and analyze existing processes in accordance with MPM Article 1300-1400.

Recommendations Regarding the Suicide Prevention Program

18. Similar to TRiPS (Travel Risk Planning System), recommend OPNAV explore the development of a screening or mission-planning system for Sailors in crisis prior to being granted personal leave. In three of these four cases, individuals had been placed on routine personal leave in the days/weeks leading up to their respective deaths. A screening process could help to identify Sailors who are at increased risk for suicide based on overall risk factors and

leadership's knowledge of their individual stressors. A screening process could also prompt at-risk Sailors to invest time and thought with respect to anticipated support needed and how they would implement their safety plan once the Sailor has left their primary duty station.

19. Recommend OPNAV revise annual Navy Suicide Prevention and Awareness GMT to be more interactive, to include the incorporation of knowledge checks, case-studies/vignettes, and peer-to-peer engagement. This would increase the recognition of suicide-related behaviors (SRBs)/risk factors and enable more effective intervention. Additionally, Navy policy should mandate, vice recommend, that this training be accomplished in-person.

20. Recommend MARMC conduct a comprehensive assessment of their Suicide Prevention program to ensure their program complies with governing instructions. This assessment should include a review of command instructions, a review of the Sailor Assistance and Intercept for Life (SAIL) program, and validation of MARMC's Crisis Response Plan completeness.

21. Recommend MARMC conduct a Crisis Response Drill at their earliest opportunity.

22. Recommend MARMC implement a more aggressive public relations/advertising campaign in order to call broader attention to Suicide Awareness, Intervention, and Prevention across the Command. This campaign should include, among other elements, the public posting of educational materials that highlight individual member roles in recognizing the signs of suicide, accompanying risk factors, as well as resources available to individuals in crisis. These materials should be posted in all public spaces where Sailors are known to assemble/congregate.

Recommendations Regarding Other MARMC Programs

23. Recommend OPNAV update OPNAVINST 1740.3E, Command Sponsor and Indoctrination Program, to include suicide prevention and awareness as a required topic during Command INDOC.

24. Recommend MARMC conduct assessments of the FEP and INDOC programs, to include an assessment of accompanying instructions.

Recommendation Regarding Final Disposition

25. Beyond the remedial administrative actions recommended above, the CI Team recommends no punitive or disciplinary action be taken against any MARMC command member(s), as their actions were not assessed as causal or contributing factors to any of the four deaths.

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Ref: (e) MILPERSMAN 1320-300, Types of Orders
(f) SECNAVINST 1000.10B, Department of the Navy Policy on Parenthood and Pregnancy
(g) OPNAVINST 6000.1D, Navy Guidelines Concerning Pregnancy and Parenthood
(h) BUMEDINST 6000.19, Medical Evaluation Board Composition, Function, Management, Staffing and Standardization
(i) DODM 6025.18, Implementation of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule in DOD Health Care Programs
(j) DODI 6490.08, Command Notification Requirements to Dispel Stigma in Providing Mental Health Care to Service Member
(k) OPNAVINST 1720.4B, Suicide Prevention Program
(l) NAVADMIN 201/22, GMT Requirements for FY23
(m) OPNAVINST 1740.3E, Command Sponsor and Indoctrination Program
(n) ET2(SW) Kody Decker's Medical Records
(o) MILPERSMAN 1900-120, Separation by Reason of Convenience of the Government - Medical Conditions Not Amounting to a Disability
(p) ETSN Cameron Armstrong's Medical Files
(q) MILPERSMAN 1610-015, Documentation of Fitness Reports and Performance Evaluations for Failure to Maintain Deployability or Individual Medical Readiness
(r) NAVADMIN 071/20, Physical Readiness Policy Update
(s) NAVADMIN 193/20, Physical Readiness Program Policy Update for Physical Fitness Assessment Cycle Two 2020 Due to COVID 19 Mitigation
(t) MILPERSMAN 1300-800, Transfer of personnel to Operational Duty (Operational Screening)
(u) DODI 6490.15, Integration of Behavioral Health Personnel (BHP) Services Into Patient-Centered Medical Home (PCMH) Primary Care and Other Primary Care Service Settings
(v) MMFN Deonte Autry's Medical Record
(w) FC2 Janelle Holder's Medical Record
(x) BUPERSINST 1430.16G, Advancement Manual for Enlisted Personnel of the U.S. Navy and U.S. Navy Reserve
(y) OPNAVINST 6110.1K, Physical Readiness Program

Encl: (5) MARMC Command Brief dtd Jan 23
(6) MARMC 1190 LIMDU, HUMS, and PREGNANCY Brief dtd 2 Dec 22
(7) USFFC Management Advisory for Regional Maintenance Center Project Teams dtd 17 Jul 14
(8) Email from Ms. Dawn Dick, MARMC Corporate Operations, dtd 14 Dec 22
(9) BSO 60 LIMDU HLPP Metrics
(10) MARMC CI RFI's from BUMED dtd 8 Dec 22
(11) Summary of Interview of CAPT Tanap, MARMC XO
(12) MyNavy Assignment Screenshot of Billet Allocation dtd 6 Jan 23

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(13) (b) (6), (b) (5)
(14) DTM 18-004, Revised Timeline Goals for the Integrated Disability Evaluation System dtd 23 Jul 19
(15) (b) (6), (b) (7)(C)
(16) (b) (6), (b) (7)(C)
(17) (b) (6), (b) (7)(C)
(18) (b) (6), (b) (7)(C)
(19) (b) (6), (b) (7)(C)
(20) (b) (6), (b) (7)(C)
(21) (b) (6), (b) (7)(C)
(22) Overview of Navy Medicine's Limited Duty Population dtd Nov 22
(23) (b) (6), (b) (5)
(24) (b) (6), (b) (7)(C)
(25) (b) (6), (b) (7)(C)
(26) (b) (6), (b) (7)(C)
(27) (b) (6), (b) (7)(C)
(28) FY22 Annual GMT Training for Suicide Prevention
(29) (b) (6), (b) (7)(C)
(30) (b) (6), (b) (7)(C)
(31) (b) (6), (b) (7)(C)
(32) (b) (6), (b) (7)(C)
(33) (b) (6), (b) (7)(C)
(34) (b) (6), (b) (7)(C)
(35) NAVSEA IG Military Focus Groups Presentation
(36) NAVSEA IG Military Focus Groups Engagement Report
(37) SAIL Commanders Toolkit (selected portions)
(38) (b) (6), (b) (7)(C)
(39) (b) (6), (b) (7)(C)
(40) (b) (6), (b) (7)(C)
(41) (b) (6), (b) (7)(C) ETSN Armstrong (b) (6), (b) (7)(C)
(42) (b) (6), (b) (5)
(43) (b) (6), (b) (7)(C)
(44) (b) (6), (b) (7)(C)
(45) DEOCS TRIFOLD
(46) MARMC DEOCS Executive Summary Report 2021
(47) MARMC DEOCS Executive Summary Report 2022
(48) (b) (6), (b) (7)(C)

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(49) (b) (6), (b) (7)(C)
(50) (b) (6), (b) (7)(C)
(51) (b) (6), (b) (7)(C)
(52) (b) (6), (b) (7)(C)
(53) (b) (6), (b) (7)(C)
(54) (b) (6), (b) (7)(C)
(55) NBC News Article dtd 1 Dec 22
(56) (b) (6), (b) (7)(C)
(57) (b) (6), (b) (7)(C)
(58) (b) (6), (b) (7)(C)
(59) (b) (6), (b) (7)(C)
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(67) ET2(SW) Decker (b) (6), (b) (7)(C)
(68) ET2(SW) Decker (b) (6), (b) (7)(C)
(69) ET2(SW) Decker (b) (6), (b) (7)(C)
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(76) ET2(SW) Decker (b) (6), (b) (7)(C)
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(83) ET2(SW) Decker (b) (6), (b) (7)(C)
(84) ET2(SW) Decker (b) (6), (b) (7)(C)
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(86) ETSN Armstrong (b) (6), (b) (7)(C)
(87) ETSN Armstrong (b) (6), (b) (7)(C)
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(90) ETSN Armstrong (b) (6), (b) (7)(C)
(91) ETSN Armstrong (b) (6), (b) (7)(C)

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(92) ETSN Armstrong (b) (6), (b) (7)(C)
(93) ETSN Armstrong (b) (6), (b) (7)(C)
(94) ETSN Armstrong (b) (6), (b) (7)(C)
(95) Navy Physical Readiness Program Guide 6
(96) ETSN Armstrong (b) (6), (b) (7)(C)
(97) ETSN Armstrong (b) (6), (b) (7)(C)
(98) (b) (6), (b) (7)(C)
(99) Patient Health Questionnaire (PHQ) 9
(100) PHQ 9 - Questionnaire
(101) Generalized Anxiety Disorder (GAD) 7
(102) GAD7 - Questionnaire
(103) (b) (6), (b) (7)(C)
(104) (b) (6), (b) (7)(C)
(105) (b) (6), (b) (7)(C)
(106) ETSN Armstrong (b) (6), (b) (7)(C)
(107) (b) (6), (b) (7)(C)
(108) ETSN Armstrong (b) (6), (b) (7)(C)
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(110) (b) (6), (b) (7)(C)
(111) ETSN Armstrong (b) (6), (b) (7)(C)
(112) (b) (6), (b) (7)(C)
(113) (b) (6), (b) (7)(C) ETSN Armstrong (b) (6), (b) (7)(C)
(114) Hurricane Ian Update dtd 27 Sep 22
(115) ETSN Armstrong (b) (6)
(116) MMFN Autry's (b) (6)
(117) MMFN Autry (b) (6)
(118) (b) (6), (b) (7)(C)
(119) MMFN Autry (b) (6), (b) (7)(C)
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(122) MMFN Autry (b) (6)
(123) (b) (6), (b) (7)(C)
(124) (b) (6), (b) (7)(C)
(125) MMFN Autry (b) (6)
(126) FC2 Holder (b) (6)
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(129) FC2 Holder (b) (6)
(130) FC2 Holder (b) (6)
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(133) FC2 Holder (b) (6), (b) (7)(C)
(134) (b) (6), (b) (7)(C)

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(135) (b) (6), (b) (7)(C)
(136) (b) (6), (b) (7)(C)
(137) FC2 Holder (b) (6), (b) (7)(C)
(138) FC2 Holder (b) (6), (b) (7)(C)