ORIGINAL

US COURT OF APPEALS FOR VETERANS CLAIMS
NOV 15 2019
RECEIVED

Docket No: 19-2509

Charles A. Watson, Appellant

v.

Robert L. Wilkie
Secretary of Veterans Affairs, Appellee

Appellant's Informal Brief

Type or legibly write your answers to each question. If the Court cannot read your handwriting, your brief may be returned to you.

1. If there is more than one issue listed on the first page of that Board decision, which Issue(s) are you appealing?

Please note that if you choose not to list an issue here, the Court might not review that issue.

My appeal was as follows:

Service connection for Sleep Apnea - Record Before The Agency (R.) Exhibit A

The NOD dated February 10, 2012 was not in the Record Before the Agency.

I have attached as Exhibit A

Questions 2 – 6 ask you for information regarding the issues you believe were incorrectly decided by the Board.

2. For each issue(s) you listed in Question 1, did the Board incorrectly state any facts?

Yes _X_ No____

If yes, what are the correct facts? Please list the page number(s) from the Record Before the Agency (RBA) that support your argument.

The BVA made finding as follows:

SEE ATTACHMENT FOR #2

3. Are there any documents in the Record Before the Agency (RBA) that support your claims?

Yes ____ No__X__

If yes, what are those documents? Please list the page number(s) in the RBA where they can be found and explain why you think they support your claim.

See Attachment for #2

4. Did VA fail to obtain any documents identified by you or your representative or mentioned in the Record Before the Agency (RBA) when it was gathering evidence for your case?

Yes____ No__X__

If yes, list the page number(s) of the RBA that show that these documents exist and explain:

- How each document relates to your claim(s)
- Why each document is important to your case

The Court cannot consider documents that were not before the Board. Also, please do not attach any pages from the RBA.

5. To your knowledge, did the Board fail to apply or misapply any law, case, or regulation?

Yes_X__ No____

If yes, what is that law, case or regulation and/or how should the Board have applied it?

38 U.S.C. § 5107(b) & 38 C.F.R. 3.303 should have been applied I was entitled to the benefit of the doubt. I was entitled to have my claim decided on "all" the evidence.

6. Do you think that the Board decision is wrong for any other reason(s)?
Yes__X__ No____
If yes, what are those reasons(s)? Please list the page number(s) from the Board Before the Agency (RBA) that support your argument.

See Argument at Exhibit A & 583-588.

Finally, Questions 7 – 8 ask you for information that will help the Court process your case:

7. What action do you want this Court to take?

Grant service-connection for Sleep Apnea secondary to PTSD.

8. If you needed extra pages to answer the questions above, how may extra pages did you attach to this form? __2__

Please remember that your brief cannot exceed 30 pages total (including this form). Do not attach any pages from the Record Before the Agency (RBA).

On any attached pages, make sure to include your name and your Court docket Number, which is listed at the top of each page of this form.

Please sign and date this form after you have finished completing it:

Date: 11-13-19 Appellant's Signature Mark A. Watson

ATTACHMENT #2

CHARLES A. WATSON **DOCKET NO: 19-2509**

The Board has considered the Veteran's assertions that his sleep apnea is caused by his military service or by his service-connected PTSD. The Veteran is not competent, however, to offer an opinion as to the etiology of this type of condition due to the medical complexity of the matter involved. (R.)6

A preponderance of the evidence is against a finding that the Veteran's sleep Apnea originated during service or was caused or aggravated by his Service connected PTSD. (R.) 6.

I did not make a medical diagnosis that my Sleep Apnea was secondary to my PTSD. See the NOD dated February 10, 2012 & 583.

Luck of the Draw

If I had been lucky and got a difference Veteran Law Judge, my claim may have Been granted. See below:

Citation Nr: 1404457

Decision date: 01/31/14 Archive Date: 02/10/14

DOCKET NO. 13-02 800

The Board notes that the VA examiners and private LPA have provided conflicting opinions as to whether the Veteran has established a diagnosis for PTSD. However, as these opinions were provided by competent mental health professionals using the DSM-IV criteria, and the Board cannot find a basis for which one opinion is more probative than the other, the Board finds that when resolving all reasonable doubt in favor of the Veteran, the Veteran has established a current diagnosis of PTSD.....

ATTACHMENT #2 cont'd

CHARLES A. WATSON **DOCKET NO: 19-2509**

Order

Entitlement to service connection for PTSD is granted.

See Also

THE VA EXAMINER VS VETERANS TREATING PHYSICIAN

BVA DOCKET NO. 13-02 800 (Citation Nr: 1404457) sets forth that:

> "The Board cannot find a basis for which one opinion is more probative than the other, [therefore] the Board finds all reasonable doubt in favor of the Veteran"

The VA examiner's opinion, according to the Board, is not due greater weight than that of the treating doctor.

In the BVA DECISION DOCKT NO. 16- 959 dated August 29, 2019, the Veteran was Granted Sleep Apnea secondary to PTSD. Whether a claim is granted is based on which VLJ you are lucky enough to get a VLJ who follow medical treatise.

In the BVA DECISION DOCKT NO. 08-17 407 dated April 12, 2013, the Veteran was granted Sleep Apnea secondary to PTSD. Weather a claim is granted is based which VLJ you are lucky enough to get who follows medical treatise.

In the BVA DECISION DOCKT NO. 13-12 222 dated December 20, 2013, the Veteran was granted Sleep Apnea secondary to PTSD. Weather a claim is granted is based on which VLJ you are lucky enough to get who follows medical treatise.

There are many many cases like the above. Everything is based on the luck of the draw on which VLJ you are able to draw.

COPY

REGIONAL OFFICE
DEPARTMENT OF VETERANS AFFAIRS

Charles A. Watson
505 E. Canary Street
Dunn, NC 28334
Tele: 910-891-5597

In Reply Refer To: 318/AUTH/DLB [redacted]

February 10, 2012

REQUEST FOR RECONSIDERATION, IN THE ALTERNATE,
NOTICE OF DISAGREEMENT

ISSUE

Service-connection for Sleep Apnea

BACKGROUND

There is medical evidence from Carolina Sleep & Respiratory, including studies from Dr. Hassan Jabbour, Lakeview Sleep Center, Dr. Matthew Juill, Dr. James M. Youakim, Dr. Karl Doghramji, Dr. Sharon L. Schutte and The Lakeview Sleep Center stating that Watson's PTSD does contribute to his Sleep Apnea condition, Exhibit A. It is not clear from the Decision dated September 7, 2011 why this claim was denied.

ANALYSIS

Watson contends that he is entitled to the Benefit-of-the-Doubt Rule, under 38 U.S.C. § 5107(b), because the only evidence against Watson's claim is the PA, who disagreed with Dr. Hoeper and the medical studies.

> "According to the benefit-of-the-doubt rule in U.S.C. § 5107(b), a VA claimant need have only an "approximate balance of positive and negative evidence in order to prevail". Gilbert, 1 Vet. App. at 54. Further, the reasons-or-bases requirement of 38 U.S.C. § 7104(d)(1) applies to the Board's application of the benefit-of-the-doubt rule. See id at 58. Where "there is significant evidence in support of an appellant's claim, the Board must provide a satisfactory explanation as to why The evidence was not in equipoise". Williams (Willie) v. Brown, 4 Vet. App. 270, 273-74 (1993).

Exhibit - A

In Gilbert v. Derwinski, 1 Vet. App. 49, 58 (1990). The Court set the criteria for denying a Veteran's claims when there is evidence that support the claim. Further, the Court set the criteria for applying 38 U.S.C. 5107(b), as follows:

> "Perhaps the analogy most helpful to an understanding of the application of the "benefit of the doubt" rule was provided by Deputy Assistant General Counsel Mullen at oral argument when he stated that the "benefit of the doubt" standard is similar to the rule deeply embedded in sandlot baseball folklore that "the tie goes to the runner." If the ball clearly beats the runner, he is out and the rule has no application; if the runner clearly beats the ball, he is safe and, again, the rule has no application; however, the play is close, then the runner is called safe by operation of the rule that "the tie goes to the runner." (It should be noted that there is no such formal Major League rule; the closest is Rule 7.01 which provides that: "A runner acquires right to an unoccupied base when he touches it before he is out." *1990 Official Baseball Rules.*) Similarly, if a fair preponderance of the evidence is against a veteran's claim, it will be denied and the "benefit of the doubt" rule has no application; if the veteran establishes a claim by a fair preponderance of the evidence, the claim will be granted and, again, the rule has no application; if, however, the play is close, *i.e.*, "there is an approximate balance of positive and negative evidence," the ***veteran prevails*** by operation of 38 U.S.C. § 3007(b). Gilbert, 1 Vet. App. at 55.

The medical treatise shows that there is a relationship between PTSD and Sleep Apnea.

CONCLUSION

The decision in this case was in "bad faith", was in violation of the laws and "clearly erroneous" within the meaning of 38 U.S.C. 7261(a)(4) and must be reversed, as a matter of law.

Respectfully submitted,

Charles A. Watson, pro se

Watson requests the Traditional Appeal

Hassan Jabbour, M.D.
8380 Six Forks Road, Suite 101
Raleigh, NC 27615
Phone (919) 636-1664 Fax (919) 518-0880

COPY

August 04, 2008

PTSD and Sleep Apnea:

Sleep complaints are an essential component of the constellation of symptoms that make up posttraumatic stress disorder (PTSD). Recurrent distressing dreams and difficulty falling asleep or staying asleep are salient features of the disorder.[1] Attempts to explain the physiology of PTSD must account for these sleep symptoms. Ross et al.[2-4] have suggested that rapid eye movement (REM) sleep mechanisms in particular are dysfunctional in patients with PTSD. Others have reported nightmares episodes during both REM and Stage II sleep.[1]

Obstructive sleep apnea syndrome (OSAS) is a common disorder in which disturbed breathing during sleep, usually attributable to obstruction of the airway, leads to oxyhemoglobin desaturations with concomitant hypercapnia. The resulting interruptions disrupt normal sleep architecture and lead to excessive daytime somnolence. Obstructive apneas are often more common in REM sleep than in non-REM stages of sleep, because the decreased tone of muscle of the airway during REM is more likely to lead to partial or complete upper airway obstruction. Thus, OSAS generally disrupts the continuity of REM periods and decreases the proportion of REM sleep per night. OSAS also decreases the amount of delta (Stages 3 and 4) sleep. The severity of OSAS is determined by nocturnal polysomnography. The number of abnormal respiratory events per hour of sleep, as determined by polysomnography, is called the apnea-hypopnea index.

In conclusion PTSD might not cause Sleep apnea but might exacerbate the symptom, because there are more REM sleeps in PTSD and because the apnea episodes happen during the REM sleep due to the decrease in the muscle tone in airway. We can argue that PTSD worsens the Sleep Apnea.

Exhibit A

12737

LAKEVIEW SLEEP CENTER

SLEEP ANALYSIS REPORT

Patient Name :	LIVINGSTON, DOUGLAS	**Project :**	CPAP
Hospital # :	LAKEVIEW	**Subject Code :**	LKV-056-10
Study Date :	Aug. 18, 2010	**Referring Physician :**	DR. FERGUSON
SSC/SIN :	1	**Sleep Specialist :**	DR. SILVER
Sex :	Male	**Study Indications :**	CPAP FOLLOW UP
D.O.B. :	Aug. 26, 1960		
Age :	49	**Physical Findings :**	RESP. STABILIZED WITH NASAL CPAP
Height :	5'11"		
Weight :	225.0 lbs.	**Medications :**	SEE CHART
B.M.I. :	31.4 kg/m2		

Recording Technician's (J. WILLIAMS) Comments :

Scoring Technician's (D. VALENZUELA, RPSGT) Comments :

TECHNICAL FINDINGS:

1. The patient's respirations were stabilized with an optimal nasal CPAP pressure of 10cm H_2O. At this pressure, the apnea/hypopnea index was reduced to 0/hr.
2. The mean SaO_2 at the optimal nasal CPAP pressure was 97 % with a nadir of 94 %.
3. The patient's EKG showed sinus bradycardia rhythm with a heart rate from 49 to 88 b.p.m.
4. Snoring was eliminated with nasal CPAP.
5. Periodic Leg Movements without arousal were insignificant with an index of 0/hr.
6. Periodic Leg Movements with arousal were insignificant with an arousal index of 0/hr.
7. The spontaneous arousal index was 3/hr.
8. The Sleep Efficiency was 77 %. REM sleep and Slow Wave sleep constituted 34 % and 20 % of the Total Sleep Time, respectively. The REM Latency was 79 minutes and the first REM period lasted 13 minutes.

MASK: ULTRA MIRAGE FF — *SIZE: MEDIUM*

HUMIDITY: HEATED — *CHINSTRAP: NO*

Jeffery Silver, M.D.

Diplomate, American Board Of Sleep Medicine

Send for CPAP machine

[illegible]

8/26/10

5/21/10 - Lm x 2 [illegible]

LAKEVIEW SLEEP CENTER

Patient Name: LIVINGSTON, DOUGLAS **Subject Code:** LKV-056-10 **Study Date:** Aug. 18, 2010

SLEEP ANALYSIS REPORT

Sleep Architecture

Time at Lights Off :	10:20:52
Time at Lights On :	04:40:36
Total Recording Time (TRT) :	379.7 min.
Total Sleep Period (TSP) :	378.3 min.
Total Sleep Time (TST) :	294.8 min.
Sleep Efficiency (SE) :	77.6 %
Sleep Onset Latency (SOL) :	1.4 min.
Number of Stage 1 Shifts :	23
Number of Stage Shifts :	64
Number of Awakenings :	13
Number of REM Periods :	3
REM Latency :	79.5 min.
REM Latency-minus Awake :	56.5 min.

Sleep Stages

STAGES	TIME (min.)	TST (%)	LATENCY (min.)
Wake:	83.5	–	–
Stage 1:	14.5	4.9	0.0
Stage 2:	117.3	39.8	1.5
Stage 3	61.5	20.9	46.5
Stage 4:	0.0	0.0	N.A
REM:	101.5	34.4	79.5

LAKEVIEW SLEEP CENTER

Patient Name: LIVINGSTON, DOUGLAS **Subject Code:** LKV-056-10 **Study Date:** Aug. 18, 2010

SLEEP ANALYSIS REPORT

Apnea / Hypopnea Distribution

PARAMETER	APNEA EVENTS				HYPOPNEA EVENTS	TOTAL EVENTS Apneas/Hypopneas
	Central	Obstructive	Mixed	All Apneas		
Number of Events:	1	0	0	1	14	15
Index (Events/Hr.):	0.2	0.0	0.0	0.2	2.8	3.1
Mean Duration (sec):	14.2	N/A	N/A	14.2	19.9	19.5
Longest Duration (sec):	14.2	N/A	N/A	14.2	24.6	24.6
Events in REM:	1	0	0	1	0	1
Events in Non-REM:	0	0	0	0	14	14
REM Index:	0.6	0.0	0.0	0.6	0.0	0.6
Non-REM Index:	0.0	0.0	0.0	0.0	4.3	4.3

Apnea & Hypopnea Analysis

PARAMETER	INDEX	TOTAL
Total Apneas & Hypopneas:	3.1	15
REM Events:	0.6	1
Non-REM Events:	4.3	14
Supine Events:	0.0	0
Non-Supine Events:	0.3	1

Apnea & Hypopnea Arousal Analysis

PARAMETER	INDEX	TOTAL
Apnea & Hypopnea Arousals:	3.1	15
REM Arousals:	0.6	1
Non-REM Arousals:	4.3	14
Supine Arousals:	0.0	0.0
Non-Supine Arousals:	0.3	1

Oxygen Saturation

PARAMETER	WAKE	Non-REM	REM	TOTAL RECORD
Mean SaO2 %:	96.2	96.4	96.6	96.4
Min. SaO2 %:	82.0	88.0	94.0	82.0
Max. SaO2 %:	100.0	99.0	99.0	100.0
% Duration of SaO2 In Range :				
90 – 100 %:	91.1	98.8	97.8	96.8
80 – 90 %:	0.8	0.6	0.0	0.5
70 – 80 %:	0.0	0.0	0.0	0.0
60 – 70 %:	0.0	0.0	0.0	0.0
50 – 60 %:	0.0	0.0	0.0	0.0
Below 50 %:	0.0	0.0	0.0	0.0

LAKEVIEW SLEEP CENTER

Patient Name: LIVINGSTON, DOUGLAS **Subject Code:** LKV-056-10 **Study Date:** Aug. 18, 2010

SLEEP ANALYSIS REPORT

PLM Analysis

PARAMETER	PLM AROUSAL INDEX	TOTAL PLM INDEX	PLM AROUSALS	TOTAL PLM's
Total Sleep Time:	0.2	0.4	1	2
Stage 1:	0.0	0.0	0	0
Stage 2:	0.5	1.0	1	2
Stage 3:	0.0	0.0	0	0
Stage 4:	0.0	0.0	0	0
REM:	0.0	0.0	0	0
Non-REM:	0.3	0.6	1	2

Spontaneous Arousals

PARAMETER	INDEX	TOTAL
Total Arousals:	3.1	15
REM Arousals:	3.5	6
Non-REM Arousals:	2.8	9
Supine Arousals:	0.0	0
Non-Supine Arousals:	2.6	13

Upper Airway Resistance (Snore Arousals)

PARAMETER	INDEX	TOTAL
Total Arousals:	2.4	12
REM Arousals:	1.8	3
Non-REM Arousals:	2.8	9
Supine Arousals:	0.0	0
Non-Supine Arousals:	1.8	9

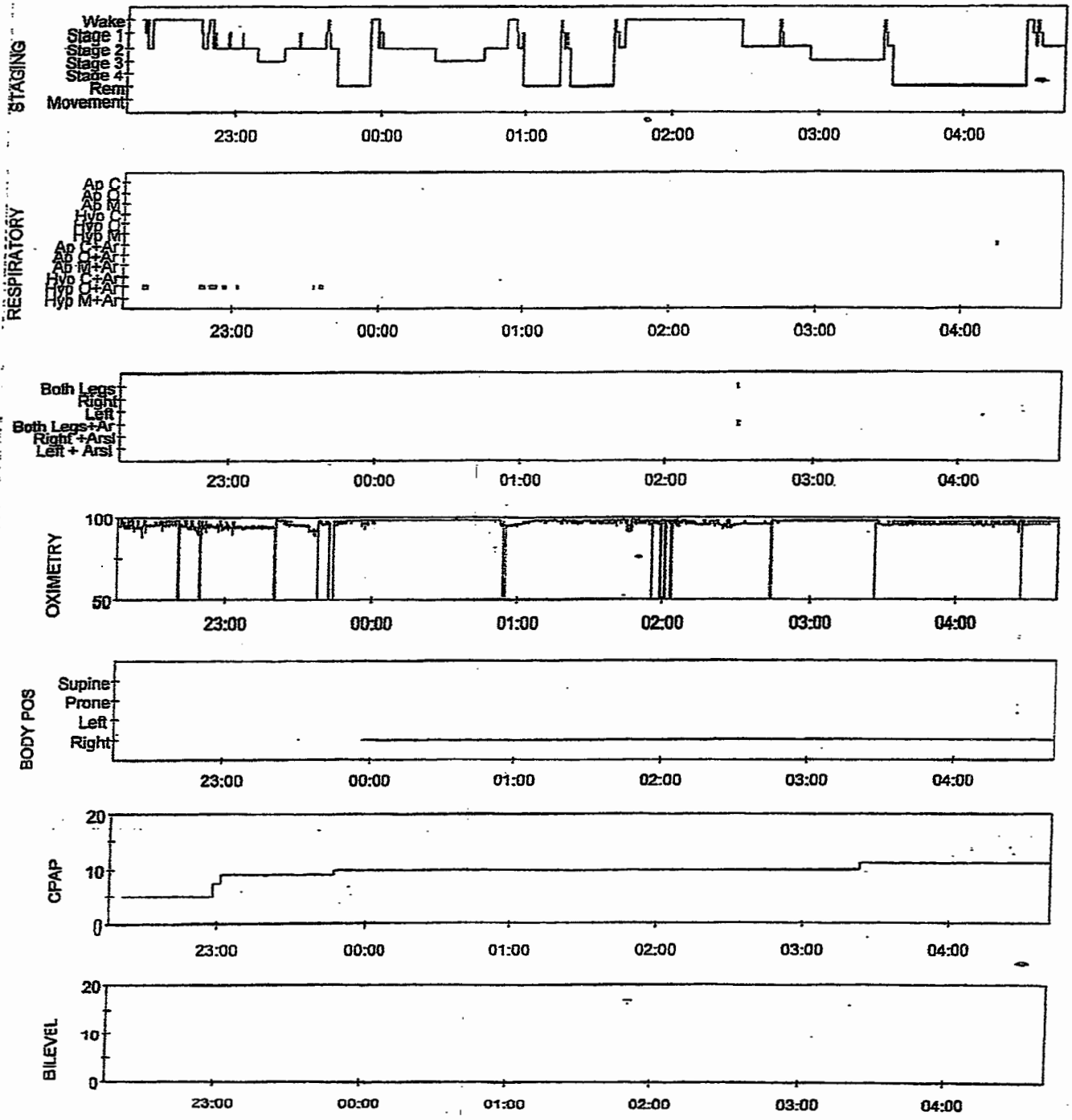
Pressure Level Analysis:

Pressure (cm H_2O)	TRT (min)	REM (min)	Non-REM (min)	Obs. Apnea	Cen. Apnea	Mixed Apnea	Hypop-neas	Total Events	RDI	Max. SaO_2 %	Min. SaO_2 %	Mean SaO_2 %
Cpap Tags												
5	37.2	0.0	13.3	0	0	0	10	10	45.0	99.0	87.0	95.0
7	3.1	0.0	3.1	0	0	0	0	0	0.0	97.0	92.0	94.1
9	45.7	5.1	40.1	0	0	0	4	4	5.3	99.0	85.0	94.7
10	216.1	40.9	118.7	0	0	0	0	0	0.0	100.0	94.0	97.0
11	77.7	55.5	18.2	0	1	0	0	1	0.8	100.0	92.0	96.4
Bi-Level Tags												

LAKEVIEW SLEEP CENTER

Patient Name: LIVINGSTON, DOUGLAS **Subject Code:** LKV-056-10 **Study Date:** Aug. 18, 2010

SLEEP ANALYSIS REPORT



WOULD YOU GO BACK TO SCHOOL IF YOU QUALIFIED FOR A GRANT? SEE IF YOU QUALIFY. SELECT YOUR AGE
Under 18 19-25 26-35 36-45 46-55 56-65 66-75 Over 75
ADVERTISEMENT

Sleep Apnea and PTSD

By Heather Tull, PhD, About.com Guide *Created December 16, 2010*

About.com Health's Disease and Condition content is reviewed by the Medical Review Board

Free Post Traumatic Stress (PTSD) Newsletter!
Enter email address Sign Up
Discuss in my forum

If you have posttraumatic stress disorder (PTSD) and have difficulty sleeping, then it is possible that you suffer from sleep apnea. A 2010 study by researchers at Walter Reed Army Medical Center in Washington, D.C., looked at sleep problems among 80 OEF/OIF soldiers returning from combat who were diagnosed with PTSD. Almost all of them said that they had problems sleeping, and almost two-thirds were found to suffer from sleep apnea.

This finding is not surprising given that it is very common for people with a diagnosis of PTSD to experience some type of problem sleeping. In fact, difficulty falling and/or staying asleep is considered one of the hyperarousal symptoms of PTSD, and studies have found that sleep problems are one of the most commonly reported symptoms reported by people with PTSD.

What Is Sleep Apnea?

Sleep apnea is a fairly common sleep disorder where a person may have one or more brief (a few seconds to minutes) pauses in their breathing or experience shallow breathing while sleeping. Although these pauses may be brief, they can occur frequently during the night. Normal breathing eventually starts up again; however, these pauses can greatly disrupt a person's sleep. In addition, these pauses in breathing can prevent someone from going into a deep sleep, resulting in sleep that is not satisfying or restorative.

Many people have sleep apnea but don't know it. It can often go undiagnosed. Most people figure out they have it from a bed partner who first notices the symptoms of sleep apnea.

Symptoms of Sleep Apnea

There are several tell-tale signs of sleep apnea:

- Loud and persistent snoring
- Choking or gasping for air at night
- Feeling tired and sleepy during the day
- Headaches, especially in the morning
- Concentration or memory problems
- Being jarred out of sleep at night due to lack of air

Why Does Sleep Apnea Develop?

There are a number of causes of sleep apnea.

- A person's throat muscles and tongue may become more relaxed than normal during sleep, preventing the airway from staying open.
- A person with sleep apnea may also have a tongue and tonsils that are larger compared to the opening into their airway.
- People who are overweight or obese are also at risk for sleep apnea, as they may develop a thicker airway wall due to extra fat tissue.
- The shape of a person's head and neck may result in a smaller airway.
- Aging may also increase risk for sleep apnea.

Sleep apnea is also more common in men than women, as well as in racial/ethnic minority populations. There may also be a genetic basis to sleep apnea. If someone in your family has sleep apnea, you are at greater risk for developing it as well. Sleep apnea has also been connected with a number of physical conditions and unhealthy behavior, including smoking, diabetes, and high blood pressure.

Why people with PTSD might be more likely to develop sleep apnea has not been explored by researchers as of yet. However, people with PTSD do often show many of the risk factors for sleep apnea described above. People with PTSD may be more likely than people without PTSD to have high blood pressure, be overweight, smoke, and have diabetes or other physical health problems, and they are more likely to abuse alcohol. All of these factors may put people with PTSD at risk for developing sleep apnea.

Managing Your Sleep Apnea

Sleep apnea can be successfully managed. The first step however is getting it diagnosed. You can learn more about sleep apnea and its treatment from Dr. Brandon Peters, About.com Guide to Sleep. There are also a number of easy things you can do to improve your sleep in general. Check out this article for some basic ways of improving your sleep quality when you have PTSD.

Sources:

Harvey, A. G., Jones, C., & Schmidt, D. A. (2003). Sleep and posttraumatic stress disorder: A review. *Clinical Psychology Review, 23*, 377-407.

Lee, H., Cortez, R., Colla, J. F., Hoffman, R., Kelly, A. B., & Lettieri, C. J. (2010). Prevalence of sleep disorders among soldiers with combat-related posttraumatic stress disorder. *CHEST, 138*, 7044.

U.S. Department of Health and Human Services, National Institutes of Health (August 2008). Sleep Apnea. http://www.nhlbi.nih.gov/health/dci/Diseases/Sleep_Apnea/Sleep_Apnea_WhatIs.html

Related Searches Sleep Apnea Symptoms Walter Reed Army Medical Army Medical Center Walter Reed Army Walter Reed Army Medical Center Reed Army Medical Center

CERTIFICATE OF SERVICE

I certify under penalty of perjury under the laws of the United States of America that on ***November 13, 2019***, a copy of this Informal Brief with Exhibit A was mailed, postage prepaid to:

LANCE STEAHLY
Appellate Attorney
Office of the General Counsel (027J)
Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420
(202) 632-6809

Charles H Watson
Appellant's signature

Mr. Charles A. Watson
700 N. Ellis Avenue
Dunn, NC 28334

PLACE STICKER AT TOP OF ENVELOPE TO THE RIGHT
OF THE RETURN ADDRESS. FOLD AT DOTTED LINE

CERTIFIED MAIL®

7018 3090 0001 3856 0898

UNITED STATES POSTAL SERVICE®

1000

20004

U.S. POSTAGE PAID
FCM LG ENV
CARY, NC
27519
NOV 13, 19
AMOUNT
$9.10
R2305P150935-04

RETURN RECEIPT REQUESTED

Clerk, U.S. Court of Appeals for Veterans Claims
625 Indiana Avenue, N.W. Suite 900
Washington, DC 20004-2950

RETURN RECEIPT REQUESTED