

U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of JOHN JOSEPH DOLAN and U.S. POSTAL SERVICE,
POST OFFICE, Lehigh Valley, PA

*Docket No. 98-520; Submitted on the Record;
Issued October 1, 1999*

DECISION and ORDER

Before MICHAEL J. WALSH, GEORGE E. RIVERS,
WILLIE T.C. THOMAS

The issue is whether appellant has met his burden of proof in establishing that he sustained an injury in the performance of duty on July 1, 1997.

On July 8, 1997 appellant, then a 45-year-old administrative clerk, at the vehicle maintenance facility filed a notice of traumatic injury and claim for continuation of pay/compensation (Form CA-1). Appellant alleges that on July 1, 1997, he injured his lower back while he was unloading an engine from the back of a postal pick-up truck. Appellant indicated that he was pulling the engine to the rear of the truck box when he felt a sharp pain in his lower back. He also noted that his lower back condition started getting worse the next day and he contacted his private doctor. There is also an eyewitness who stated that he/she saw appellant bend over and grab his back when he was delivering and pulling an engine to the rear of the truck's tailgate at the "Brandon's Garage." The record, however, shows that appellant lost no time from work due to this alleged lower back injury.

By letter dated September 10, 1997, the employing establishment controverted appellant's claim alleging that there are inconsistencies in the information provided by him. The employing establishment indicated that appellant did not report his July 1, 1997 incident until eight days later on July 9, 1997; that appellant indicated to his supervisor that he would not be seeking medical attention; that on September 3, 1997 appellant telephoned the employing establishment and stated that at the time of the injury he was sent to a postal contract doctor, but now wanted to go to see his own private doctor; that this information is false because appellant was never seen by a postal contract doctor; that appellant has had previous workers' compensation claims involving his lower back problem which had been denied; that he had a discussion with his supervisor concerning the loss of his sick leave; and that it was common knowledge that appellant was doing remodeling and concrete work on his home himself; that on September 5, 1997, a script for a magnetic resonance imaging (MRI) scan was submitted to be performed on appellant; that appellant's previously filed a claim that included a recommendation for back surgery to correct a herniated disc and that appellant was now being referred to a

neurosurgeon for further or additional treatment. The employing establishment attached a copy of appellant's MRI request dated September 5, 1997 to its September 10, 1997 controversion letter and stated:

“Due to the inconsistencies and false information provided by [appellant], the lack of medical documentation to support causal relation, the untimely delay in reporting the alleged injury and seeking medical treatment, the strenuous outside activities performed for many months and the history of a previous back claim being disallowed and the resulting loss of sick leave, it is requested that this claim for benefits be disallowed.”

In a September 22, 1997 letter, the Office of Workers' Compensation Programs advised appellant of the type of factual and medical evidence needed to establish his claim and requested that he submit such. The Office specifically requested that appellant submit physician's reasoned opinions addressing the relationship of his claimed condition and specific employment factors. Appellant was allotted 30 days within which to submit the requested evidence.

Appellant responded to the Office's September 22, 1997 letter and submitted additional medical evidence. The evidence included a September 2, 1997 progress note from a physician or nurse whose signature is illegible. Also submitted were the September 7, 1997 medical results of the MRI examination performed on appellant by Dr. John J. Witowski, a Board-certified diagnostic radiologist and a September 18, 1997 neurosurgeon evaluation report from Dr. Romola Karumbaya, a neurological surgeon. In the September 7, 1997 report, Dr. Witowski stated that appellant has had chronic low back pain but the recent symptoms of low back pain with some radiation into the right leg may be related to an injury he had a couple of months ago. He indicated that appellant had a laminectomy at L5-S1 in 1994. Dr. Witowski then stated:

“Discussion: The study again demonstrates right-sided laminectomy defect at the L5-S1 level. The lower three lumbar discs show evidence of chronic degenerative change with desiccation and mild disc space narrowing. There is some disc bulging at L3-4 and L4-5 as previously mentioned. The L4-5 bulge is slightly larger than was noted on the previous postoperative study in October 1994 and although it is difficult to prove on the axial images, there may be a small left[-]sided herniation present at this level. At L5-S1 there is scar formation on the right side and there is some deformity of the caudal sac which appears to be retracted in a right posterolateral direction. This appearance is unchanged. There is a suggestion of a small central disc bulge at this level that is unchanged. The upper canal is normal.

“Impression: Post-surgical changes L5-S1 with small residual or recurrent disc bulge and evidence of epidural scar formation. No change at this level. At L4-5 there is a small disc protrusion and this appears to have increased in size on the right when compared to the previous postoperative study. No change in the disc bulging and degenerative change at the L3-4 level.”

In the September 18, 1997 neurosurgical evaluation, Dr. Karumbaya provided the history of injury as presented by appellant and noted that appellant had continued to have symptoms

from a prior work-related injury with severe back pain radiating to his right lower extremity. He indicated that at the time of appellant's prior injury, he was diagnosed as having a large extruded disc at the L5-S1 level and was operated on. Dr. Karumbaya, then indicated that appellant's back pain was on and off but never severe or incapacitating since the operation. However, since the July 1, 1997 incident, Dr. Karumbaya stated:

“[Appellant] had increased back pain and a few days later he had pain going down his right lower extremity. The right lower extremity pain resolved in approximately [three] days. He has continued to work. [Appellant] still has mild back pain but it is very minimal and back to the status prior to the recent event of [July] [19]97.

“Physical exam[ination]: Straight leg raising is negative bilaterally. Patellar reflexes are [two] [plus] bilaterally. Right ankle reflex is absent. Left ankle reflex is [two] [plus]. Sensory exam is entirely within normal limits. Motor exam[ination] is normal including hamstrings, quadriceps, plantar flexors and dorsiflexors of the feet and extensor hallucis. He has no point tenderness in the lumbar spine. Lumbar movements are not limited due to pain. [Appellant's] most recent MRI [scan] done in [September] [19]97 showed some epidural scar formation with deformity of the cal sac in the right posterior lateral direction. He had a small disc herniation at L4-5 to the right and a question of a small recurrent disc bulge at L5-S1.

“With this marked improvement of symptoms at this time and the major abnormality on the MRI [scan] being compatible with scar tissue I would recommend conservative management at this time. I would recommend [that] [appellant] be on a lumbar strengthening program as his work involves moving awkward objects at time[s]. Ideally I would recommend he be on a club membership program for a lumbar strengthening regimen. I discharged [appellant] from my care.”

In an October 29, 1997 decision, the Office denied appellant's claim for benefits for the reason that “fact of an injury was not established.” The Office stated: “that the initial evidence of file was insufficient to establish that [appellant] experienced the claimed accident, [at] the time, place and in the manner alleged because the evidence indicated that you had delayed reporting this alleged accident for seven days and had not submitted any medical evidence to support your claim.”

The Board finds that appellant has established that a work incident occurred as alleged on July 1, 1997.

An employee seeking benefits under the Federal Employees' Compensation Act has the burden of establishing the essential elements of his or her claim, including that the individual is an “employee of the United States” within the meaning of the Act, that the claim was timely filed within the applicable time limitation of the Act, that an injury was sustained in the performance of duty as alleged and that any disability or specific condition for which compensation is claimed is causally related to the employment injury. These are essential

elements of each compensation claim regardless of whether the claim is predicated upon a traumatic injury or an occupational disease.¹

To determine whether a federal employee has sustained a traumatic injury in the performance of duty, it must first be determined whether a “fact of injury” has been established. First, the employee must submit sufficient evidence to establish that he or she actually experienced the employment incident at the time, place and in the manner alleged.² Second, the employee must submit sufficient evidence, generally only in the form of medical evidence, to establish that the incident caused a personal injury.³

The Board has previously stated that an injury does not have to be confirmed by eyewitnesses in order to establish the fact that an employee sustained an incident in the performance of duty, as alleged, but the employee’s statements must be consistent with surrounding facts and circumstances and his subsequent course of action. Such circumstances as late notification of injury, lack of confirmation of injury, continuing to work without apparent difficulty following the alleged injury and failure to obtain medical treatment, if otherwise unexplained, may cast serious doubt on an employee’s statements in determining whether he or she has established a *prima facie* case. The employee has not met his or her burden when there are such inconsistencies in the evidence as to cast serious doubt on the validity of the claim.⁴ However, an employee’s statement that an injury occurred at a given time, place and in a given manner is of great probative value and will stand unless refuted by strong or persuasive evidence.⁵

Appellant has consistently alleged that an incident occurred on July 1, 1997, when he was unloading an engine from the back of the employing establishment’s postal pick-up truck when he felt a sharp pain in his lower back while pulling the engine to the rear of the truck; and that he filled out a traumatic injury claim Form CA-1, seven days later on July 8, 1997. Similarly, the September 18, 1997 medical report, of Dr. Karumbaya is consistent with appellant’s report of the July 1, 1997 incident, although appellant did not seek medical treatment for his alleged condition for two months after the alleged incident occurred. In addition, the record shows that there is a statement from an eyewitness verifying that the incident occurred as alleged. Meanwhile, the employing establishment has controverted appellant’s claim. However, while appellant’s supervisor has indicated that he did not inform him of the July 1, 1997 incident until eight days later on July 9, 1997 and while the medical reports indicate that appellant had a preexisting back condition in which a claim for benefits was denied back in 1994; that appellant discussed outside activities being worked on with his supervisor, including remodeling his home and putting in a large concrete pad without subcontractors, there is no such evidence of record which indicates

¹ *Jerry A. Miller*, 46 ECAB 243 (1994).

² *Gene A. McCracken*, 46 ECAB 593 (1995); *Robert J. Krstyen*, 44 ECAB 227 (1992); *John J. Carlone*, 41 ECAB 354 (1989).

³ *Nathaniel Cooper*, 46 ECAB 1053 (1995).

⁴ *Linda S. Christian*, 46 ECAB 598 (1995); *Carmen Dickerson*, 36 ECAB 409 (1985).

⁵ *Id.*; *Virgil F. Clark*, 40 ECAB 575 (1989).

that the July 1, 1997 incident did not occur at the time, place and in the manner alleged by appellant. Furthermore, upon review, the Board finds that the evidence of record is devoid of any inconsistent statements made by either appellant or the physicians of record.⁶ Therefore, the record does not contain any strong or persuasive evidence to refute appellant's account of the July 1, 1997 incident, or otherwise cast serious doubt upon the validity of appellant's claim. Consequently, the Board finds that the claimed incident occurred as alleged by appellant.

As the Office has not evaluated the medical evidence of record to determine whether appellant had sustained a medical condition, an aggravation of a preexisting condition, or both, causally related to his accepted July 1, 1997 incident and any employment factors, the case will be remanded to the Office for further development. After any further development as deemed necessary, the Office shall issue an appropriate *de novo* decision regarding whether appellant sustained a medical condition, an aggravation of a preexisting condition, or both, in the performance of duty on July 1, 1997.

The decision of the Office of Workers' Compensation Programs dated and finalized on October 29, 1997 is hereby set aside and the case is remanded to the Office for further proceedings consistent with this decision of the Board.

Dated, Washington, D.C.
October 1, 1999

Michael J. Walsh
Chairman

George E. Rivers
Member

Willie T.C. Thomas
Alternate Member

⁶ The record does not contain evidence of the September 3, 1997, alleged telephone conversation between appellant and his supervisor. Therefore, this conversation will not be given special consideration.