United States Department of Labor
Employees' Compensation Appeals Board

B.D., claiming as widow of R.D., Appellant	)	
and	)	**Docket No. 06-1064** **Issued: January 24, 2007**
DEPARTMENT OF DEFENSE, CORPS OF ARMY ENGINEERS, Marion, OH, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
DAVID S. GERSON, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On April 3, 2005 appellant, filed a timely appeal of the Office of Workers' Compensation Programs' merit decision dated February 1, 2006 which found that she had not established that she was entitled to death benefits. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether the employee's death on September 29, 2003 was due to his accepted employment-related injuries.

FACTUAL HISTORY

On August 30, 1956 the employee, a 24-year-old forklift operator, sustained a compound fracture of the right leg as well as laceration of the scalp and abrasions of the left elbow and leg in the performance of duty when a forklift he was driving turned over. The Office also accepted that he developed left leg phlebitis and osteomyelitis, right leg thrombophlebitis as well as

anxiety reaction as a result of his employment injuries. The employee sustained a nonfederal employment injury in 1972 when he slipped and fell injuring his right femur while employed by the private sector. He pursued this claim through the state workers' compensation system. The employee underwent a right leg below the knee amputation on April 24, 1991 due to his chronic osteomyelitis. The Office awarded him schedule awards for 92 percent impairment of his right lower extremity and 15 percent impairment of his left hand in 1959 and 1992. The employee had a total knee replacement on July 24, 1998 which was paid for by the state workers compensation system.

The employee was hospitalized on March 2, 2003 as he reported problems with his right knee resulting in an injection. Following the injection by Dr. Arron Fritz, an osteopath,[1] he developed nausea, vomiting and diarrhea. He felt that the employee's right knee joint was septic. The employee's diagnosed conditions were diabetes mellitus, acute myositis, renal failure, rhabdomyolysis, history of atria fibrillation and postamputation for osteomyelitis. He was assessed for a right septic knee joint. Dr. Benjamin Laracuente, a Board-certified pulmonologist, examined the employee on March 6, 2003 and diagnosed systemic inflammatory response syndrome, sepsis, shock, respiratory failure and an elevated right hemidaphragm. He suggested that the employee's conditions were due to rheumatological disease or a previous secondary paralysis due to a stroke. The employee underwent an incision and drainage, irrigation and debridement of the right total knee replacement on March 11, 2003.

By letter dated October 7, 2003, appellant notified the Office that the employee died on September 29, 2003. She filed a claim for compensation by widow on October 28, 2003 and submitted a copy of her marriage license and the employee's death certificate. The employee's cause of death was listed as respiratory arrest as a result of worsening respiratory failure caused by multiple infections from his work-related injuries.

Dr. Fritz opined on October 20, 2003 that the employee's death was due to respiratory arrest secondary to infection of the right knee. He indicated with a checkmark "yes" that the employee's death was due to his employment injuries. Dr. Fritz stated:

> "[The employee] sustained work-related injury to right knee, femur underwent open reduction internal fixation right femur/knee, then subsequent right total knee replacement. This total knee became infected, requiring multiple surgeries. The infection persisted despite aggressive and appropriate treatment and the [employee] became septic and subsequently died."

Dr. David K. Halley, a Board-certified orthopedic surgeon, completed the attending physician portion of the claim form on October 22, 2003 and indicated that the employee had an infected right total knee replacement. He performed a radical debridement on August 7, 2003. Dr. Halley stated that the cause of death on September 29, 2003 was respiratory arrest secondary to right knee infections.

[1] There are no medical reports in the record detailing the type of injection or the reasons the employee received the injection.

Dr. Michael J. Hayes, a Board-certified internist, completed a report on October 23, 2003 and stated that the employee's death was due to osteomyelitis of his right leg. He stated, "[t]his was related to the previous injury which had caused the osteomyelitis leading to the amputation."

The Office requested additional factual and medical evidence by letter dated November 12, 2003. Appellant responded and submitted medical records from the employee's hospitalizations dating from March 2 through September 29, 2003. Following the March 2, 2003 hospital admission, the employee was discharged on March 14, 2003 with diagnoses of septemia, infected knee, rhabdomyolysis, renal failure, diabetes mellitus, cardiac arrhythmia, respiratory distress, hypotension and anemia.

The employee entered Marion General Hospital on April 22, 2003 due to congestive heart failure and respiratory failure. The discharge diagnoses included respiratory distress, pneumonitis, cardiac arrhythmia, hypotension, renal failure, diabetes mellitus and history of staph aureus infection.

On May 26, 2003 the employee was again admitted to Marion General Hospital due to nausea and vomiting. The admitting diagnoses were septic shock, atrial flutter, diabetes mellitus, history of congestive heart failure, history of chronic obstructive pulmonary disease, anemia and renal failure and prior right leg amputation. The hospital discharged the employee on June 25, 2003 with diagnoses of pancreatic cyst, anorexia, cardiac arrhythmia, diabetes mellitus, anemia, urinary tract infection, malnutrition, history of septicemia and respiratory distress.

The employee was hospitalized on July 9, 2003 due to anorexia, intractable nausea, pancreatic pseudocyst, diabetes mellitus, anemia, malnutrition and history of septicemia postamputation and history of respiratory disease. The employee received a feeding gastroscopy tube.

The employee returned to the hospital on August 5, 2003 due to a reddened swollen right knee. Dr. Halley performed a radical debridement of the right knee with removal of total knee replacement and bone cement on August 7, 2003. Postoperatively, the employee developed respiratory failure secondary to pneumonitis. Initially he was intubated, the breathing tube was then removed, but the employee had to be reintubated and treated with additional antibiotics. The employee was extubated on August 16, 2003 and on August 25, 2003 he was transferred to a long-term care hospital.

Dr. Shoghi McLean, a Board-certified internist, examined the employee on August 25, 2003 and noted that he had developed an infection with swelling and tenderness on his right knee replacement. While in the hospital for treatment of this condition beginning August 5, 2003, the employee developed respiratory failure with resultant intubation. Dr. McLean noted that appellant had a staphylococcal infection in his right knee, a history of congestive heart failure, arrhythmia and diabetes. He stated that the employee did not wish further intubations and that treatment was to include physical therapy, occupational therapy, nutrition therapy and antibiotics.

Dr. McLean also provided a death summary dated November 4, 2003 listing the employee's final diagnoses as right total knee replacement and thigh abscess, sepsis, diabetes

mellitus, congestive heart failure, urinary tract infection, gastroparesis and chronic obstructive pulmonary disease with chronic hypoxia. He noted that on September 24, 2003 the employee had an episode of decreased saturations of 55 percent which increased to 99 percent with a nonrebreather mask. Dr. McLean stated that the employee remained stable throughout the remainder of his hospitalization but on September 29, 2003 died suddenly. In a separate note, Dr. McLean stated that the direct cause of death was most likely secondary to poor respiratory status and chronic obstructive pulmonary disease and that his general deconditioning and worsening status most likely secondary to his leg infection.

In a letter dated June 29, 2005, the Office requested that appellant provide additional information regarding the employee's 1998 right knee replacement. The Office noted that the employee had stated that the right knee replacement was authorized by the state workers' compensation as related to his 1972 injury rather than as due to his 1956 federal employment injury. Appellant submitted reports from Dr. Juan B. Segarra-Vidal, an orthopedic surgeon, beginning May 5, 1998 noting that the employee fractured his right knee on January 1, 1972 and began to experience additional symptoms following laying tile at his home. Following x-ray evaluation, Dr. Segarra-Vidal recommended a total knee replacement due to a complete loss of joint space at the level of the right knee joint with a collapse of both compartments. He stated appellant's claim should be expanded to include additional diagnosis of post-traumatic arthritis of the right knee.

The Office referred the employee's medical records and a list of questions to Dr. James Galbraith, a physician Board-certified in infectious disease, on October 28, 2005. It asked that Dr. Galbraith provide a history of work-related injury and subsequent course of treatment, provide an opinion as to whether or not the claimant has suffered from infections of the right leg since 1956 related to the original injury and provided an opinion as to whether or not the injury of 1956 and subsequent sequelae of this injury either caused or precipitated the claimant's death on September 29, 2003. In a report dated November 11, 2005, Dr. Galbraith noted the employee's accepted employment injuries and reviewed the medical history. He stated that following the accepted fracture of the right tibia in 1956 appellant developed osteomyelitis which required repeated surgical debridements. Dr. Galbraith stated that following the below-the-knee amputation on April 24, 1991, the employee did not have further infectious symptoms until after the July 24, 1998 total knee replacement and removal of femur hardware. He noted that Dr. Segarra-Vidal suggested that the employee's right knee arthritis was due to the accepted employment injury. However, Dr. Galbraith discounted this opinion as the conclusion was not included in the statement of accepted facts. He, therefore, opined that the employee's original infections were cured as of 1991 and appellant's below-the-knee amputation. Dr. Galbraith stated that the employment injuries did not precipitate or cause the employee's death. He concluded:

> "It is my opinion after chart review that a multifactorial process was ongoing here and this would included diabetes mellitus, COPD [chronic obstructive pulmonary disease], pancreatitis with a cyst that was impairing his ability to receive adequate nutrition as well as a host of infections including a septic knee joint, arthritis, as well as eventual … pneumonia. Again I do not think these are directly related to his original work injury."

By decision dated February 1, 2006, the Office denied appellant's claim finding that the weight of the medical opinion evidence rested with Dr. Galbraith who opined that the employee's death was not due to his federal employment injuries.

LEGAL PRECEDENT

A claimant has the burden of proving by the weight of the reliable, probative and substantial evidence that the employee's death was causally related to his employment.[2] As part of a claimant's burden of proof, he or she must present rationalized medical opinion evidence, based on a complete factual and medical background, establishing causal relation. The question of whether there is a causal relationship is medical in nature, and generally, can be established only by medical evidence. This medical opinion must be based upon a complete factual and medical background with an accurate history of the employment injury. The weight of the medical evidence is determined by its reliability, its probative value, its convincing quality, the care of analysis manifested and the medical rationale expressed in support of the physician's opinion.[3]

An award of compensation may not be based on surmise, conjecture or speculation. The mere showing that an employee was receiving compensation at the time of his or her death does not establish that the death was causally related to the condition resulting from the employment. The receipt of compensation for total disability for work is not proof of the fact or sufficient to raise a presumption of a causal relation between an employee's death and an accepted injury. Such an issue is medical in nature and must be resolved through probative medical opinion evidence.[4]

ANALYSIS

Appellant attributed the employee's death to his accepted federal employment injuries including the compound fracture of his right leg, osteomyelitis of the right leg and resultant amputation. She also appears to attribute the employee's 1998 total knee replacement to his federal employment injuries. The Office did not authorize the total knee replacement and the employee received compensation benefits for this surgery through his 1972 State Workers' Compensation claim. There is no indication that at the time of the employee's death, the Office had accepted that the 1998 total knee replacement was related to his accepted federal job injuries. Therefore, in order to meet her burden of proof in establishing that the employee's death was due to his accepted federal employment injuries, appellant must identify a chain of causation which establishes that the employee's death was due to his right knee infection and which includes the arthritis (which necessitated the 1998 total knee replacement) as caused in some part the accepted federal job injuries of below the knee amputation. In the alternative, appellant must show a chain of causation which establishes that the knee led to the employee's death and that

[2] *Jacqueline Brasch* (*Ronald Brasch*) , 52 ECAB 252 (2001).

[3] *James Mack*, 43 ECAB 321, 328-29 (1991).

[4] *Bertha J. Soule* (*Ralph G. Soule*), 48 ECAB 314, 317 (1997).

this infection would have occurred because of his accepted federal job injuries regardless of whether he underwent the 1998 total knee replacement.

Dr. Segarra-Vidal, an orthopedic surgeon, who performed the employee's right total knee replacement, attributed the need for this surgery to post-traumatic arthritis in the knee joint. He provided a history of injury including only a right knee fracture on January 1, 1972. As Dr. Segarra-Vidal did not provide an opinion that the post-traumatic knee arthritis was due in part to the employee's accepted federal employment injuries such as osteomyelitis or the resulting below the knee amputation, his report does not support this claim. This report does not provide an opinion on the causal relationship between the employee's federal injuries and his total knee replacement, therefore, the report does not support appellant's claim for federal death benefits.

Appellant submitted medical evidence dated March 2, 2003 noting that the employee reported problems with his right knee resulting in an injection from Dr. Fritz, an osteopath. Following the injection the employee developed nausea, vomiting and diarrhea. Dr. Fritz felt that the employee's right knee joint was septic. The employee underwent a surgical debridement of his right total knee replacement on March 11, 2003 and again on August 7, 2003. On October 20, 2003 Dr. Fritz indicated that the employee had a work-related injury to his right knee resulting in an internal fixation of the right femur and knee and later in a total knee replacement. He stated that the total knee replacement became infected, resulted in septemia and the employee died. Dr. Fritz does not specifically delineate the employee's federal and private sector injuries. However, as noted previously, the Office did not accept a right knee injury or any right knee surgeries as due to the federal job injuries. Dr. Fritz appears to attribute the employee's death to his state workers' compensation claim. This report is not sufficient to meet appellant's burden of proof as Dr. Fritz did not attribute the right knee surgeries, injection or sepsis to the employee's federal job injuries or employment.

Dr. Halley, a Board-certified orthopedic surgeon, opined on October 22, 2003 that the employee had an infected right total knee replacement. He attributed the employee's death to respiratory arrest secondary to the right knee infections. This report is also insufficient to meet appellant's burden of proof. Dr. Halley did not provide a history of injury describing the employee's various employment injuries and did not provide an opinion on the causal relationship of the right knee replacement to the employee's accepted federal employment injuries.

In a brief report dated October 23, 2003, Dr. Hayes, a Board-certified internist, stated that the employee's death was due to the osteomyelitis of his stump. He stated, "[t]his was related to the previous injury which had caused the osteomyelitis leading to the amputation." While this report does attribute the employee's death to his accepted federal job injuries, Dr. Hayes did not provide a history of injury, including both the federal and private sector injuries and did not provide any medical reasoning explaining how he reached the conclusion that the employee's death was due to the accepted condition of osteomyelitis. Without any explanation of how the accepted osteomyelitis resulted in infection of the total knee replacement and without evaluating the effect of a seven-year period between the amputation and the infection, this report lacks the necessary medical rationale to meet appellant's burden of proof.

On November 4, 2003 Dr. McLean, a Board-certified internist, provided a summary of the employee's hospitalization and diagnosed right total knee replacement and thigh abscess, sepsis, diabetes mellitus, congestive heart failure, urinary tract infection, gastroparesis and chronic obstructive pulmonary disease with chronic hypoxia. He concluded that the direct cause of death was poor respiratory status and chronic obstructive pulmonary disease. Dr. McLean also opined that the employee's general deconditioning and worsening status was due to his leg infection. While this report appears to attribute the employee's death to his leg infection, Dr. McLean did not provide a detailed history of the employment injuries and conditions. He did not offer any opinion regarding whether the federal or private sector injuries caused or contributed to the employee's leg infection. Because Dr. McLean did not offer an opinion on the causal relationship between the employee's death and his federal employment injuries, his report is not sufficient to meet appellant's burden of proof.

The Office referred the case record, a list of questions and a statement of accepted facts to Dr. Galbraith, a physician Board-certified in infectious disease, for a second opinion. Dr. Galbraith reviewed the medical records and noted that following the April 24, 1991 below the knee amputation, the employee had no further infectious symptoms until after the July 24, 1998 total knee replacement. He opined that the employee's original infections were cured by the 1991 amputation. Dr. Galbraith noted that the Office had not accepted the 1998 total knee replacement as causally related to the employee's accepted employment injuries.[5] He opined that the employee's death was due to diabetes mellitus, chronic obstructive pulmonary disease and pancreatitis in addition to infections such as the septic knee joint and pneumonia. Dr. Galbraith concluded that these conditions were not related to the employee's federal work injuries. His report was based on a correct factual history, a detailed review of the medical evidence and included an opinion that the employee's osteomyelitis was cured in 1991. Dr. Galbraith opined that the employee's death was not due to his federal job injuries and attributed his death to conditions other than the employee's right leg infection. For these reasons, his report does not support appellant's claim for death benefits.

CONCLUSION

The Board finds that appellant failed to supply the necessary medical evidence including a detailed history of injury and medical rationale explaining the relationship between the employee's death and his accepted employment injuries. For this reason, appellant failed to meet her burden of proof and the Office properly denied her claim.

[5] The Office did not ask for and Dr. Galbraith did not offer any opinion as to whether the employee's right knee post-traumatic arthritis was due in part to his accepted federal conditions.

ORDER

IT IS HEREBY ORDERED THAT the February 1, 2006 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: January 24, 2007
Washington, DC

Alec J. Koromilas, Chief Judge
Employees' Compensation Appeals Board

David S. Gerson, Judge
Employees' Compensation Appeals Board

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board