



performance of duty as appellant's fall occurred prior to clocking in for work. His regular work hours were noted as being from 2:30 to 11:00 p.m., Tuesday through Saturday.

In a physician's report of December 11, 2007, Dr. Joshua Hawkins, a general surgeon, noted that appellant was "said to have had a seizure and fell back onto an object, injuring head." A left frontal lobe contusion and left temporal bone fracture were diagnosed.

In a letter dated January 14, 2008, the Office requested that appellant submit additional factual and medical evidence regarding his claim. In a January 22, 2008 response, appellant advised that he did not know how the incident happened. All he remembered was getting ready for his shift in the men's locker room. In an undated statement, Coworker Philip Omil stated that on December 11, 2007, between the hours of 2:15 to 2:30 p.m., appellant and he were in the men's locker room changing in preparation for work. Appellant grabbed his chest with his right hand, made a noise like "hum" or "ohh" and fell to the floor hitting his head. Mr. Omil gave appellant chest compressions and paramedics were called, who took him to the hospital. Appellant provided copies of medical records dated December 14, 2007 to February 4, 2008.

The records from Harborview Medical Center, where appellant was initially hospitalized for his fall, include a December 11, 2007 x-ray of the cervical spine, computerized tomography (CT) scan of the head and x-ray trauma series. He underwent additional diagnostic testing. The December 13, 2007 discharge summary noted appellant was found by his coworker on the floor of a locker room at the employing establishment. He had a decreased level of consciousness and witnesses did cardiopulmonary resuscitation briefly. No one saw appellant fall, but he appeared rigid. There was no known past history of seizure. Appellant was taken by ambulance awake, but confused, to the emergency department and admitted. The syncope workup was negative. Throughout his hospitalization, appellant was on telemetry with no arrhythmias/irregular heart rate noted. He was also seen by a speech therapist, occupational therapist and physical therapist. Appellant was discharged with a diagnosis of bifrontal contusion/hemorrhage. Secondary diagnoses included: nondisplaced fracture to the left temporal bone, bilateral partial middle ear and left mastoid and bony external auditory canal, right occipital bone fracture and syncope.

In a December 14, 2007 progress note, Dr. Sanders Chai, Board certified in occupational medicine, noted the history of injury and his review of the medical records and objective testing from Harborview Medical Center. He provided an assessment of intracranial hemorrhage, closed head injury, seizure, concussion with moderate loss of consciousness, skull fracture and syncope. Dr. Chai opined the closed head injury and its sequelae, including intracranial bleeding and fractures, were work related. However, the underlying cause for the loss of consciousness was probably not work related. In a January 18, 2008 report, Dr. Chai assessed: intracranial hemorrhage, seizure, closed head injury, syncope and skull fracture, concussion with moderate loss of consciousness, blurred vision and unspecified meningitis.

In a December 17, 2007 medical report, Dr. David Becerril, a Board-certified family practitioner, noted that appellant had a recent closed head injury with multiple skull fractures and was treated at Harborview Medical Center and placed on Dilantin for seizure prevention. Appellant also had a history of chronic bilateral tympanic membrane perforations and right mastoiditis, treated for staph right otitis media one month prior and had bloody drainage from left tympanic membrane at the time of the head injury. Dr. Becerril noted a concern about

possible meningitis and advised that appellant needed to be further evaluated at the Providence Everett Medical Pacific campus. He opined that appellant's syncopal event was likely not cardiac, although echocardiogram and Holter monitor were ordered. Dr. Becerril noted that appellant had an echocardiogram and was monitored on telemetry at Harborview for several days, with no revealing pathology.

Appellant was admitted to Providence Everett Medical Hospital on December 18, 2007 with presumed active bacterial meningitis. The likely source was identified as being mastoid/chronic otitis media, recent skull fracture.

In a January 2, 2006 report, Dr. Robert D. Highley, Board certified in cardiovascular diseases, reviewed the history of injury and advised that appellant's fall was of unknown etiology. He noted that a seizure disorder and syncope needed to be ruled out.

In a January 4, 2008 report, Dr. Kyle Shephard, a Board-certified internist, noted that appellant suffered an on-the-job syncope with resultant fracture of the left temporal bone with subsequent meningitis. Appellant was subsequently diagnosed with central serous retinopathy. Dr. Shephard noted that there was a question of a possible seizure as to the etiology of his syncope, although the details of this were unclear. He noted that one report stated appellant become stiff, while another report noted there may have been shaking. Dr. Shephard advised the etiology of appellant's syncope was unclear and that Dr. Highley's records stated that seizure disorder and cardiac remained as differential diagnoses. In a January 29, 2008 report, he noted that appellant's meningitis resolved with antibiotic treatment. With respect to the syncope, Dr. Shephard noted that appellant underwent a repeat Holter monitor which revealed no significant abnormalities. He advised the etiology of the fall was still uncertain. Dr. Shephard noted that appellant had an extensive cardiac workup and may have a possible seizure disorder.

In a February 6, 2008 report, Dr. Ming Hong, a Board-certified neurologist, noted that on December 11, 2007 appellant fell at work and hit his head on the right side. At Harborview Medical Center, appellant was found, by CT scan, to have a hemorrhagic contusion of the left frontal cortex, a nondisplaced fracture of the left temporal bone, partial middle ear left mastoid fracture and bony exterior auditory canal right occipital bone fracture. Dr. Hong diagnosed closed head injury, memory loss, confusion and seizure. He noted that appellant was back to work and a brain magnetic resonance imaging (MRI) scan a few days prior was normal. He noted appellant was on Dilantin for seizure prevention.

By decision dated February 22, 2008, the Office denied appellant's claim for compensation finding that his injury did not occur in the performance of duty. It noted that the employing establishment controverted the claim and several of the medical reports submitted diagnosed a history of chronic ear disease, previous ear surgeries and a recent diagnosis of meningitis.

### **LEGAL PRECEDENT**

It is a general rule of workers' compensation law that an injury occurring on the industrial premises during working hours is compensable unless it falls within an exception to

the general rule.<sup>1</sup> One exception to the general rule applies to falls in the workplace. Where a personal, nonoccupational pathology causes an employee to collapse and to suffer injury upon striking the immediate supporting surface and there is no intervention or contribution by any hazard or special condition of the employment, the injury is not a personal injury while in the performance of duty as it does not arise out of a risk connected with the employment.<sup>2</sup> This is referred to as an idiopathic fall.<sup>3</sup> On the other hand, if the cause of the fall cannot be determined or the reason it occurred cannot be explained, then it is an unexplained fall that comes within the general rule that an injury occurring on the industrial premises during working hours is compensable.<sup>4</sup>

### ANALYSIS

Appellant contends that the injuries he sustained on December 11, 2007 occurred when he fell in a men's locker room at approximately 2:18 p.m., while getting ready for work. The Board notes that appellant was in the performance of duty at the time of the December 11, 2007 fall as it was reasonable for him to be on the employment premises about 12 minutes before his work shift started at 2:30 p.m.<sup>5</sup> The record establishes that he was changing clothes in preparation for work. However, coverage under the Federal Employees' Compensation Act is not merely determined by appellant's presence on the premises. As noted, a general rule of workers' compensation law is that an injury occurring on the industrial premises during working hours is compensable unless it falls within an exception to the general rule. The Office found that appellant's fall was due to an idiopathic condition and denied the claim. However, the Board finds that the evidence of record does not support that appellant's fall was due to an idiopathic condition.

To properly apply the idiopathic fall exception, there must be two elements present: a fall resulting from a personal, nonoccupational pathology, and no contribution from the employment. Appellant did not allege that he struck any object related to his employment when he fell to the floor. Mr. Omil, appellant's coworker, did not witness appellant striking any object before he reached the floor. Dr. Hawkins' December 11, 2007 report indicated that appellant fell back on an object, injuring his head. However, this statement is not specific regarding the nature of any object and his statement is at odds with those of appellant and Mr. Omil. There is no other evidence supporting that appellant struck any object related to his employment when he fell to the floor. The evidence does not establish that an employment factor contributed to the claimed injury.

---

<sup>1</sup> *Martha G. List*, 26 ECAB 200 (1974).

<sup>2</sup> *John R. Black*, 49 ECAB 624, 626 (1998).

<sup>3</sup> *See Karen K. Levene*, 54 ECAB 671 (2003).

<sup>4</sup> *John R. Black*, *supra* note 2.

<sup>5</sup> The Board has accepted the general rule of workers' compensation law that, as to employees having fixed hours of work, injuries occurring on the premises of the employing establishment, while the employee is going to or from work, before or after working hours or at lunch time, are compensable. *See James P. Schilling*, 54 ECAB 641 (2000); *see also Narbik A. Karamian*, 40 ECAB 617 (1989); *Charles Crawford*, 40 ECAB 474 (1989).

The fall must also result from a personal, nonoccupational pathology. The discharge summary from Harborview Medical Center reveals that the syncope workup was negative and no arrhythmias/irregular heart rates were noted on telemetry. Dr. Chai opined that the cause of appellant's syncope or loss of consciousness was probably not work related. However, Dr. Chai did not explain the reasons for his stated conclusion.<sup>6</sup> Thus, Dr. Chai's opinion is insufficient to establish that appellant's fall was due to a known etiology. The other physicians of record opined that appellant's fall was of an unknown etiology. Dr. Becerril opined that appellant's syncopal episode was not likely cardiac in nature. He reviewed a proper history of injury as well as appellant's preexisting medical conditions. Dr. Becerril noted that appellant's cardiac monitoring as well as the echocardiogram at Harborview Medical Center failed to reveal any pathology. Dr. Highley opined that appellant's fall was of unknown etiology, although he noted a seizure disorder needed to be ruled out. Dr. Shephard also opined that the etiology of appellant's fall was uncertain, even after appellant underwent a repeat Holter monitor of his heart. While the record reflects that he was on medication for seizure prevention, there is no affirmative medical opinion of record which attributes appellant's fall to a seizure or any other specific nonoccupational cause. Because the cause of appellant's fall cannot be determined, it is an unexplained fall and comes within the general rule that an injury occurring on the employing establishment's premises during working hours is compensable.<sup>7</sup>

The Board finds that the idiopathic fall exception to coverage is not applicable and appellant's fall and the medical conditions resulting therefrom are compensable. The medical evidence reveals that he sustained multiple conditions related to his fall. Thus, the case will be remanded to the Office for further development on the nature and extent of any disability related to the December 11, 2007 injury.

### **CONCLUSION**

Appellant's fall on December 11, 2007 occurred in the performance of duty.

---

<sup>6</sup> See *Patricia J. Glenn*, 53 ECAB 159 (2001) (the opinion of a physician must be one of reasonable medical certainty).

<sup>7</sup> *John R. Black*, *supra* note 2.

**ORDER**

**IT IS HEREBY ORDERED THAT** the February 22, 2008 decision is reversed. The case is remanded for further action consistent with this decision of the Board.

Issued: May 8, 2009  
Washington, DC

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

Michael E. Groom, Alternate Judge  
Employees' Compensation Appeals Board

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