

patient, falling from his bed as he tried to remove his robe. She stopped work on May 21, 2008. The employing establishment stated that appellant did not sustain a traumatic injury as there were discrepancies between her account of events and a witness statement. Also, the patient “stated that the incident did not occur.”

In a May 27, 2008 letter, the Office advised appellant of the additional medical and factual evidence needed to establish her claim. It emphasized the importance of corroborating the claimed incident and submitting rationalized medical evidence explaining how and why that incident would cause the claimed injury. Appellant was afforded 30 days to submit additional evidence.

In a May 20, 2008 report, Dr. Sailaja Bandi, an employing establishment physician, noted examining appellant at 8:12 p.m. that day. He stated that appellant “was trying to catch a falling patient and says her back and right hip hurts, no fall seen. [Appellant] was working on 13b at the time of injury.” Dr. Bandi noted tenderness to palpation in the lumbosacral region. He diagnosed a lumbosacral strain and prescribed medication.

In an undated accident report, an employing establishment supervisor stated that on May 20, 2008 at 7:40 p.m., a patient was “taking off housecoat and started to fall. [Appellant] caught patient and hurt her neck and back.”

In a May 21, 2008 telephone memorandum, the employing establishment related appellant’s account that, on May 20, 2008, she sat with the patient to relieve a coworker during lunch. The coworker informed a supervisor that appellant would sit with the patient. Appellant observed that the patient “was about to roll out of bed,” went to “the bed and reached for him.” She then experienced back pain.

In a May 22, 2008 form, an employing establishment supervisor noted that appellant reported a May 20, 2008 back injury sustained when “getting up from chair to prevent a patient from rolling off his bed.... The patient and witness deny this occurred.”

In a May 22, 2008 report, Dr. Thomas E. Craft, an attending Board-certified family practitioner, related appellant’s account of injuring her back and neck at work when “she caught a patient as he was falling out of bed.” Appellant saw an employing establishment physician immediately after the injury. She complained of severe neck, back pain and left hip pain. Appellant presented with paraspinal lumbar spasm. Dr. Craft obtained x-rays showing degenerative disc disease from C4 to C6 and thoracolumbar scoliosis.¹ He diagnosed left lumbar radiculopathy, acute lumbosacral and cervical strains and degenerative cervical disc disease. In an accompanying form, Dr. Craft noted work limitations due to the May 20, 2008 injuries.

In a May 28, 2008 letter, the employing establishment advised the Office that the patient and his roommate both denied that the May 20, 2008 incident occurred. The employing establishment noted that appellant returned to light duty on May 6, 2008 after an occupational back injury accepted under another claim.

¹ On May 22, 2008 Dr. Craft ordered spinal x-rays that demonstrated moderate degenerative disc disease at C5-6, C6-7 and C7-T1 with anterior spurring, straightening of the cervical lordosis indicating muscle spasm and mild left convex thoracolumbar scoliosis.

By decision dated July 2, 2008, the Office denied appellant's claim on the grounds that fact of injury was not established. It found that appellant did not establish the May 20, 2008 incident as factual.

In a July 9, 2008 letter, appellant requested a telephonic hearing, held November 13, 2008. At the hearing, she stated that, on May 20, 2008, she was working on an Alzheimer's ward for patients who wandered or were in danger of falling. Appellant watched the patient while a coworker went to lunch. The patient was sitting on his bed with his legs straight, starting to take off his robe. He leaned over, lost his balance and began to fall out of bed. The side rails were not up. Appellant "jumped up and caught him and helped him back up in the sitting position." A coworker then entered the room and assisted appellant in turning the patient and getting his feet on the floor. As soon as the patient was back in bed, the coworker sat with him while appellant reported the incident to the duty nurse. The duty nurse filled out an accident report and took appellant in a wheelchair to the employee health doctor on call. Appellant's attorney noted appellant's history of a herniated L4-5 disc with annular tears from L3 to L5 and L4 nerve root irritation.

In a December 10, 2008 letter, the employing establishment provided comments to the hearing transcript. It asserted that the patient's roommate was watching television at the time of the alleged incident but that he should have been able to see appellant and the patient.

In an undated statement received by the Office on December 17, 2008, the coworker stated that appellant relieved him during his lunch break. When he returned, appellant was "standing at the nurse's station. She said she got hurt trying to catch" the patient. The coworker asked the patient "what happened. [H]e said he rolled over in the bed" while appellant was "sitting in the chair." The coworker asked the other patient in the room "what happened. He said he did not want to get involved."

In an undated statement received by the Office on December 17, 2008, an employing establishment nurse asserted that, on an unspecified date, the patient "stated that he did not fall on May 20, 2008. He was lying in bed and when he awoke the nurse was sitting in a chair at his bedside." In a second undated statement received by the Office on December 17, 2008, another employing establishment nurse noted speaking with the patient's roommate on an unspecified date. The gentleman stated that he was watching television for the entire time appellant was in the room. He recalled that the patient slept while appellant sat by his bed.

By decision dated and finalized February 6, 2009, the Office denied modification on the grounds that the evidence submitted was insufficient to establish fact of injury. It found that the statements of the patient and his roommate, as related by employing establishment nurses, established that the claimed May 20, 2008 incident did not occur as alleged.

LEGAL PRECEDENT

An employee seeking benefits under the Federal Employees' Compensation Act² has the burden of establishing the essential elements of his or her claim, including the fact that the individual is an "employee of the United States" within the meaning of the Act; that the claim

² 5 U.S.C. §§ 8101-8193.

was filed within the applicable time limitation; that an injury was sustained while in the performance of duty as alleged; and that any disability and/or specific condition for which compensation is claimed are causally related to the employment injury.³ These are the essential elements of each and every compensation claim regardless of whether the claim is predicated on a traumatic injury or an occupational disease.⁴

In order to determine whether an employee sustained a traumatic injury in the performance of duty, the Office begins with an analysis of whether “fact of injury” has been established. Generally, fact of injury consists of two components that must be considered jointly. First, the employee must submit sufficient evidence to establish that he or she actually experienced the alleged employment incident.⁵ Second, the employee must submit sufficient evidence, generally only in the form of medical evidence, to establish that the employment incident caused a personal injury.⁶

ANALYSIS

Appellant claimed that she injured her neck, back and left hip on the evening of May 20, 2008 when she prevented an Alzheimer’s patient from falling out of bed. The Office denied the claim as appellant submitted insufficient evidence to establish the May 20, 2008 incident as factual. However, the Board finds that there is considerable evidence corroborating appellant’s account of the May 20, 2008 incident.

Two witness statements confirm that appellant reported a back injury on May 20, 2008 due to catching the patient as he began to fall from his bed. One of appellant’s coworkers confirmed that, on May 20, 2008, appellant watched the patient while he went to lunch. He saw appellant telling a nurse supervisor that she injured her back catching the patient to prevent him from falling out of bed. A nurse supervisor stated that on May 20, 2008 at 7:40 p.m., appellant injured her neck and back when she caught a patient who began to fall while taking off his housecoat.

Appellant also submitted contemporaneous medical evidence documenting a lumbar injury. Dr. Bandi, an employing establishment physician, examined appellant at 8:12 p.m. on May 20, 2008, less than an hour after the incident. He stated in a May 20, 2008 report that appellant related injuring her back and hip while catching a falling patient. Appellant presented with lumbar paraspinal spasm. Dr. Bandi’s report established that appellant presented with objective lumbar findings on May 20, 2008 within minutes of the claimed incident.

The Office denied the claim based on nurse reports of statements made by the patient and his roommate. In a May 22, 2008 form, a supervisor related appellant’s account of events but that the “patient and witness deny this occurred.” In two undated statements, employing establishment nurses asserted that the patient “stated that he did not fall on May 20, 2008.” His

³ *Joe D. Cameron*, 41 ECAB 153 (1989).

⁴ *See Irene St. John*, 50 ECAB 521 (1999); *Michael E. Smith*, 50 ECAB 313 (1999).

⁵ *Gary J. Watling*, 52 ECAB 278 (2001).

⁶ *Deborah L. Beatty*, 54 ECAB 340 (2003).

roommate recalled watching television as the patient slept. The two gentlemen gave different accounts of those events to appellant's coworker, who stated that the patient recalled "roll[ing] over in his bed." Regarding the patient's roommate, when the coworker asked him what occurred, he stated that he "did not want to get involved." The patient and his roommate gave different versions of events to different personnel. Their statements are therefore too inconsistent to outweigh the statements of appellant, her coworker, the nurse supervisor and Dr. Bandi. The Board therefore finds that appellant has established the May 20, 2008 incident as factual.⁷ Therefore, the Office will modify the July 2, 2008 and February 6, 2009 decisions to accept that the May 20, 2008 incident occurred at the time, place and in the manner alleged.

Appellant sought care on May 22, 2008 from Dr. Craft, an attending Board-certified family practitioner, who related an accurate history of injury and treatment and provided objective x-ray and clinical findings showing lumbar spasm. He diagnosed acute cervical and lumbar strains superimposed on underlying degenerative disc disease.

Although the opinions of Dr. Craft and Dr. Bandi are not sufficiently rationalized⁸ to meet appellant's burden of proof in establishing her claim, they stand uncontroverted in the record and are, therefore, sufficient to require further development of the case by the Office.⁹ In particular, Dr. Bandi and Dr. Craft both evinced a detailed knowledge of the May 20, 2008 incident. Both physicians performed clinical examinations and diagnosed lumbar injuries. However, the Office did not undertake further development of the medical record, such as referring the record to an Office medical adviser or referring appellant for a second opinion examination. In view of the above evidence, the Board finds that the Office should have referred the matter to an appropriate medical specialist to determine whether appellant sustained neck, low back, left hip or other injuries as a result of the accepted May 20, 2008 incident.

Proceedings under the Act are not adversarial in nature and the Office is not a disinterested arbiter. While the claimant has the burden to establish entitlement to compensation, the Office shares responsibility in the development of the evidence. It has the obligation to see that justice is done.¹⁰ Accordingly, the case will be remanded to the Office for preparation of a statement of accepted facts concerning appellant's working conditions, medical history and the May 20, 2008 incident. The Office shall refer the matter to an appropriate medical specialist, consistent with Office procedures, to determine whether appellant sustained neck, back, left hip or other injuries as a result of the May 20, 2008 incident. Following this and any other development deemed necessary, the Office shall issue an appropriate decision in the case.

On appeal, appellant, through her attorney, asserts that the Office's July 2, 2008 and February 6, 2009 findings that fact of injury was not established were "contrary to fact and law."

⁷ *Gregory J. Reser*, 57 ECAB 277 (2005) (an employee's statement regarding the occurrence of an employment incident will stand unless refuted by strong or persuasive evidence).

⁸ See *Jimmie H. Duckett*, 52 ECAB 332 (2001); *Frank D. Haislah*, 52 ECAB 457 (2001) (medical reports not containing rationale on causal relationship are entitled to little probative value).

⁹ *John J. Carlone*, 41 ECAB 354 (1989); *Horace Langhorne*, 29 ECAB 280 (1978).

¹⁰ *Jimmy A. Hammons*, 51 ECAB 219 (1999); *Marco A. Padilla*, 51 ECAB 202 (1999); *John W. Butler*, 39 ECAB 852 (1988).

As set forth above, the Board found that appellant submitted sufficient evidence to establish fact of injury.

CONCLUSION

The Board finds that the case is not in posture for a decision. As appellant has established fact of injury, the case will be remanded to the Office for further development of the medical evidence.

ORDER

IT IS HEREBY ORDERED THAT the decisions of the Office of Workers' Compensation Programs dated February 6, 2009 and July 2, 2008 are set aside and the case remanded to the Office for further development consistent with this decision.

Issued: November 17, 2009
Washington, DC

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

David S. Gerson, Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board