U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of CHRISTINE M. BACON and U.S. POSTAL SERVICE,
POST OFFICE, Sharonville, OH

Docket No. 01-1506; Submitted on the Record;
Issued February 4, 2002

DECISION and ORDER

Before MICHAEL J. WALSH, MICHAEL E. GROOM,
A. PETER KANJORSKI

The issue is whether appellant sustained an injury causally related to a July 25, 1999 employment incident.

The Office of Workers' Compensation Programs accepted that on July 25, 1999 appellant, then a 35-year-old keyer clerk, was struck in the head by a shepherd's hook, which fell out of its holder. Appellant claimed that she was struck in the right temple, was knocked temporarily unconscious and was taken to Good Samaritan Hospital. She noted the nature of her injury as "concussion."

In support of her claim, appellant submitted a July 25, 1999 Good Samaritan Hospital admission report, which noted as history that appellant was struck in the head with a hook at work. The report noted: "Here today for concussion, laying down increases the pain and dizziness and has numbness to the post[erior] head, weak all over, having feeling of passing out feeling worse." Appellant's final diagnosis was acute neurologic syndrome, probable to post-concussion syndrome.

A July 25, 1999 Ohio Workers' Compensation form, signed by another physician with an illegible signature, reported appellant's history of injury and diagnosed closed head injury and probable concussion.

Additional records from July 25, 1999 were submitted, signed by a physician with an illegible signature, which as history that appellant was "hit in head [with] shepherd's hook," and the diagnoses as a closed head injury and probable mild concussion. A computerized tomography (CT) scan of appellant's head was noted to be negative. Hospital discharge paperwork included the diagnoses "Acute neurologic syndrome. Probable [secondary] to post-concussive syndrome."

A July 26, 1999 treatment record, signed by a physician with an illegible signature, noted that appellant's accident history, ongoing symptoms as right temporal pain, dizziness, numbness and tingling, the inability to talk and the right side of her face drawn.

On an August 9, 1999 Form CA-20, a family nurse practitioner noted appellant's history of injury and diagnosed "head injury [with] visual changes." She indicated that appellant was unable to return to work until cleared.

The report of the CT scan performed on August 9, 1999 noted as history "Head trauma July 25, 1999. Headache and occasional blurred vision," and its findings were noted as being "Normal."

On an August 12, 1999 medical progress note a physician identified as a "Dr. Brown" noted that appellant had been under his care since July 28, 1999. He diagnosed a concussion and advised that appellant could return to work on August 5, 1999. However, the physician thereafter noted appellant's diagnosis as "status post concussion -- failed vision test," and indicated that appellant could return to work on August 17, 1999.

On August 16, 1999 a treating physician examining appellant's vision noted as history that she was hit in the head quite severely, which knocked her out temporarily and which caused pain in her eyes and blurred vision since then. On September 13, 1999 the physician treating appellant's visual problems indicated that appellant had had blurred vision since being hit by the pole.

On August 18, 1999 the employing establishment controverted appellant's claim arguing that there was no medical evidence demonstrating causal relation between appellant being hit in the head by a piece of aluminum and her present disability.

A September 11, 1999 report from appellant's treating chiropractor, Dr. Mark K. Cawley was also submitted. A rotational malposition of C2 was noted in radiologic findings.

An additional state workers' compensation form noted appellant's diagnoses as "Segmental dysfunction, [p]ost[-][c]oncussion [s]yndrome [h]eadache [and] [c]ervicalgia," noted that her present symptoms included periodic slurred speech, dizziness, inability to concentrate, difficulty with vision and altered depth perception. For these symptoms, appellant chose to seek treatment with Dr. Cawley, who opined that she was totally disabled from July 25 through October 1, 1999.

By decision dated October 5, 1999, the Office rejected appellant's claim for compensation finding that the evidence of record "fail[ed] to establish that an injury was sustained as alleged." The Office found that the incident occurred as alleged but that the medical evidence of record did not support that a medical condition was proximately caused by the July 25, 1999 incident.

On November 3, 1999 Dr. Robert F. Otte, Jr., a Board-certified family practitioner, noted that appellant was having severe headaches that Dr. Otte felt were post-concussion headaches. He further noted that she was displaying signs of dysarthria and was having difficulty ambulating and he recommended a magnetic resonance imaging (MRI) scan.

A November 5, 1999 report of a MRI scan revealed "cerebellar atrophy, much greater than expected for [appellant's] age." Clinical correlation was recommended.

In a report transcribed December 7, 1999, Dr. James J. Anthony, Jr., a Board-certified neurologist, noted that appellant "clearly has a severe concussion," and he reviewed her neurologic status.

In a January 7, 2000 medical progress note, Dr. Otte reported on appellant's continuing symptoms, including headaches and slow mentation and he diagnosed "[p]ost-concussion syndrome with persistent headache."

A May 5, 2000 Ohio insurance form signed by Dr. Otte noted appellant's diagnosis as "closed head injury, headaches, status post[-]concussion syndrome [and] nausea"

A follow-up neurologic report from Dr. Anthony noted on August 22, 2000 that appellant's diagnosis was "[i]ntracranial injury with brief loss of consciousness." He noted that appellant continued with both headache and dizziness, but noted that her neurologic examination was normal. Further, brain scanning was noted as revealing normal results. A further neurologic report from Dr. Anthony noted that appellant clearly had a major concussion problem with persisting severe headaches, nausea, vertigo and some double vision as well as some memory involvement.

By report dated October 20, 2000, Dr. Anthony noted that he had first treated appellant on November 23, 1999 following her head injury, that she had persistent problems with headaches and dizziness and that she clearly had suffered a concussion injury and had persisting symptoms of a concussion syndrome.

By decision dated January 29, 2001, the Office denied modification of the October 5, 1999 decision. The Office found that the medical evidence of record did not support that an injury had occurred as a result of the accepted incident on July 25, 1999.

The Board finds that this case is not in posture for decision.

In this case, the Office accepted that appellant was struck in her right temple with a hook. Appellant's subsequent actions, however, are consistent with being injured as she immediately reported her injury, which she described as a concussion and sought medical care.

At the hospital on the date of the incident, triage indicated that appellant was there for treatment of a concussion and was diagnosed by the emergency room physician as having "acute neurologic syndrome and probably [secondary] to post-concussion syndrome."

Thereafter, "Dr. Brown" noted that appellant failed a vision test, status post concussion. Subsequent critical care records on the date of the incident, July 25, 1999, were signed by a physician and contained two specific diagnoses, "[c]losed [h]ead [i]njury [and] [p]robable [m]ild [c]oncussion." These medical reports identified more symptomatology including headache, occasional blurred vision, dizziness and slow mentation. Further, diagnoses included acute neurologic syndrome, probably secondary to post-concussive syndrome, segmental dysfunction and cephalgia.

Dr. Anthony diagnosed "intracanial injury with brief loss of consciousness" and opined that appellant had experienced a major concussion problem with persisting severe headaches, nausea, vertigo and some double vision as a result.

Dr. Otte diagnosed "closed head injury" status post-concussion syndrome.

The evidence from the date of injury and subsequent to it, documents a of closed head injury, concussion, or acute neurologic syndrome, as a result of the falling metal hook striking appellant's head at work.

Proceedings under the Act are not adversary in nature, nor is the Office a disinterested arbiter. While the claimant has the burden to establish entitlement to compensation, the Office shares responsibility in the development of the evidence to see that justice is done.[1] In this case, although none of appellant's treating physician's reports contain rationale sufficient to discharge her burden of proving by the weight of reliable, substantial and probative evidence that she sustained an injury, causally related to her July 25, 1999 traumatic incident, they constitute substantial, uncontradicted evidence in support of appellant's claim and raise an uncontroverted inference of causal relationship between her being struck in the head by a metal hook and subsequent noted symptoms. The evidence is sufficient to require further development of the case record by the Office.[2] There is no opposing medical evidence in the record.

The case will be remanded to the Office for the creation of a statement of accepted facts, questions to be resolved and the relevant case records, to be followed by a referral to an appropriate physician for a rationalized opinion on whether the traumatic incident of July 25, 1999 caused an injury to appellant.

[1] *William J. Cantrell*, 34 ECAB 1223 (1983).

[2] *John J. Carlone*, 41 ECAB 354 (1989); *Horace Langhorne*, 29 ECAB 820 (1978); *see also Cheryl A. Monnell*, 40 ECAB 545 (1989); *Bobby W. Hornbuckle*, 38 ECAB 626 (1987) (if medical evidence establishes that residuals of an employment-related impairment are such that they prevent an employee from continuing in the employment, he is entitled to compensation for any loss of wage-earning capacity resulting from such incapacity).

The January 29, 2001 decision of the Office of Workers' Compensation Programs is hereby set aside and the case is remanded for further development in accordance with this decision and order of the Board.

Dated, Washington, DC
February 4, 2002

Michael J. Walsh
Chairman

Michael E. Groom
Alternate Member

A. Peter Kanjorski
Alternate Member