U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of JAMES B. BAKER and DEPARTMENT OF TRANSPORTATION, FEDERAL AVIATION ADMINISTRATION, Oklahoma City, OK

Docket No. 01-1187; Submitted on the Record;
Issued January 17, 2002

DECISION and ORDER

Before DAVID S. GERSON, WILLIE T.C. THOMAS,
BRADLEY T. KNOTT

The issue is whether appellant sustained an injury in the performance of duty, as alleged.

The Board has duly reviewed the case record and finds that appellant did not sustain an injury in the performance of duty, as alleged.

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.[1] 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.[2]

To establish that an injury occurred as alleged, the injury need not be confirmed by eyewitnesses, but the employee's statements must be consistent with the surrounding facts and circumstances and his subsequent course of action. In determining whether a *prima facie* case has been established, such circumstances as late notification of injury, lack of confirmation of injury and failure to obtain medical treatment may, if otherwise unexplained, cast serious doubt on a claimant's statements. The employee has not met his burden when there are such inconsistencies in the evidence as to cast serious doubt on the validity of the claim.[3] However, an employee's statement that an injury occurred at a given time and in a given manner is of great probative value and will stand unless refuted by strong or persuasive evidence.[4]

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[1] *Robert J. Krstyen*, 44 ECAB 227, 229 (1992); *John J. Carlone*, 41 ECAB 354, 356-57 (1989).

[2] *Id*.

[3] *Linda S. Christian*, 46 ECAB 598, 600-01 (1995); *Carmen Dickerson*, 36 ECAB 409, 415 (1985).

[4] *Linda S. Christian*, *supra* note 3 at 601; *Virgil F. Clark*, 40 ECAB 575, 584-86 (1989).

On March 12, 1999 appellant, then a 58-year-old warehouse work leader, filed a claim for a traumatic injury, Form CA-1, alleging that, on March 12, 1998, while in the performance of duty, he stubbed the second toe on his left foot, almost ripping the toenail completely off. The toe subsequently became gangrenous, eventually leading to the amputation of appellant's left leg below the knee on May 5, 1998. Appellant stated that he did not report the incident because despite his best efforts, he could not find a supervisor to report the incident to. He further explained that he was unable to get a medical appointment on the same day as the incident, but did schedule one for the following day, March 13, 1998. Appellant stated that he telephoned his supervisor and left a message on his answering machine, notifying him that he had a doctor's appointment the following day. He stated that he also told his supervisor that he would inform him of the medical results the following Monday. Appellant asserted that when he returned to work on Monday, March 16, 1998, he showed his supervisor a medical release for light-duty work, but was sent back to his regular job.

Appellant submitted witness statements from six coworkers to corroborate his claim. Lafreda R. Luster stated that appellant had worked light duty for at least two days due to foot problems, but that she did not remember the dates. Jim Garden stated that appellant had worked with him in the traffic office performing light duty for two or three days due to problems with his foot, but that he did not remember the dates. Noveta Battles stated that she was aware appellant had injured his left foot in March 1998 and that appellant had gone to the medical center on site where he was placed on light duty. Louise Shambra stated that, in March 1998, appellant had problems with a swollen left foot. Alwin Welsh stated that in March 1998 appellant was talking to him about work when his injury occurred and appellant had asked him if he had seen Supervisor Wright. Mr. Welsh added that, after being out on injury leave, appellant was placed on light duty for two days. Lenora Larson stated that appellant was injured on the job and came to her office on light duty, but she did not mention any dates. As a witness had reported that appellant had been seen at the employing establishment health unit, the Office of Workers' Compensation Programs contacted the employing establishment health unit and asked for any treatment notes pertaining to visits by appellant in March or April 1998. The health unit personnel declined to release any treatment notes without a signed release from appellant, however, they did inform the Office that appellant had only been treated for an ankle problem, not a toe condition.

In a treatment note dated March 13, 1998, Dr. Keith I. Bernhardt stated that appellant had a history of diabetes mellitus and had "stubbed his left second toe-almost tore the toenail off." He noted that the toenail was almost completely torn off, except for the skin distally on the lateral side, that he removed the nail and dressed the wound and that he instructed appellant to clean and dress the wound daily until it healed. Dr. Bernhardt does not mention the date the incident occurred or the circumstances surrounding the injury. In addition, he does not discuss appellant's capacity for work. On March 27, 1998 appellant returned for medical treatment and was seen by Dr. William G. Bernhardt, Dr. Keith Bernhardt's brother and associate. In his treatment note, Dr. William Bernhardt noted that appellant's second toe on his left foot was now black and probably gangrenous. He stated that appellant would be admitted to the hospital in an attempt to save his toe. Dr. William Bernhardt did not give any history of the injury. Appellant was admitted to the hospital on March 27, 1998 and shortly thereafter, his left second toe was amputated. He was discharged from the hospital on April 3, 1998, but on April 21, 1998 was seen by Dr. Jon Senkowsky, to whom he was referred for treatment of nonhealing wounds and a

severe case of peripheral vascular disease, possibly related to diabetes and hypertension. Appellant was readmitted to the hospital on April 25, 1998 with a severe fetid diabetic foot infection of his left foot, secondary to peripheral vascular disease and neuropathy. He was treated with antibiotics, however, attempts to control the infection and spread of gangrene failed and appellant's left leg was amputated below the knee on May 5, 1998. None of the preoperative or postoperative treatment notes give any history of appellant's injury, beyond stating that appellant had stubbed his toe.

In a report dated January 7, 1999, Dr. Griffith C. Miller, to whom appellant was referred by counsel, stated that on March 2, 1998 appellant reported having stubbed his toe in a storage area at work, almost knocking off the toenail. He described the worsening of appellant's condition, as set forth in the medical evidence and related to him by appellant, related his findings on physical examination and concluded that appellant has a 70 percent permanent impairment of the left lower extremity due to his below the knee amputation. The next and final medical report of record, dated October 23, 2000, is from Dr. John W. Ellis who related the history of injury as told to him by appellant, reviewed the relevant medical evidence of record and reported his findings on physical examination. Dr. Ellis stated that, on March 12, 1998, appellant had been working as a warehouse work leader when his left foot slipped up under a conveyor line, nearly tearing the toenail off his left second toe. He stated that the injury resulted in an infection which eventually required a below the knee amputation. Dr. Ellis further stated that, if appellant had not been injured on March 12, 1998, he would not have developed the infection in his toe which led to the amputation. He explained that while appellant's diabetes and peripheral vascular disease decreased his ability to fight off the infection caused by the bacteria entering his body at the site of the torn toenail, if he had not had the March 12, 1998 injury to his toe, his left foot and leg would be the same as his right foot and leg without impairment or amputation.

By decision dated May 25, 1999, the Office denied the claim, stating that the evidence did not establish that appellant sustained an injury due to the claimed event. Following an oral hearing held at appellant's request, in a decision dated February 29, 2000, an Office hearing representative affirmed the Office's prior denial. Appellant requested reconsideration and in a decision dated February 28, 2001, the Office found the additional evidence submitted by appellant to be insufficient to warrant modification of its original decision.

In the present case, the March 13, 1998 treatment note from Dr. Keith Bernhardt corroborates that appellant's toenail became separated from his foot. However, it does not contain any reference to how this injury occurred. The Office contacted Dr. William Bernhardt in hope of obtaining a history of the injury, but he responded that appellant had been initially treated by his brother and associate, Dr. Keith Bernhardt and that his office had no record as to the location or circumstances of the injury. In addition, the record contains evidence of a prior toe problem. A treatment note dated February 5, 1998, predating the alleged injury, in which Dr. William Bernhardt noted that one of appellant's toes was draining and that appellant needed to have his toenails removed because they were so deformed. Also, while appellant stated that he did not immediately report the injury to his supervisor because he could not locate him, this does not explain why appellant did not inform his supervisor of the injury at a later date. In fact, appellant's supervisor had no knowledge of appellant's alleged work injury until appellant filed his claim for compensation. Additionally, none of the witnesses who submitted statements as to

appellant's left foot problems could provide any specifics as to the time, place or manner in which appellant injured his left foot and the health unit denied having treated appellant for a toe condition in March or April 1998. Finally, there is no medical evidence in the record supporting appellant's allegation that he was restricted to light duty in March 1998 due to an employment-related incident.

Due to the fact that the medical evidence does not mention appellant had an employment-related injury until January 7, 1999 and the fact that the evidence shows that appellant waited an entire year to report the incident to his supervisor through the filing of his claim, appellant has not established that the fact of injury occurred, as alleged. Although there do not have to be eyewitnesses to the injury, there must be supporting evidence.[5] The evidence in this case is insufficient to corroborate the alleged March 12, 1998 employment incident. Although the Office provided appellant with the opportunity, appellant failed to submit sufficient evidence to establish his claim. Appellant has therefore not met his burden of proof.

The decision of the Office of Workers' Compensation Programs dated February 28, 2001 is hereby affirmed.

Dated, Washington, DC
January 17, 2002

David S. Gerson
Member

Willie T.C. Thomas
Member

Bradley T. Knott
Alternate Member

[5] *Linda S. Christian*, *supra* note 3 at 600-01.