United States Department of Labor
Employees' Compensation Appeals Board

K.H., claiming as a widow of N.H., Appellant	)	
and	)	**Docket No. 12-1930**
	)	**Issued: March 28, 2013**
DEPARTMENT OF JUSTICE, U.S. ATTORNEY'S OFFICE, Oxford, MS, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
PATRICIA HOWARD FITZGERALD, Judge
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On September 19, 2012 appellant, the employee's widow, filed a timely appeal from a March 23, 2012 merit decision of the Office of Workers' Compensation Programs (OWCP) denying her claim for survivor's benefits. Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 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 is causally related to his accepted employment injury.

FACTUAL HISTORY

On April 25, 1997 the employee, then a 45-year-old law enforcement coordinator, filed an occupational disease claim alleging that he sustained bilateral femoral deep vein thrombosis

[1] 5 U.S.C. § 8101 *et seq.*

causally related to factors of his federal employment. He attributed his condition to extensive sitting during a business trip. The employee stopped work on February 3, 1997. OWCP accepted the claim for bilateral venous thrombosis, an injury to the inferior vena cava and lateral popliteal nerve lesions. It paid the employee compensation for disability beginning September 14, 1997.

On November 30, 2006 appellant advised OWCP that the employee died on November 18, 2006. A death certificate dated December 1, 2006 listed the cause of death as a myocardial infarction.

In a report dated October 27, 2009, Dr. R. Barry Jones, Board-certified in family medicine, related that he had treated the employee beginning January 1997. He attributed many of the employee's health problems to "gunshot wound injuries he sustained in the line of duty. These injuries le[d] to venous thrombosis in his legs and resultant post phlebitis syndrome as well as nerve damage in his legs. [The employee] was also found to have severe sleep apnea that never was adequately corrected with forced air and supplemented oxygen." Dr. Jones related that it was unlikely a heart condition caused the employee's death as he was taking anticoagulates for his chronic venous condition. He stated, "With [the employee's] severe sleep apnea and the severe pain that he was in it is likely that he died of either respiratory failure from a pulmonary embolus or cardiac failure from chronic hypoxemia and pulmonary hypertension. Since he was anticoagulated I feel that the latter possibility is more likely." Dr. Jones noted that the employee took pain medication the morning of his death that "would have contributed to his respiratory failure."

In a report dated October 29, 2009, Dr. Frank Nichols, a Board-certified surgeon, related that he treated the employee during his hospitalization in January 1997 for bilateral deep vein thrombosis. He subsequently evaluated the employee every six months and performed "aggressive treatment for venous pooling related to valve damage from clots, including prescription of compression stockings, pneumatic cuffs and continued Coumadin therapy." In 1999, Dr. Nichols referred the employee for the placement of a catheter to dissolve the clot and improve the flow of blood. He stated, "For [the employee], this was a last resort effort since he was pooling 80 percent of the blood in [his] lower extremities and suffering significant shortness of breath." Dr. Nichols related that his condition progressively deteriorated. He asserted that the employee had no history of a myocardial infarction and opined that the identification of myocardial infarction as the cause of death was "premature." Dr. Nichols noted that the pain medications he took for his popliteal nerve lesions could cause respiratory depression and that his position on the ground when found indicated that "respiratory depression leading to arrest could have been the direct cause of death." He asserted:

> "In my opinion, [the employee's] death was accelerated by or precipitated by the diagnoses of venous thrombosis, bilateral, injury to vena cava or treatment of lateral popliteal nerve lesions. [He] had been seated with his legs in a dependent position with limited movement for approximately three hours. He placed himself in a position on the ground in order to assist the return flow of blood to his heart as if he were experiencing acute distress of lower extremity pain or shortness of breath. These facts suggest a possible pulmonary embolus as the cause of death."

In an undated statement received November 17, 2009, John Conrad, a friend and former coworker of the employee, described his pain and limitations following his 1997 employment injury. He related that he found the employee after he died and that it seemed that he had "lain down intentionally as opposed to falling down…."

On November 2, 2009 appellant filed a claim for death benefits.[2]

On August 6, 2010 an OWCP medical adviser reviewed the case record and noted that the cause of death listed on the death certificate as a heart attack was "largely speculative without a postmortem exam[ination]." He asserted that if the death resulted from a pulmonary embolism it would be employment related.

On March 29, 2012 OWCP referred the case record and a statement of accepted facts to Dr. Soheila Benrazavi, a Board-certified internist, for a second opinion examination. The statement of accepted facts provided that the employee had a preexisting gunshot injury to his inferior vena cava in 1974 and resulting pulmonary emboli.

In a report dated March 9, 2012, Dr. Benrazavi reviewed the history of the employee's injury and the medical evidence of record. He noted that the employee had a preexisting injury to his inferior vena cava from a gunshot wound. Dr. Benrazavi related that a review of the records revealed no history of heart failure or coronary artery disease. He discussed the employee's history of sleep apena but found that it was not likely that it caused a heart condition based on a review of the medical evidence. Dr. Benrazavi stated:

> "What we do have substantial evidence for in the medical records is the picture of a man who, unfortunately for him, had a longstanding history of problems with deep venous thrombosis. Although initially this came to light more so on January 31, 1997 after returning from the business trip and prolonged sitting during that travel and the claimant was granted disability based on that, unfortunately for him the condition never resolved. To the contrary, by review of medical records, over time his condition worsened. Although Dr. Nichols attempted to help him by referring the claimant to an outside hospital to perform invasive radiological procedures in an attempt to open up the occluded lower extremity veins, we do know that in the September 1999 hospitalization, in fact there were multiple complications related to this procedure. It was a very extensive hospitalization with multiple complications.
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> "Unfortunately, over time, not only did the condition not get better, but worsened. This is firmly established by review of medical records and results of venogram and venous studies of the lower extremities."

[2] Appellant submitted her marriage certificate.

Dr. Benrazavi related that the employee's deep venous thrombosis became chronic. He indicated that a probable cause of death for a person with significant deep venous thrombosis would be pulmonary embolism. Dr. Benrazavi stated:

> "Not having access to any eye witness account, I would just state that if there is any account of eye witnesses that such symptoms developed shortly before he collapsed and died, I would say that there is more than 75 percent probability that he was experiencing a deadly condition of pulmonary embolism.
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> "In his case, with such extensive history of chronic deep venous thrombosis, he might also have had showers of emboli to the lungs and overwhelming of the pulmonary system if not saddle emboli. However, if there are no eye witness accounts in the last moment before his death, I would say that given this man's history by review of medical records and the pathophysiology of sudden death in the context of his history of extensive chronic venous thrombosis, it is more likely than not (more than 50 percent likelihood) that this man's death was caused by pulmonary embolism.
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> "As such pulmonary embolism would be directly related to the chronic condition of deep venous thrombosis of the lower extremities as the blood clot from the legs is what migrates up to the pulmonary system and unfortunately ending up near the great vessels of the heart and in the case of saddle embolism and in the case of shower emboli, could overwhelm the pulmonary system and cause hypoxemia, which in turn places the myocardium in hypoxic stress leading to cardiac arrhythmia and ventricular fibrillation and death.
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> "Given that, it is less probable and less likely than not, (less than 50 percent probability) that another condition such as myocardial infarction or a cardiac failure for which we have no evidence in the medical records and by history, could have caused the claimant's death."

By decision dated March 23, 2012, OWCP denied appellant's claim for survivor's benefits. It found that the evidence was insufficient to show that the employee's death was causally related to his accepted work injury.

On appeal, appellant discusses Dr. Benrazavi's report and contends that his opinion supports her claim for death benefits.

LEGAL PRECEDENT

The United States shall pay compensation for the death of an employee resulting from personal injury sustained while in the performance of duty.[3] An appellant 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 or her federal employment. This burden includes the necessity of furnishing medical opinion evidence of a cause and effect relationship based on a proper

[3] 5 U.S.C. § 8102(a).

factual and medical background.[4] The opinion of the physician must be one of reasonable medical certainty and must be supported by medical rationale.[5] The mere showing that an employee was receiving compensation for total disability at the time of death does not establish that the employee's death was causally related to his or her federal employment.[6]

It is not necessary to provide a significant contribution of employment factors for the purpose of establishing causal relationship.[7]

Once OWCP starts to procure a medical opinion, it must do a complete job.[8] It has the responsibility to obtain from its referral physician an evaluation that will resolve the issue involved in the case.[9]

ANALYSIS

OWCP accepted that the employee sustained bilateral venous thrombosis, an injury to the inferior vena cava and lateral popliteal nerve lesions as a result of extensive sitting while on travel in the course of his federal employment. The employee had a preexisting injury to his inferior vena cava as a result of a 1974 gunshot injury with a resulting history of pulmonary emboli. OWCP paid the employee compensation for total disability until his death on November 18, 2006. A December 1, 2006 death certificate provided the cause of death as a myocardial infarction.

Appellant filed a claim for death benefits. On October 27, 2009 Dr. Jones, who had treated the employee since January 1997, found that many of his health problems resulted from his gunshot injury. He indicated that the gunshot wound caused bilateral venous thrombosis, nerve damage and postphlebitis. Dr. Jones also discussed the employee's history of sleep apnea that required oxygen. He asserted that his death was more likely due to respiratory failure from a pulmonary embolus or cardiac failure from hypoxemia and pulmonary hypertension than to a heart condition.

In a report dated October 29, 2009, Dr. Nichols, another attending physician, related that he treated the employee during his hospitalization in January 1997 for deep vein thrombosis in both legs. He described his attempts to treat the employee for venous pooling and noted that his condition steadily deteriorated. Dr. Nichols attributed the cause of death resulted to his bilateral vena cava injury or from the treatment of his popliteal nerve lesions.

[4] *Viola Stanko (Charles Stanko)*, 56 ECAB 436 (2005).

[5] *L.R. (E.R.)*, 58 ECAB 369 (2007); *Jacqueline Brasch (Ronald Brasch)*, 52 ECAB 252 (2001).

[6] *Susanne W. Underwood (Randall L. Underwood)*, 53 ECAB 139 (2001).

[7] *See Richard E. Simpson*, 55 ECAB 490 (2004).

[8] *See Beth P.Chaput*, 37 ECAB 158 (1985); *William N. Saathoff*, 8 ECAB 769 (1956).

[9] *See Melvin James*, 55 ECAB 406 (2004); *Mae Z. Hackett*, 34 ECAB 1421 (1983).

OWCP referred the employee's case record to Dr. Benrazavi for a second opinion examination. Dr. Benrazavi reviewed the history of the employee's accepted employment injury, his preexisting gunshot wound to the inferior vena cava and his sleep apnea. He found that the employee's death was not likely due to a heart condition as he had no history of treatment for a heart condition or coronary artery disease. Dr. Benrazavi related that the employee had an extensive history of deep venous thrombosis that "came to light" after his business trip in January 1997. He asserted that with the employee's history of deep venous thrombosis a pulmonary embolism was a probable cause of death. Dr. Benrazavi concluded that it was more likely than not that a pulmonary embolism caused his death. He attributed the pulmonary embolism to the deep venous thrombosis.

Dr. Benrazavi's medical opinion is supportive of appellant's claim that the employee died as a result of his work injury. As noted, it is not necessary to prove a significant contribution of employment factors to a condition for the purpose of establishing causal relationship. If the medical evidence reveals that a work factor contributed in any way to the employee's condition, the condition is compensable.[10] Dr. Benrazavi offered a detailed explanation of how the deep venous thrombosis could cause a pulmonary embolism leading to hypoxemia, cardiac arrhythmia and death. He did not, however, specifically address whether the deep venous thrombosis, which he found more likely than not caused a pulmonary embolism and the employee's death, was due to the accepted employment injury or the 1974 gunshot injury. As noted, Dr. Jones attributed a large portion of the employee's problems to a prior history of a gunshot wound causing venous thrombosis bilaterally.

Proceedings under FECA are not adversarial in nature and OWCP is not a disinterested arbiter. Once OWCP undertakes to develop the medical evidence further, it has the responsibility to do in a manner that will resolve the relevant issues in the case.[11] The Board finds that, although Dr. Benrazavi's report insufficiently addressed the issue of causal relationship, it raises an inference of causal relationship sufficient to require further development. Accordingly, the Board finds that the case must be remanded to OWCP. On remand, OWCP should request that Dr. Benrazavi submit a supplemental, clarifying report on the issue of whether the employee's death was due to deep venous thrombosis resulting from the accepted work injury. Following this and any other development deemed necessary, OWCP shall issue a *de novo* decision.

CONCLUSION

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

[10] *See R.M.*, Docket No. 11-1701 (issued March 19, 2012); *Arnold Gustafson*, 41 ECAB 131 (1989).

[11] *See Melvin James*, *supra* note 9.

ORDER

IT IS HEREBY ORDERED THAT the March 23, 2012 merit decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further proceedings consistent with this opinion of the Board.

Issued: March 28, 2013
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

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