United States Department of Labor
Employees' Compensation Appeals Board

R.G., claiming as widow of O.G., Appellant	)	
and	)	**Docket No. 17-0916**
	)	**Issued: September 6, 2017**
DEPARTMENT OF VETERANS AFFAIRS, DANVILLE NATIONAL CEMETERY, Danville, IL, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On March 20, 2017 appellant filed a timely appeal from an October 21, 2016 merit decision of the Office of Workers' Compensation Programs (OWCP). 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 appellant has met her burden of proof to establish that the employee's death on March 13, 2016 was causally related to his accepted May 1, 1978 employment injuries.

On appeal appellant contends that the medical opinion of Dr. Ashley Norris, an attending Board-certified internist, establishes that the employee's death was caused by his work-related injury.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

This case has previously been before the Board with respect to the employee's schedule award claim. The facts of the case as set forth in the prior Board decision are incorporated herein by reference. The facts relevant to the present appeal are set forth below.

OWCP accepted that on May 1, 1978 the employee, then a 29-year-old cemetery keeper, sustained internal derangement and torn medial meniscus of the right knee when he stepped in a hole while mowing along a fence line. He stopped work on May 2, 1978.

The employee underwent authorized right knee fusion on October 11, 1982. On April 28, 1985 he returned to limited-duty work as an engineering technician at the employing establishment. The employee stopped work on June 3, 1985 due to his physical inability to perform certain job requirements.

In a February 23, 1988 decision, OWCP granted the employee a schedule award for 61 percent permanent loss of use of the right leg.

The employee appealed to the Board on April 28, 1988. In a September 30, 1988 decision, the Board affirmed OWCP's February 23, 1998 schedule award decision, finding that the employee had no more than 61 percent permanent impairment of the right leg.[2]

The record reflects that OWCP continued to pay the employee appropriate wage-loss compensation benefits after expiration of his schedule award payments. The employee also continued to submit reports required by OWCP certifying that he was not employed. OWCP also received periodic medical reports noting the employee's treatment and status.[3]

On March 22, 2016 appellant, widow of the deceased employee, informed OWCP that the employee died on March 13, 2016.

On June 1, 2016 appellant filed a claim for compensation by widow, widower, and/or children (Form CA-5). She alleged that the employee's debilitating knee injury and total knee fusion caused his death.

In support of her claim, appellant submitted a certificate of marriage, a death certificate, and an itemized bill for funeral services for the employee. The death certificate indicated that the employee died on March 13, 2016 and that the immediate cause of death was cardiac dysrhythmia. It noted that other conditions contributing to death, but not resulting in the underlying cause previously noted, included diabetes, hypertension, and heart disease.

[2] Docket No. 88-1133 (issued September 30, 1988).

[3] These included a March 16, 2012 report from Dr. David A. West, a Board-certified orthopedic surgeon and OWCP referral physician, who noted that the employee was currently wheelchair bound and weighed 505 pounds. He indicated that the employee remained totally disabled due to his work injury. In a February 10, 2014 report, Dr. Norris noted treating the employee for morbid obesity, his right knee condition, diabetes, and abnormal cardiac rhythms.

By letter dated June 23, 2016, OWCP informed appellant of the deficiencies of her claim and requested that she submit additional medical and factual evidence. It requested that the employing establishment provide all available assistance to appellant to obtain the supporting documentation necessary to facilitate her claim.

In a July 16, 2016 letter, Dr. Norris noted that she was the employee's primary care physician and saw him in both the hospital and office numerous times during the past several years. She indicated that during his last office visit, he complained about mild stomach cramps which he attributed to eating too many bowls of beans. Dr. Norris related that he would follow-up if his condition did not get any better. Dr. Norris noted that the employee's symptoms worsened and a family friend placed him on antibiotics for acute diverticulitis. His condition worsened and he was later brought to an emergency room where she provided treatment. Dr. Norris and an emergency room physician thought the employee was probably septic from a gastrointestinal source, likely a perforated bowel. However, Dr. Norris indicated that a computerized tomography scan could not be performed due to his size. Arrangements were made to transport the employee to an alternate facility to accommodate his size so that appropriate imaging could be obtained. At that time, Dr. Norris noted that he arrested and was intubated. Numerous attempts to resuscitate the employee were unsuccessful. Dr. Norris related that although his work-related injuries did not cause diverticulitis, they contributed to his overall health status and largely his morbid obesity. She related that his leg contributed to his growing weight and limited mobility. Dr. Norris advised that the employee also became a diabetic and had hypertension. She indicated that his other comorbidities included chronic pain, depression with anxiety, renal cancer, osteoarthritis, and atrial fibrillation. Dr. Norris concluded that all of these combined to contribute to the employee's poor health status and his death.

On August 24, 2016 OWCP requested that an OWCP district medical adviser (DMA) review the medical record including, Dr. Norris' report, and a statement of accepted facts (SOAF). The SOAF provided to the DMA noted a history of the May 1, 1978 employment injuries, the accepted conditions, and the authorized October 11, 1982 right knee fusion. It also noted that concurrent disability was not accepted as work related regarding the employee's right knee osteoarthritis, gout, morbid obesity, pneumonia, May 1, 1978 removal of right knee cartilage,[4] 1978 fractured rib, and June 18, 1989 ventral hernia repair.

On September 8, 2016 a DMA reviewed the medical record and the SOAF. She noted that the employee's death certificate listed cardiac dysrhythmia as the only immediate cause of death. The DMA indicated only cardiac dysrhythmia was listed on the death certificate even though the certificate allows for a listing of multiple conditions and underlying causes. She maintained that, while Dr. Norris' July 12, 2016 letter was a thoughtful account of the employee's overall health status and events leading to his death, it failed to establish a direct link between his accepted work-related conditions competent to produce death. The DMA advised that internal derangement of the knee and/or meniscal tear did not cause cardiac dysrhythmia, which was the primary cause of the employee's death. She noted Dr. Norris' opinion that the employee's work injuries may have contributed to his morbid obesity, but related that the SOAF

[4] Although the SOAF lists May 1, 1978 as the date of the unrelated surgery, initial medical report from May 1 and June 16, 1978, advised that the employee had right knee surgery 12 years earlier for removal of a cartilage. The subsequent SOAF provided to Dr. Barbour, *infra*, lists the same right knee history.

specifically provided that right knee osteoarthritis and morbid obesity, were not accepted conditions. The DMA, thus, concluded that the accepted right knee condition was not competent to produce the claimed death.

On September 22, 2016 OWCP referred the medical record, an updated SOAF, and a list of questions to Dr. Galen L. Barbour, a Board-certified internist and nephrologist, for a second opinion. The SOAF again noted the history of the May 1, 1978 employment injuries, accepted conditions, authorized October 11, 1982 right knee fusion, nonaccepted conditions and surgeries. It also noted that the employee's preexisting or concurrent medical conditions, which included renal cancer, atrial fibrillation, hypertension, diabetes mellitus, chronic depression, and anxiety, were not accepted as work related.

In a September 29, 2016 report, Dr. Barbour reviewed the medical record and SOAF. In response to queries, he opined that after reviewing the documentation, the employee most likely died from an undiagnosed myocardial infarction (MI). Dr. Barbour indicated that his presenting symptom of abdominal pain and ultimate demise from cardiac arrest were consistent with an acute posterior MI. He related that the employee had a consistent history of several risk factors for the development of coronary artery disease (CAD) that included hypertension, obesity, and inactivity. Dr. Barbour advised that in the presence of these risk factors and a clinical picture at demise consistent with an acute infarction, it was certainly more likely than not that the presence of known risk factors contributed to the employee's death. He maintained that although the physical limitations of a knee fusion likely led him to be inactive and, thus, contributed to his obesity, such inactivity was not a predictable outcome and was generally accepted as related to controllable factors. Dr. Barbour referenced medical literature in support of his opinion. In summary, Dr. Barbour found that the accepted right knee condition was not medically connected as a predictable cause for the medical conditions of obesity, hypertension, or diabetes. He also found that because of this lack of connection, it was not possible to accord any aggravation, precipitation, or acceleration of these conditions by the work-related injury. Dr. Barbour concluded that the cause of death was most likely an undiagnosed posterior wall myocardial infarction contributed to by many risk factors including, hypertension, diabetes, and inactivity. He further concluded that in this clinical scenario, it was not possible to place any causal linkage between the work-related injury and the cause of death, which was the most common cause of death in the United States.

By decision dated October 21, 2016, OWCP denied appellant's claim. It found that the weight of the medical evidence rested with the opinion of Dr. Barbour that the employee's death was not caused by his accepted employment injuries.

LEGAL PRECEDENT

The United States shall pay compensation for the disability or death of an employee resulting from personal injury sustained while in the performance of his duty.[5] An award of compensation in a survivor's claim may not be based on surmise, conjecture, or speculation or on appellant's belief that the employee's death was caused, precipitated, or aggravated by the

[5] 5 U.S.C. § 8133(a).

employment.[6] Appellant has the burden of proof to establish by the weight of the reliable, probative, and substantial medical evidence that the employee's death was causally related to an employment injury or to factors of his or her employment.[7] This burden includes the necessity of furnishing rationalized medical opinion evidence of a cause and effect relationship, based on a complete factual and medical background.[8]

The medical evidence required to establish a causal relationship is rationalized medical opinion evidence. The opinion of the physician must be based on a complete factual and medical background of the employee, must be one of reasonable certainty, and must be supported by medical rationale explaining the nature of the relationship between the employee's death and the accepted conditions or employment factors identified by the employee.[9]

ANALYSIS

The Board finds that appellant failed to establish that the employee's death was causally related to his May 1, 1978 work-related injury.

OWCP accepted that on May 1, 1978 the employee sustained internal derangement and torn medial meniscus of the right knee while in the performance of duty. He underwent authorized right knee fusion on October 11, 1982. The employee briefly returned to limited-duty work on April 28, 1985 before stopping work on June 3, 1985. Appellant, the employee's widow, filed a claim for death benefits on June 1, 2016. She asserted that the employee's death was caused by his debilitating knee injury and total knee fusion. On October 21, 2016 OWCP denied the claim, basing its decision on the September 29, 2016 report of the second opinion physician, Dr. Barbour.

In support of her claim, appellant submitted a July 16, 2016 report from Dr. Norris, the employee's treating physician. Dr. Norris noted that the employee had diverticulitis, morbid obesity, diabetes, hypertension, chronic pain, depression with anxiety, renal cancer, osteoarthritis, and atrial fibrillation. She opined that these conditions combined to contribute to his poor health status and death. The Board notes that none of these noted conditions have been accepted by OWCP as work related. For conditions not accepted by OWCP as being employment related, it is the employee's burden of proof to provide rationalized medical evidence sufficient to establish causal relation, not OWCP's burden to disprove such relationship.[10] Dr. Norris related that while the accepted work-related injuries did not cause the employee's diverticulitis, they contributed to his overall health status, particularly his morbid obesity which limited his mobility. However, as noted, OWCP has not accepted morbid obesity

[6] *See Sharon Yonak (Nicholas Yonak)*, 49 ECAB 250 (1997).

[7] *L.R. (E.R.)*, 58 ECAB 369 (2007).

[8] *Id.*

[9] *Donna L. Mims*, 53 ECAB 730 (2002).

[10] *P.J. (S.J.)*, Docket No. 15-686 (issued June 15, 2015); *E.C.*, Docket No. 10-1554 (issued April 1, 2011); *Alice J. Tysinger*, 51 ECAB 638 (2000).

as employment related. Moreover, Dr. Norris did not provide any opinion as to whether the employee's morbid obesity and other noted medical conditions were caused or aggravated by the accepted May 1, 1978 employment injuries prior to his death.[11] The physician's opinion on causal relationship is of limited probative value as she did not provide adequate medical rationale in support of her conclusions.[12] Thus, the Board finds that appellant failed to meet her burden of proof as she failed to provide a rationalized, probative medical opinion relating the employee's death to the accepted work injuries.

On September 8, 2016 OWCP's DMA reviewed the medical record and found that while Dr. Norris' report provided the employee's overall health status and events leading to his death, it did not establish that the accepted employment-related right knee conditions were competent to produce death. She explained that the accepted work conditions did not cause cardiac dysrhythmia, the primary cause of the employee's death. The DMA further explained that the SOAF she reviewed specifically indicated that right knee osteoarthritis and morbid obesity were not accepted conditions. In addition, she reasoned that neither cardiac dysrhythmia nor the other significant conditions contributing to the employee's death listed on the death certificate were accepted by OWCP as work related. The DMA concluded that the accepted right knee injury was not competent to produce his death.

OWCP referred the employee's case record to Dr. Barbour for a second opinion. In his September 29, 2016 report, Dr. Barbour reviewed the medical record and SOAF. He opined that the employee's death was not caused by the accepted right knee injuries. Dr. Barbour maintained that his death was more likely than not caused by an undiagnosed posterior wall MI. He explained that the employee's presenting symptom of abdominal pain and ultimate death from cardiac arrest were consistent with an acute posterior MI. Dr. Barbour reasoned that he had a consistent history of risks for the development of CAD that included hypertension, obesity, and inactivity. He advised that the accepted right knee conditions were not medically connected as a predictable cause of these known risks. Dr. Barbour explained that while the employee's knee fusion likely led to his physical limitations which resulted in his inactivity and, thus, the development of his obesity, the inactivity was not a predictable outcome and was generally accepted as related to controllable factors.

The Board finds that Dr. Barbour's report represents the weight of the medical evidence and that OWCP properly relied on his report in finding that the employee's death on March 13, 2016 was not causally related to the accepted May 1, 1978 work injuries. Dr. Barbour provided a well-rationalized medical opinion based on a complete factual background and an extensive and thorough review of the SOAF and medical record. The Board will affirm OWCP's October 21, 2016 decision denying compensation for death benefits.

On appeal appellant contends that Dr. Norris' opinion establishes that the employee's death was caused by his work-related injury. However, for the reasons noted above, Dr. Norris failed to explain with medical rationale how the accepted May 1, 1978 employment injuries

[11] *P.J. (S.J.), id.*; *E.C., id.*

[12] *Su-Lan Popow (John S. Popow)*, Docket No. 00-581 (issued January 18, 2001).

caused or aggravated the employee's conditions that resulted in his death.[13] Thus, Dr. Norris' opinion is insufficient to establish that the employee's death was caused by the accepted work injuries.

Appellant may submit new evidence or argument with a written request for reconsideration to OWCP within one year of this merit decision, pursuant to 5 U.S.C. § 8128(a) and 20 C.F.R. §§ 10.605 through 10.607.

CONCLUSION

The Board finds that appellant has failed to meet her burden of proof to establish that the employee's death on March 13, 2016 was causally related to his accepted May 1, 1978 employment injuries.

ORDER

IT IS HEREBY ORDERED THAT the October 21, 2016 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: September 6, 2017
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

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

Valerie D. Evans-Harrell, Alternate Judge
Employees' Compensation Appeals Board

[13] *Id.*