United States Department of Labor
Employees' Compensation Appeals Board

W.C., claiming as widow of R.C., Appellant	)	
and	)	**Docket No. 18-0531**
	)	**Issued: November 1, 2018**
DEPARTMENT OF HOMELAND SECURITY, CUSTOMS & BORDER PROTECTION, Imperial, CA, Employer	)	

Appearances:
Jonathan M. Perkins, for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA H. FITZGERALD, Deputy Chief Judge
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On January 18, 2018 appellant, through her representative, filed a timely appeal from a July 25, 2017 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[2] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

[1] In all cases in which a representative has been authorized in a matter before the Board, no claim for a fee for legal or other service performed on appeal before the Board is valid unless approved by the Board. 20 C.F.R. § 501.9(e). No contract for a stipulated fee or on a contingent fee basis will be approved by the Board. *Id.* An attorney or representative's collection of a fee without the Board's approval may constitute a misdemeanor, subject to fine or imprisonment for up to one year or both. *Id.; see also* 18 U.S.C. § 292. Demands for payment of fees to a representative, prior to approval by the Board, may be reported to appropriate authorities for investigation.

[2] 5 U.S.C. § 8101 *et seq.*

ISSUE

The issue is whether appellant has met her burden of proof to establish that the employee's death on August 4, 2015 was causally related to the accepted May 19, 2004 employment injury.

FACTUAL HISTORY

The employee, then a 42-year-old senior border patrol agent, filed a traumatic injury claim (Form CA-1) on May 19, 2004, alleging that he was injured that day when a suspect ran his vehicle into the employee's vehicle.[3] OWCP initially accepted the claim for cervical strain, and later expanded the acceptance of the claim to include cervical disc herniations at C4-5 and C5-6, left shoulder strain, psychogenic pain, dysphagia, and nonunion of fracture. The employee underwent cervical fusion surgery on February 3, 2005. OWCP paid wage-loss compensation benefits on the supplemental rolls as of November 3, 2004 and on the periodic rolls as of December 25, 2005. The employee underwent further cervical surgical procedures on April 25, 2006 and March 8, 2008. He returned to full duty on October 8, 2008, but was again disabled from work on May 26, 2009. OWCP again paid the employee wage-loss compensation on the periodic rolls. The employee did not return to work.

In a January 22, 2013 report, Dr. Charles Stevens, Board-certified in anesthesiology and pain medicine, noted seeing the employee for follow-up with complaints of neck, shoulder, and mid and lower back pain that radiated to the right leg. He reported that the employee had not been seen for almost a year and related that he took six to seven 4 milligram tablets of hydromorphone daily which were prescribed after brain surgery, and that he needed refills of other medications. Dr. Stevens diagnosed cervicalgia, postlaminectomy pain syndrome of the cervical region, brachial neuritis or radiculitis not otherwise specified, lumbosacral spondylosis without myelopathy, depressive disorder not elsewhere classified, and neck sprain. He indicated that he would restart methadone and provigil.

The employee moved from California to New Hampshire in April 2014. In a November 13, 2014 report, Dr. Mark C. Nelson, an attending Board-certified orthopedic surgeon, noted that the employee had moved to be on the east coast, but had travelled back to California and reported that he was much worse due to a flare-up of pain during his travels. He noted limited cervical range of motion on examination. Dr. Nelson indicated that the employee was being seen by a pain management specialist in the east and had run out of his pain medication. He gave him a small prescription for hydromorphone and Norco. In an attached work capacity evaluation (Form OWCP-5c), Dr. Nelson advised that the employee could work modified duty for four to six hours daily.

The employee died on August 4, 2015. Appellant, the employee's widow, filed a claim for survivor's benefits (Form CA-5) on January 7, 2016, alleging that the medications were prescribed to help the employee manage his chronic pain due to the May 19, 2004 employment injury.

A December 3, 2015 attending physician's report attached to the Form CA-5 was completed by Dr. Terrence McNamara, an osteopath, Board-certified in physical medicine and

[3] At some point after filing the traumatic injury claim, the employee changed his name from E.C. to R.C.

rehabilitation and pain medicine. He indicated that he was treating the employee for chronic neck pain status postsurgery, which was employment related. Dr. McNamara noted that he had recently seen appellant on March 24, June 17, and July 15, 2015. He noted that, according to the autopsy, the cause of death was combined effects of ethanol and multiple medications. Dr. McNamara checked a form box "no," indicating that the employee's death was not due to the employment-related neck pain.

An autopsy was completed by Dr. Monica Smiddy, Board-certified in anatomic and forensic pathology. She noted the employee's history of a remote injury of neck with surgical scars, chronic pain syndrome, chronic alcoholism and prescription medical abuse, remote craniotomy of right frontal skull with history of seizure disorder, and postmortem finding of left kidney renal cell carcinoma with no evidence of distant metastasis. An attached toxicology report showed findings above a therapeutic dose of ethanol, acetaminophen, alprazolam, dihydrocodeine/ hydrocodol, hydrocodone, hydromorphone, topiramate, tramadol, o-desmethyltramadol, venlafaxine, o-desmethylvenlafaxine, meta-chlorophenylpiperazine, and trazodone in femoral blood. Dr. Smiddy indicated that the cause of death was acute intoxication due to the combined effects of ethanol, alprazolam, hydrocodone, hydromorphone, topiramate, tramadol, venlafaxine, and trazadone. The manner of death was undetermined.

The death certificate listed the cause of death as acute intoxication with the combined effects of ethanol, alprazolam, hydrocodone, hydromorphone, topiramate, tramadol, venlafaxine, and trazodone. It further indicated "mixed prescription drugs with alcohol intoxication." No other significant condition was listed.

In a July 20, 2016 development letter, OWCP notified appellant of the deficiencies of her survivor benefits claim and requested additional factual and medical information. This was to include copies of any medical treatment records. OWCP specifically requested March 24, June 17, and July 15, 2015 treatment notes from Dr. McNamara, and other medical reports from the employee's physician to support the most recent type and level of prescriptions recommended for his accepted work-related medical conditions.

Appellant submitted a July 25, 2016 statement in which she described the employee's condition since the employment injury. She indicated that in December 2010 she took him to the hospital for an altered level of consciousness, and in January 2011 he was admitted, had a brain biopsy performed, and was diagnosed with posthypoxic leukoencephalopathy. Appellant related that she did not realize that the employee was taking tramadol, noting that they had gone to Mexico for dental work and a pharmacy employee told him that it could help his pain. She maintained that the employment injury led to chronic suffering, and his medication ultimately led to his death.

By letter dated September 16, 2016, OWCP asked Dr. McNamara to furnish his treatment notes dated March 24, June 17, and July 15, 2015, and any additional medical reports describing the employee's most recent type and level of prescriptions recommended for his accepted conditions.

In December 2016, OWCP referred the medical evidence of record to Dr. Stanley Yuan, an anesthesiologist, for a second opinion evaluation to determine whether there was a causal relationship between the employee's death and his employment-related conditions. The statement

of accepted facts (SOAF) forwarded to Dr. Yuan indicated that OWCP paid for prescribed medications topiramate, venlafaxine, hydromorphone hydrochloride, and hydrocodone-acetaminophen. It asked him to provide an opinion with a rationalized explanation as to whether the levels of prescription medication present in the employee's body at the time of death were appropriate as treatment for the accepted conditions, and if the prescribed medication caused, accelerated, precipitated or in some way contributed to his death.

In a November 28, 2016 report, Dr. Yuan noted the history of injury, his review of medical records dating from May 19, 2004, the employee's surgical history and care. In answer to OWCP's questions, he indicated that the levels of prescription medication present in the employee's body at the time of his death were appropriate as treatment for the conditions accepted as caused by the employment injury. Dr. Yuan explained that, while the list of prescribed medications did not match the toxicology report, both hydromorphone and hydrocodone-acetaminophen were appropriate for postoperative pain therapy. He also noted that the employee had been prescribed methadone in addition to hydromorphone and further indicated that it was unclear what the indications were for topiramate, venlafaxine, alprazolam, and trazodone, as these medications are commonly prescribed for neuropathic pain and depression. Dr. Yuan also noted that the record did not indicate that tramadol had ever being prescribed for the employee. He concluded that, based on the information given, the levels of prescription medication present in the employee's body at the time of his death were appropriate as treatment for the conditions accepted as related to his employment. Dr. Yuan further indicated that he did not believe that the medications listed in the SOAF as having been approved by OWCP caused, accelerated, precipitated or in some way contributed to the employee's death. He explained that, when used together, the combination of opioid and benzodiazepine (BZD) drugs could have serious detrimental effects upon physical health, mental health, and sobriety, and that in addition to increasing the risk of overdose, BZD and opioid poly drug use could exacerbate psychological and medical problems commonly seen among drug users. Dr. Yuan noted that the autopsy determined that the cause of the employee's death was due to the effects of ethanol and multiple medications (alprazolam, hydrocodone, hydromorphone, topiramate, tramadol, venlafaxine, and trazodone), and that in addition to alcohol, there was a toxicology report of cannabinoids with no indication of medical marijuana approval. He further noted that the employee took methadone and Norco for several years, and that he received hydromorphone postoperatively after brain surgery. Dr. Yuan indicated that there was a high degree of poly-pharmacological self-administration, which likely contributed to the employee's death. He concluded that the medications listed in the SOAF did not cause, accelerate, precipitate or in some way contribute to the employee's death.

By decision dated January 13, 2017, OWCP denied appellant's claim, finding that the medical evidence of record was insufficient to establish that the employee's death was causally related to his May 19, 2004 employment injury.

In correspondence postmarked February 7, 2017 and received by OWCP on February 10, 2017, appellant requested a hearing before an OWCP hearing representative.

In an April 17, 2017 statement, appellant voiced her disagreement with Dr. Smiddy's autopsy findings and Dr. Yuan's conclusions. She also described medical findings regarding December 2010 and January 2011 hospitalizations for a hypoxic brain insult. Appellant noted that

her husband had been prescribed opiates and BZDs for many years and was not a drug abuser. She concluded that the medications prescribed for the employee's employment injury caused his death.

Appellant submitted medical records from the employee's December 2010 hospital admission. In a December 13, 2010 history and physical report, Dr. Sunny Richley, a Board-certified internist, noted a history of hyperlipidemia and chronic pain syndrome secondary to multiple cervical surgeries due to a motor vehicle accident. She described symptoms of right-sided numbness and altered behavior beginning the previous day. Dr. Richley examined the employee and noted that a computerized tomography (CT) scan study of the head showed possible bilateral basal ganglia close to a possible infarct, but could not elucidate any areas of stroke. She ordered further studies.

Dr. Andres N. Jacobo, a Board-certified neurologist, saw the employee in consultation on December 14, 2010 for numbness and abnormal CT of the head. He reported that the employee's medication had recently been changed and he was started on Dilaudid and amitriptyline. Dr. Jacobo described the employee's complaint of chronic neck pain and right upper extremity numbness. He performed neurological examination and reviewed the head CT scan. Dr. Jacobo's diagnoses included new onset of a right C7-8 radiculopathy with weakness and numbness, right L5-S1 with numbness, status post one fall, apparently while intoxicated, chronic pain, status post four surgical spine surgeries, headaches, and abnormal CT of the head. He ordered a CT scan of the cervical spine, magnetic resonance imaging (MRI) scans of the cervical and lumbosacral spine, and a brain MRI scan. Dr. Jacobo opined that there appeared "to be a tiny relationship" between the employee's recent changes in medications and his intoxication and fall. He requested consultation with Dr. Stevens, who had previously treated the employee.

Dr. Bernardo Ng, a Board-certified psychiatrist, treated the appellant on December 15, 2010 for a history of depression. He performed mental status examination and diagnosed major depressive, recent, rule-out pain syndrome, and chronic pain syndrome, status post cervical surgery due to motor vehicle accident injury. Dr. Ng noted that the employee declined antidepressant medication. He indicated that consideration should be made to decrease pain medications, specifically narcotics, and recommended a rehabilitation program to prevent worsening of employee's pain, which was declined by the employee.

Dr. Stevens reported on December 15, 2010 that the employee was unavailable at the time of consultation. He noted the employee's long-standing history of chronic pain syndrome due to multiple neck surgeries and migraine headache, noting that he had been in a pain clinic earlier that year and had been seen on December 9, 2010 for uncontrolled pain symptoms which were not helped by methadone. Dr. Stevens noted that he prescribed Dilaudid and amitriptyline at that time which the employee began taking, with subsequent right-sided numbness and pain that initiated hospitalization on December 13, 2010. He indicated that an MRI scan of the brain was normal. Dr. Stevens noted that, according to the employee's report, he had only taken two Imitrex and one Dilaudid pill on the day he started having mental status changes, and opined that it was unlikely that this combination, along with amitriptyline, caused him to have a syncopal episode. He indicated that the employee's hospital laboratory studies showed elevated liver enzymes and that he had recently been started on niaspan, a cholesterol medication, a known cause of hepatic dysfunction consistent with the employee's symptoms. Dr. Stevens recommended that the employee not restart niaspan and be discharged on an oral morphine equivalent. A handwritten

notation on Dr. Stevens' consultation report indicated that the employee was admitted to a different hospital on January 1, 2011, readmitted in the middle of January, released approximately February 8, 2011, and then followed by a neurologist in Boston, Massachusetts. The note referenced a March 2, 2011 neurology report from Massachusetts General Hospital. The record contains no reports of any 2011 hospitalization in California or Massachusetts.

Appellant also forwarded Dr. McNamara's treatment notes dated March 24 to July 15, 2015 in which he described the employee's pain management regimen, noting treatment with venlafaxine, Dilaudid, and Norco. Dr. McNamara diagnosed chronic pain, neck pain, chronic use of opiate drugs for therapeutic purposes, and history of traumatic brain injury. He noted that the employee was followed by neurology in Boston regarding chronic central nervous systems issues which appeared to have improved over time. In each report Dr. McNamara referenced his initial office note regarding his medical history.[4] In the June 17, 2015 note, Dr. McNamara noted that the employee reported resuming smoking after many years and that he was drinking three beers a day. He indicated that he informed the employee that this was not compatible with chronic opioid therapy or his medication agreement. On July 15, 2015 Dr. McNamara indicated that the employee reported that he continued to smoke, but had discontinued alcohol.

At the hearing, held on May 15, 2017, appellant's representative discussed the employee's medical history including reports from a Dr. Tracey Cho, a Board-certified neurologist, and a Dr. Patrick Wolcott, a Board-certified internist and pulmonologist. He maintained that the employee's death was employment related.[5]

On June 13, 2017 appellant and her representative requested that OWCP expand the acceptance of the claim to include additional conditions of hepatic steatosis, posthypoxic leukoencephalopathy, hypoxemia, central sleep apnea, depression, respiratory system depression, bradycardia, and hypotension. The correspondence also referenced OWCP's opioid policy, effective June 26, 2017.

In a June 8, 2017 report, Dr. Jacobo noted his review of some medical records of the employee including the autopsy. He disagreed with Dr. Smiddy's findings and conclusions, alleging that her diagnosis of chronic alcoholism was incorrect. Dr. Jacobo further disagreed with Dr. Yuan's assertion that a toxicology report noted the presence of cannabinoids without indication of medical marijuana approval. He maintained that the employee's chronic use of opioids provoked his death, noting factors of depression provoked by chronic pain, chronic use of narcotics, and being disabled and unemployed; the unauthorized use of prescribed medicine and use or abuse of alcohol provoked by long-term use of narcotics; and delayed posthypoxic leukoencephalopathy which was work related because the narcotics produced hypoxemia and central sleep apnea. Dr. Jacobo acknowledged that the employee was self-medicating at the time of his death, but asserted that this type of drug abuse was highly associated with the long-term use of opioids. He referenced a sleep study and report by Dr. Cho, and medical publications. Dr. Jacobo concluded that, while the employee died from an acute intoxication with alcohol and a combination of narcotics and other medicines, his death was the final act that began with his motor

[4] Dr. McNamara's initial office note is not found in the case record before the Board.

[5] The record does not contain a report from either doctor.

vehicle accident which occurred in the line of duty. He advised that the employee lived trying to control his pain, but at the end, the treatment he was prescribed to control his pain provoked his death. Dr. Jacobo asserted that the employee was not a drug abuser and died from the lesions and complications from the treatment for his chronic pain.

By decision dated July 25, 2017, an OWCP hearing representative found that appellant had not established that the employee's death was causally related to his accepted employment injury. She noted that Dr. McNamara, his attending pain management specialist, indicated that the death of the employee was not related to his accepted injury, and that Dr. Yuan carefully reviewed the record and noted a high degree of poly-pharmacological self-administration, which likely contributed to the employee's death, but that the medications listed in the SOAF did not cause or contribute to his death.[6] The hearing representative found Dr. Jacobo's report of limited probative value as he cited medical literature to support his opinion which did not specifically address the employee's situation and work factors. She concluded that the weight of the medical evidence rested with the opinion of Dr. Yuan and affirmed the January 13, 2017 decision.

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 duty.[7] 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 employment.[8] 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 federal employment. As part of this burden, appellant must submit a rationalized medical opinion, based upon a complete and accurate factual and medical background, showing a causal relationship between the employee's death and an employment injury or factors of his or her federal employment. Causal relationship is a medical issue and can be established only by medical evidence.[9]

The mere showing that an employee was receiving compensation for total disability at the time of his or her death does not establish that the employee's death was causally related to the previous employment.[10] The Board has held that it is not necessary that there is a significant

[6] The hearing representative also noted that the record contained a toxicology report that was positive for cannabinoids. The record contains a January 31, 2013 report which was interpreted as positive for cannabinoids which indicated prescribed or illicit use of marijuana.

[7] 5 U.S.C. § 8133 (compensation in case of death).

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

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

[10] *Edna M. Davis (Kenneth L. Davis)*, 42 ECAB 728 (1991).

contribution of employment factors to establish causal relationship.[11] If the employment contributed to the employee's death, then causal relationship is established.[12]

The general rule respecting consequential injuries is that, when the primary injury is shown to have arisen out of and in the course of employment, every natural consequence that flows from the injury is deemed to arise out of the employment, unless it is the result of an independent intervening cause, which is attributable to the employee's own intentional conduct. The subsequent injury is compensable if it is the direct and natural result of a compensable primary injury. With respect to consequential injuries, the Board has stated that, where an injury is sustained as a consequence of an impairment residual to an employment injury, the new or second injury, even though nonemployment related, is deemed, because of the chain of causation to arise out of and in the course of employment and is compensable.[13] A claimant bears the burden of proof to establish a claim for a consequential injury. As part of this burden, he must present rationalized medical opinion evidence.[14]

ANALYSIS

The Board finds that appellant has not met her burden of proof to establish that the employee's death on August 4, 2015 was causally related to his accepted May 19, 2004 employment injury.

OWCP accepted cervical strain, cervical disc herniations at C4-5 and C5-6, left shoulder strain, psychogenic pain, dysphagia, and nonunion of fracture caused by a May 15, 2004 motor vehicle accident. The employee died on August 4, 2015 of acute intoxication with combined effects of ethanol, alprazolam, hydrocodone, hydromorphone, topiramate, tramadol, venlafaxine, and trazodone. Appellant asserted that the medications were prescribed to help the employee manage pain due to the May 109, 2004 employment injury.

On a December 3, 2015 attending physician's report attached to appellant's death benefits claim, Dr. McNamara an attending pain management specialist, noted that the employee's autopsy listed the combined effects of ethanol and multiple medications as the cause of death. He indicated on the December 3, 2015 report that the employee's death was not due to the pharmacological management of the employment-related neck pain.

OWCP referred a SOAF and the medical record to Dr. Yuan for a second opinion evaluation. In his comprehensive November 28, 2016 report, Dr. Yuan noted his review of the medical evidence dating from May 19, 2004. He advised that the medications listed in the SOAF that had been approved by OWCP did not cause, accelerate, precipitate or in some way contribute to the employee's death. Dr. Yuan noted, however, that the toxicology report did not match the prescribed medications. He explained that when used together, the combination of opioid and

[11] *See T.H. (M.H.)*, Docket No. 12-1018 (issued November 2, 2012).

[12] *Id*.

[13] *N.H.*, Docket No. 10-0536 (issued October 4, 2010).

[14] *Id.*

BZD drugs could have serious detrimental effects upon physical health, mental health, and sobriety, and that in addition to increasing the risk of overdose, BZD and opioid poly drug use could exacerbate psychological and medical problems commonly seen among drug users. Dr. Yuan noted that the autopsy determined that the cause of the employee's death was due to the effects of ethanol and multiple medications (alprazolam, hydrocodone, hydromorphone, topiramate, tramadol, venlafaxine, and trazodone). The Board notes that Dr. Yuan also indicated that a toxicology report was positive for cannabinoids. Contrary to appellant's representative's assertion on appeal, the record contains a January 31, 2013 report positive for cannabinoids use which indicated prescribed or illicit use of marijuana. Dr. Yuan indicated that there was a high degree of poly-pharmacological self-administration, which likely contributed to the employee's death.

The Board has reviewed the opinion of Dr. Yuan and finds that it has reliability, probative value, and a convincing quality with respect to its conclusions regarding the issue presented on appeal.[15] Dr. Yuan's opinion is based on a proper factual and medical history and he thoroughly reviewed the factual and medical history by accurately summarizing the relevant medical evidence.[16] As noted, he provided medical rationale explaining that the employee's prescribed medications for treatment of his accepted employment-related conditions did not cause his death. Rather, the toxicology report indicated other substances, as well as alcohol and cannibus, contributed to the employee's death. Thus, Dr. Yuan's opinion is entitled to the weight of the medical evidence and establishes that the employee's death was not caused or a consequence of the accepted employment injury.[17]

In support of her claim for death benefits, appellant submitted a June 8, 2017 report in which Dr. Jacobo, who had treated the employee for a nonemployment-related hospitalization in 2010, noted his review of some of the employee's medical records including the autopsy. Dr. Jacobo disagreed with Dr. Smiddy's autopsy findings and conclusions, alleging that her diagnosis of chronic alcoholism was incorrect. He further disagreed with Dr. Yuan's assertion that a toxicology report noted the presence of cannabinoids without indication of medical marijuana approval.[18] Dr. Jacobo maintained that the employee's chronic use of opioids for the employment injury caused his death. He acknowledged that the employee was self-medicating at the time of his death, but asserted that this type of drug abuse was highly associated with the long-term use of opioids. He concluded that, while the employee died from an acute intoxication with alcohol and a combination of narcotics and other medicines, his death was the final act that began with his motor vehicle accident which occurred in the line of duty. Dr. Jacobo asserted that the employee was not a drug abuser and died from the lesions and complications from the treatment for his chronic pain. Due to the lack of an accurate factual background regarding appellant's substance abuse and the lack of medical reasoning explaining how the employee's accepted employment-

[15] *See R.T.*, Docket No. 17-2019 (issued August 24, 2018).

[16] *See Melvina Jackson*, 38 ECAB 443 (1987).

[17] *Supra* note 13

[18] *Supra* note 12.

related conditions lead to the consequential overdose, Dr. Jacobo's report is insufficient to meet appellant's burden of proof.[19]

The Board also notes that it is unclear what Dr. Jacobo was referencing when he indicated that the employee died from lesions. While appellant submitted evidence from the employee's hospitalization in 2010, she also referenced additional hospitalizations in 2011 and treatment at Massachusetts General Hospital. The medical record also does not contain any of these reports and does not contain reports of any studies done during the December 2010 hospitalization.

As to Dr. Jacobo's reliance on medical publications, the Board has long held that excerpts from publications have little probative value in resolving medical questions unless a physician shows the applicability of the general medical principles discussed in the articles to the specific factual situation at issue in the case.[20] Dr. Jacobo merely referenced the publications to support an opinion that patients on chronic opioid therapy had been shown to have relatively higher levels of clinical depression and to support that a potentially life-threatening side effect of opioid therapy was respiratory depression, bradycardia, and hypotension, which occurred in opioid overdose.

The medical evidence of record also contains reports from other physicians, including Drs. Stevens, Nelson, Richley and Ng, who provided histories regarding the employee's medical treatment, but offered no opinion regarding the cause of his death. Lacking an opinion regarding the cause of the employee's death, these reports are insufficient to meet appellant's burden of proof.[21] Similarly Dr. Smiddy's autopsy report related the employee's toxicology findings and indicated that the cause of death was acute intoxication due to the combined effects of ethanol, alprazolam, hydrocodone, hydromorphone, topiramate, tramadol, venlafaxine and trazadone. However, she did not provide a rationalized medical opinion relating the employee's death to his accepted employment injury.[22]

Appellant alleges that the employee's death due to drug and alcohol intoxication stemmed from the pain caused by his accepted condition. If the employee's drug dependency could be attributed to his disability, then the side effects of such dependency could be considered a consequential injury.[23] Appellant, however, did not submit a medical report of sufficient rationale explaining how the accepted employment injury of May 19, 2004 or the accepted employment conditions caused or contributed to the employee's death. None of the medical evidence submitted provided a physician's rationalized medical opinion causally relating the employee's death on August 4, 2015 to the accepted employment injury. By letter dated July 20, 2016, OWCP advised appellant of the specific evidence needed to establish her claim, and again informed her of what was required in its initial denial on January 13, 2017.

[19] *See T.D.*, Docket No. 14-0262 (issued April 28, 2014).

[20] *Roger G. Payne*, 55 ECAB 535 (2004).

[21] *See J.P., (T.P.)*, Docket No. 17-0563 (issued June 20, 2018).

[22] *Id.*

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

Appellant's belief that the employee's chronic pain caused by the May 19, 2004 employment injury caused his reliance on drugs that led to his death on August 4, 2015 is insufficient, absent medical rationale, to establish the requisite causal relationship. As she failed to submit medical evidence containing a rationalized medical opinion that the employee's accepted conditions contributed to his August 4, 2015 death, she has not met her burden of proof.[24]

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 not met her burden of proof to establish that the employee's death on August 4, 2015 was causally related to his accepted May 15, 2004 employment injury.

ORDER

IT IS HEREBY ORDERED THAT the July 25, 2017 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: November 1, 2018
Washington, DC

Patricia H. Fitzgerald, Deputy 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

[24] *Supra* note 19.