

related to factors of his federal employment. He noted that he initially became aware of his condition on May 29, 2014 and attributed it to his work duties on May 30, 2014. Appellant stopped work on May 29, 2014.

On October 11, 2013 appellant received treatment in the emergency department for an ileus or small bowel obstruction. On January 30, 2014 he received treatment for a skin rash.

In a statement accompanying his claim, appellant related that beginning in 2005 he had worked as an inspector at chemical facilities and rail tank cars. He had no family history of problems with his kidneys. Appellant attributed his acute renal failure to “years of chronic exposure to chemicals and recent multiple inspections of agricultural chemical facilities” in the weeks before he became ill. He noted that the facilities contained potassium nitrate which had “health hazards known to cause blood and kidney issues.” Appellant described in detail his employment duties, noting that he conducted hundreds of inspections of rail tankers carrying chemicals such as chlorine and anhydrous ammonia from May 2005 to July 2010. In July 2010, he began inspecting facilities and worked with a state inspector from 2011 to 2013 who had physical reactions when exposed to nitrate-based chemicals in factories. Appellant related that the number of inspections he conducted had greatly increased in 2013 and that he had begun to experience “unexplained medical issues which required emergency medical care.” He received treatment for ileus on October 11, 2013, which he noted could be caused by chemical exposure, and developed a severe rash and hives on his skin after conducting five inspections of chemical facilities in Hawaii. Appellant advised that he was hospitalized on May 30, 2014 for acute renal failure and that a neurologist had opined that chemical exposure had contributed to his condition after learning of his occupation.

In a May 30, 2014 consultation, Dr. Theodore Tzeremas, a Board-certified nephrologist, evaluated appellant for an acute kidney injury. He noted that appellant had a history of hyperlipidemia and hypertension and that he took ibuprofen nightly. Dr. Tzeremas diagnosed an acute kidney injury which he suspected resulted from “severe volume depletion in the setting of nonsteroidal medication use.”

In a discharge summary dated June 1, 2014, Dr. Matthew C. Kerzan, a Board-certified internist, discussed appellant’s hospitalization for high creatinine levels after lab work revealed acute renal failure. He diagnosed acute renal failure due to either medications, urinary retention, or chemicals. Dr. Kerzan noted that appellant had a history of smoking in the past and had been exposed to chemicals in his work as a chemical inspector.

On August 15, 2014 appellant submitted a summary of recent chemical facility inspections that he had performed from September 17, 2013 to July 2, 2014.

In a progress report dated September 3, 2014, Dr. Maninder P. Chatha, a Board-certified nephrologist, diagnosed stage two chronic kidney disease with high creatinine levels for three months.

Appellant underwent a left renal biopsy on September 11, 2014. Dr. Juan M. Iturregui, a Board-certified pathologist, indicated that the biopsy had revealed tubulointerstitial fibrosis and a focal acute tubular injury. He advised, “The degree of tubulointerstitial fibrosis is out of proportion

to the damage to vessels and glomeruli, therefore, these changes could represent the chronic sequela of a previously tubulointerstitial disorder, such as acute tubular necrosis due to a toxic event or a hemodynamic disturbance.”

On September 30, 2014 appellant provided a list of additional facilities that he inspected, including ones that had environmental violations. He submitted a nonexhaustive list of chemicals that were present at the inspected facilities.

On October 13, 2014 Dr. Chatha related that he had treated appellant initially for an acute kidney injury and was currently treating him for chronic kidney disease and hypertension. He advised that appellant should avoid exposure to toxic chemicals, stress, and extensive travel.

Appellant submitted enforcement and compliance histories for various facilities that he had inspected and information regarding complaints and accidents at facilities from Occupational Safety and Health Administration (OSHA). He also submitted chemical release information for facilities.

In a development letter dated December 12, 2014, OWCP advised appellant that the evidence currently was insufficient to show that he actually had experienced the alleged employment factors or had sustained a diagnosed condition due to an employment activity. It notified him of the type of additional evidence needed, including a detailed factual statement describing the activities that he believed had contributed to his condition and a report from his attending physician addressing the causal relationship between any diagnosed condition and factors of his federal employment. OWCP afforded appellant 30 days to submit the requested evidence.

Appellant, in a January 2, 2015 response to OWCP’s development letter, noted that the renal biopsy had revealed that his condition resulted from a toxic event, a hemodynamic disturbance, or a combination of the two. He related that he had developed a rash at a facility where a fellow inspector had a reaction to airborne nitrates. The employing establishment did not provide safety equipment. Appellant advised that he had smoked cigarettes for 20 years, but stopped in November 2007. He noted that the Material Safety Data Sheet (MSDS) for ammonium nitrate listed a kidney injury as a possible consequence of prolonged exposure. Appellant advised that inspections of facilities had increased dramatically over the last five years and that he had been exposed to “nitrates, insecticides and pesticides stored in enclosed warehouse type facilities....” He indicated that his physician had asked him what he did for a living as he could not determine the etiology of his acute renal failure. Appellant had described his employment and Dr. Tzeremas had informed him that chemical exposure had caused his condition.

An official at the employing establishment, R.L., reviewed appellant’s statement and advised that it appeared to be accurate.

Appellant submitted a list of chemicals likely to be present in rail cars and chemicals of interest to the employing establishment.

In a report dated January 14, 2015, Dr. Chatha noted that appellant had been hospitalized with ileus in December 2013. In January 2014, after conducting inspections of chemical facilities, he had to obtain treatment in the emergency room for a rash. Dr. Chatha related that appellant had

been admitted to the hospital in May 2014 for elevated creatinine levels. A biopsy had revealed that appellant had kidney damage due to either acute tubular necrosis or toxic exposure, so Dr. Chatha had referred appellant to a toxicologist to determine the cause of his condition. Dr. Chatha diagnosed stage two chronic kidney disease. He related, “[Appellant] has a long list of chemical exposure that he has had for the work-related inspection of different facilities. It is difficult to specify which chemical could have contributed given that the biopsy was done after the fact.”

By decision dated February 4, 2015, OWCP denied appellant’s occupational disease claim. It found that he had not factually established the occurrence of the alleged chemical exposure. OWCP noted that appellant had a 20-year history of smoking cigarettes. It concluded, therefore, that the requirements had not been met to establish an injury as defined by FECA.

On February 25, 2015 appellant, through his then-counsel, requested a telephonic hearing before an OWCP hearing representative.

In a report dated September 15, 2015, Dr. Jeffrey D. Gaber, a Board-certified internist, evaluated appellant for chronic renal failure. He reviewed medical records, including the pathology report finding chronic tubular interstitial changes, and a focal nebular injury due to either toxic exposure or acute tubular necrosis. Dr. Gaber advised, “It is clear that since the situation did not entirely return to normal, it is not due to acute tubular necrosis (which should have resolved completely,) but instead was a chronic problem and thus more consistent with a toxic exposure.” He listed the chemicals found at sites that appellant inspected, noting that many facilities had violated federal safety regulations for releases of chemicals or an improper safety system. Dr. Gaber indicated that the biopsy showed no evidence of kidney disease from hypertension or gout, and that he had denied the use of excessive anti-inflammatory medication. He diagnosed chronic renal insufficiency as a result of chronic tubular interstitial nephritis. Dr. Gaber related, “It is clear that [appellant] has been exposed to a number of toxic chemicals during his career with [the employing establishment], many of which are well-known to be nephrotoxic. During his career, he did not have protective respiratory equipment. The pathology report on the kidney biopsy is consistent with a toxic cause of renal insufficiency.” He noted that appellant was repeatedly exposed to chemicals in his employment and that “chronic repeated exposure cause human toxicity and [it] does not require a single large exposure to do this.” Dr. Gaber advised that smoking cigarettes did not cause renal failure. He reviewed OWCP’s decision and related:

“To reiterate, [appellant] did not have any preexisting or underlying conditions to cause renal failure and, as stated just before, tobacco use is definitely not one of them. The fact that a single chemical cannot be determined as the offending agent does not, in my opinion, reduce the validity of his claim. In fact, in my opinion, since so many of the chemicals can cause renal insufficiency, that history alone strengthens [appellant’s] claim.

“To summarize, then, it is my opinion to a reasonable degree of medical certainty that there is a strong causal relationship between [appellant’s] renal insufficiency and the work[-]related exposures described above.”

A telephonic hearing was held on September 17, 2015.

Appellant's then-counsel, in a November 16, 2015 statement, asserted that the evidence from Dr. Gaber was sufficient to establish appellant's claim.

By decision dated December 8, 2015, an OWCP hearing representative affirmed the February 4, 2015 decision. She found that appellant had not established exposure to a particular toxic chemical.

Thereafter, appellant provided statements from coworkers who had accompanied him on inspections. In a statement dated November 22, 2016, P.F., a coworker, related that he accompanied appellant on around five inspections between May 2005 and May 2014. He advised that the chemical present at the facilities was potassium nitrate. In a statement dated November 23, 2016, T.W., a coworker, related that he performed around 20 inspections with appellant from May 2005 to May 2014, and provided an extensive list of chemicals likely present during the inspections.² R.R., a coworker, in a November 29, 2016 statement advised that he had accompanied appellant on three inspections and that sulfur dioxide and ammonium nitrate were present at the facilities.

In a report dated June 24, 2016, Dr. Harry F. Goss, Jr., a Board-certified internist and nephrologist, discussed appellant's belief that his exposure to chemicals had caused his renal condition. He diagnosed renal interstitial fibrosis, secondary tubulointerstitial nephritis, kidney disease, a history of hypertension, history of toxic inhalation exposure, occupational exposure to toxic agents in agriculture, occupational exposure to toxic waste, kappa light chain disease, azotemia, and gout.

Appellant submitted an affidavit on December 7, 2016 describing in detail his workplace exposure to chemicals, including ammonia nitrate, potassium nitrate, potassium permanganate, and aluminum phosphide. He described improper release and storage of chemicals at various facilities that he had inspected and asserted that the employing establishment had not provided him with respiratory equipment.

OWCP on December 7, 2016 received a November 18, 2015 statement from the employing establishment regarding the exposure of another employee to hazardous chemicals.

In a supplemental report dated December 7, 2016, Dr. Gaber noted that appellant had provided an affidavit indicating that he had experienced significant exposure to ammonia nitrate in ripped and leaking pallets during the inspection at a facility with poor ventilation. In 2014, he had performed inspections on a facility which contained the chemicals potassium nitrate, potassium permanganate, and aluminum phosphide. Dr. Gaber discussed appellant's exposure to other chemicals during the course of his inspection of nine facilities. He indicated that he had

² In a statement dated November 21, 2016, J.C., a coworker, related that he worked with appellant on fewer than 10 inspections from May 2005 and May 2014 and that he could not recall the chemicals. R.H., a coworker, in a November 30, 2016 statement advised that he accompanied appellant on between 5 to 20 inspections and that the position of chemical security inspector required exposure "to both known and unknown chemicals while conducting an inspection." R.L., a coworker, advised on November 28, 2016 that he did not know what chemicals were present at inspected facilities.

reviewed the MSDS for the various chemicals and articles relevant to renal failure after exposure to certain chemicals. Dr. Gaber related:

“Therefore, it is my conclusion, stated to a reasonable degree of medical certainty, and based on the medical literature and that contained in the [MSDS], that it is far more likely than not that the alleged exposures [appellant] had to one or all of the following -- potassium permanganate, potassium nitrate, phosphorus, phosphorus oxychloride, chlorine dioxide, and aluminum phosphide -- caused him to develop chronic renal failure. These chemicals had volatility and can cause off-gassing, as they can slowly evaporate and compromise the interior air quality.”

On December 6, 2016 the employing establishment denied the request from then-counsel for information regarding the number of inspections appellant performed from May 2005 through May 2014, the specific chemicals in the facilities, a description of the storage of the chemicals, protective clothing or respirators he wore, and chemicals leaking or improperly stored.

On December 7, 2016 appellant, through his then-counsel, requested reconsideration of the December 8, 2015 hearing decision. Counsel contended that he had submitted sufficient evidence to demonstrate exposure to toxins and asserted that OWCP had failed to obtain a statement from the employing establishment regarding alleged work exposure in accordance with its procedures. He also maintained that the medical evidence was sufficient to establish causal relationship between exposure to toxins in the course of appellant’s employment and his chronic renal failure.

By decision dated March 9, 2017, OWCP modified its December 8, 2015 decision to find that appellant had established exposure to chemicals in the course of his federal employment. It determined, however, that the medical evidence of record was insufficient to establish that he sustained a diagnosed medical condition causally related to the accepted exposure. OWCP found that Dr. Gaber did not discuss appellant’s history of hypertension.

In a report dated July 1, 2017, Dr. Gaber related that appellant’s biopsy had established that his renal insufficiency had resulted from interstitial nephritis, a condition unrelated to hypertension. He advised that there was no evidence that appellant’s controlled hypertension “played any role in the development of the renal insufficiency.”

On September 14, 2017 appellant, through his then-counsel, requested reconsideration. He asserted that the opinions of Dr. Gaber and Dr. Chatha were sufficient to establish causation.

By decision dated June 18, 2018, OWCP denied modification of its March 9, 2017 decision. It found that appellant had not submitted reasoned medical evidence explaining how his exposure to potassium permanganate, potassium nitrate, phosphorus oxychloride, chlorine dioxide, or aluminum phosphide caused renal failure.

On appeal appellant asserts that he has submitted sufficient evidence to establish his claim.

LEGAL PRECEDENT

An employee seeking benefits under FECA has the burden of proof to establish the essential elements of his or her claim, including the fact that the individual is an employee of the

United States within the meaning of FECA, that the claim was filed within the applicable time limitation period of FECA,³ that an injury was sustained while in the performance of duty as alleged, and that any disability or specific condition for which compensation is claimed is causally related to the employment injury.⁴ These are the essential elements of each and every compensation claim, regardless of whether the claim is predicated upon a traumatic injury or an occupational disease.⁵

In an occupational disease claim, appellant's burden requires submission of the following: (1) a factual statement identifying employment factors alleged to have caused or contributed to the presence or occurrence of the disease or condition; (2) medical evidence establishing the presence or existence of the disease or condition for which compensation is claimed; and (3) medical evidence establishing that the diagnosed condition is causally related to the employment factors identified by the employee.⁶

The medical evidence required to establish 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 diagnosed condition and the specific employment factors identified by the employee.⁷

Proceedings under FECA are not adversarial in nature and OWCP is not a disinterested arbiter. While the claimant has the burden of proof to establish entitlement to compensation, OWCP shares responsibility to see that justice is done.⁸ The nonadversarial policy of proceedings under FECA is reflected in OWCP's regulations at section 10.121.⁹

OWCP's procedures provide that the claims examiner should refer the case to a second opinion physician when it has gathered all the medical evidence from the attending physician and does not have enough evidence about a diagnosis or an adequately reasoned opinion about causal

³ *S.B.*, Docket No. 17-1779 (issued February 7, 2018); *J.P.*, 59 ECAB 178 (2007); *Joe D. Cameron*, 41 ECAB 153 (1989).

⁴ *J.M.*, Docket No. 17-0284 (issued February 7, 2018); *R.C.*, 59 ECAB 427 (2008); *James E. Chadden, Sr.*, 40 ECAB 312 (1988).

⁵ *K.M.*, Docket No. 15-1660 (issued September 16, 2016); *L.M.*, Docket No. 13-1402 (issued February 7, 2014); *Delores C. Ellyett*, 41 ECAB 992 (1990).

⁶ *P.D.*, Docket No. 17-1885 (issued September 17, 2018).

⁷ *R.P.*, Docket No. 17-1914 (issued November 27, 2018).

⁸ *X.V.*, Docket No. 18-1360 (issued April 12, 2019).

⁹ 20 C.F.R. § 10.121.

relationship to accept the case, but does have sufficient evidence to suggest that the claimant might be entitled to benefits.¹⁰

ANALYSIS

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

In a report dated September 15, 2015, Dr. Gaber discussed appellant's exposure to toxins in the course of his federal employment and noted that he was not provided with respiratory equipment. He advised that appellant was exposed to nephrotoxic chemicals and opined that the pathology report was consistent with toxins as a source of appellant's renal insufficiency, noting that the fact that his condition had failed to resolve demonstrated that tubular necrosis was not the causative agent. Dr. Gaber opined that tobacco use did not result in appellant's renal failure. He concluded that appellant had experienced renal insufficiency due to employment-related chemical exposure. On December 7, 2016 Dr. Gaber discussed appellant's specific exposure to chemicals at various facilities, including ammonia nitrate, potassium nitrate, potassium permanganate, and aluminum phosphide, and opined that his exposure to these chemicals resulted in his chronic renal failure. On July 1, 2017 he advised that the biopsy results had established that appellant's hypertension failed to contribute to his renal insufficiency.

Proceedings under FECA are not adversarial in nature and OWCP is not a disinterested arbiter.¹¹ It shares responsibility to see that justice is done.¹² The Board finds that Dr. Gaber provided an opinion that appellant's renal failure resulted from chemical exposure to ammonia nitrate, potassium nitrate, potassium permanganate, and aluminum phosphide in the course of appellant's federal employment. He based his opinion on an uncontradicted history of injury and the results of objective testing. Dr. Gaber's opinion is sufficient, given the absence of any opposing medical evidence, to require further development of the record.¹³ Accordingly, the Board will remand the case to OWCP.

Additionally, although it is the claimant's burden of proof to establish his or her claim, OWCP shares responsibility in the development of the evidence, particularly when such evidence is of the character normally obtained from the employing establishment or other government source.¹⁴ On remand OWCP shall obtain all relevant information from the employing establishment regarding the details of appellant's accepted chemical exposures, and his use of any protective equipment. It should prepare a statement of accepted facts and refer to a second opinion physician to determine whether he has sustained renal insufficiency causally related to the accepted

¹⁰ Federal (FECA) Procedure Manual, Part 2 -- Claims, *Developing and Evaluation Medical Evidence*, Chapter 2.0810.9.b (1) (June 2015); *see also* *K.B.*, Docket No. 18-1548 (issued March 11, 2019).

¹¹ *See J.V.*, Docket No. 17-0973 (issued July 19, 2018).

¹² *Id.*

¹³ *D.C.*, Docket No. 18-1664 (issued April 1, 2019).

¹⁴ *See G.R.*, Docket No. 18-1490 (issued April 4, 2019).

factors of his federal employment.¹⁵ Following this and any other necessary further development, OWCP shall issue a *de novo* decision.

CONCLUSION

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

ORDER

IT IS HEREBY ORDERED THAT the June 18, 2018 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: June 11, 2019
Washington, DC

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

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

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

¹⁵ See *K.B.*, *supra* note 10.