

**United States Department of Labor
Employees' Compensation Appeals Board**

D.M., widower of T.M., Appellant)	
)	
and)	
)	
DEPARTMENT OF VETERANS AFFAIRS,)	Docket No. 19-0358
VETERANS ADMINISTRATION MEDICAL)	Issued: March 19, 2020
CENTER, Salem, VA, Employer)	
)	

Appearances:
Susan A. Waddell, Esq., for the appellant¹
Office of the Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Deputy Chief Judge
JANICE B. ASKIN, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On December 3, 2018 appellant, through counsel, filed a timely appeal from a July 17, 2018 merit decision of the Office of Workers' Compensation Programs (OWCP).² Pursuant to the

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 Appellant filed a timely request for oral argument, pursuant to 20 C.F.R. § 501.5(b). After exercising its discretion the Board, by September 5, 2019 order, denied his request noting that his arguments on appeal could be adequately addressed in a Board decision based on a review of the case record. *Order Denying Request for Oral Argument*, Docket No. 19-0358 (issued September 5, 2019).

Federal Employees' Compensation Act³ (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 his burden of proof to establish that the employee's death on October 7, 2011 was causally related to the accepted exposures as a high-risk employee.

FACTUAL HISTORY

This case has previously been before the Board.⁴ The facts and circumstances as set forth in the prior Board decisions are incorporated herein by reference. The relevant facts are as follows.

On February 10, 2012 appellant filed a claim for compensation by widower (Form CA-5) alleging that his wife, the employee, died on October 7, 2011 due to factors of her federal employment.⁵ He noted that the employee worked as a nurse for the employing establishment. On the reverse side of the form, the employee's attending physician, Dr. Richard P. Konstance, a Board-certified cardiologist, noted that she suffered a suspected heart attack with increased metabolic acidosis due to a presumed bacterial infection. The employee's direct cause of death was *Neisseria meningitidis* (NM) group B bacteremia with disseminated intravascular coagulation. Dr. Konstance opined that the contributory causes of death were meningitis, septic shock, respiratory failure, and pulseless electrical activity arrest. The death certificate attributed the employee's demise to NM.

Appellant provided medical evidence including a report dated March 1, 2012 from Dr. Luthur A. Beazley, a Board-certified pediatrician, who attributed the employee's death to meningococemia. He also provided a March 1, 2012 report from Dr. Lee Anne Steffe, a Board-certified pediatrician, who opined that the employee was most likely exposed to NM bacteria at the employing establishment where she was employed as a nurse in the family practice clinic.

In a November 14, 2012 development letter, OWCP advised appellant of the deficiencies of his claim. It requested additional factual and medical evidence in support of his claim. OWCP afforded him 30 days to respond.

Appellant submitted a narrative statement detailing the events of October 6 and 7, 2011. The employee died at 4:00 p.m. on October 7, 2011. Appellant requested an autopsy. He noted that the employee's work involved patients sneezing on her as well as treating patients who lived in unsanitary conditions. Appellant noted that he was required to take antibiotics after her death due to the contagious nature of the condition.

³ 5 U.S.C. § 8101 *et seq.*

⁴ Docket No. 14-0460 (issued February 11, 2016); *Order Granting Remand*, Docket No. 17-1828 (issued March 13, 2018).

⁵ The record includes a copy of appellant's marriage license.

Appellant submitted the employee's medical records from her initial admittance at New River Valley Medical Center on October 7, 2011. Dr. Robert E. Budin, a Board-certified pathologist, performed the autopsy. He listed the employee's cause of death as NM group B bacteremia with disseminated intravascular coagulation involving kidney, gastrointestinal tract, heart, and lungs with hemorrhage of the middle lobe of the right lung and bilateral adrenal glands.

On December 27, 2012 Dr. William J. Kagey, a Board-certified pediatrician, reported that the employee worked as a nurse in the family practice clinic at the employing establishment and that she died of meningococemia on October 7, 2011.

On January 3, 2013 Dr. Steffe opined that, with reasonable medical probability, the employee was exposed to the NM bacteria at the employing establishment where she was employed as a nurse in the family practice clinic.

In an e-mail dated February 1, 2013, the employee's supervisor reported that she had worked in the surgical and urology outpatient specialty clinic. She opined that it was not possible to determine if the employee's exposure was work related. The supervisor noted that no other employees were infected. She reported that she was unable to determine to whom the employee was exposed, the dates of exposure, or the length of time that the employee may have been exposed to the source of the infection. It was confirmed that the employee worked Monday through Friday, September 26 to 30, 2011 and Monday through Thursday, October 3 through 6, 2011.

By decision dated March 7, 2013, OWCP denied appellant's claim finding that he had not established that the employee's exposure to NM occurred due to her federal employment. On March 11, 2018 appellant requested an oral hearing before a representative of OWCP's Branch of Hearings and Review.

On August 5, 2013 appellant and Dr. Kagey testified at the oral hearing that the employee contracted a bacterial infection of meningococemia. Dr. Kagey noted that this bacteria was carried in a small percentage of the population and was usually contracted through airborne exposure. He reported that the incubation period was usually one to four days from the time of exposure and explained that, as a nurse, the employee was 25 times more likely to develop meningitis in a hospital setting than the general population.

Appellant testified that he had not had meningitis and that to his knowledge he was not a carrier. He testified that the employee had not traveled nor been exposed to crowds during the week before her symptoms developed. Appellant reported that they had not eaten out that week, but stayed home and had not done much.

By decision dated November 6, 2013, the hearing representative affirmed the March 7, 2013 decision finding there was no evidence in the record to support a finding that the employee contracted NM at work or that she was exposed to the bacteria at work. He concluded that the factual evidence failed to establish when, where, and how the employee was exposed to the NM bacteria while in the performance of her federal duties. The hearing representative found that the evidence submitted was insufficient to establish that the employee's death was causally related to her federal employment.

Appellant, through counsel, appealed to the Board, and by decision dated February 11, 2016, the Board found that the reports of Drs. Kagey, Beazley, and Steffe, did not contain the necessary in-depth discussion of causal relationship by an appropriate specialist to establish causal relationship. The Board also found that “the employee’s work as a nurse at the employing establishment routinely presented situations which may lead to infection by contact with human blood, bodily secretions, and other substances” and therefore she was found to have worked in “high-risk employment.” The Board remanded the case for OWCP to prepare a complete, accurate, and updated statement of accepted facts (SOAF) and refer the medical record to an appropriate medical specialist for a reasoned opinion as to whether the employee’s high-risk employment as a nurse for the employing establishment caused or contributed to her death to be followed by a *de novo* decision.

On March 31, 2016 OWCP provided a SOAF, a copy of the medical record, and a series of questions for Dr. John L. Bruschi, Board-certified in infectious disease. In his April 26, 2016 report, Dr. Bruschi opined that the employee’s death was not medically connected in any way to her employment. He found that appellant’s work in the employing establishment clinic had not put her at an increased risk of acquiring NM. Dr. Bruschi reported that occupational acquisition of meningococcal disease was rarely described in healthcare workers and that working in healthcare was not considered to be a risk factor for meningococemia. He noted that NM was a respiratory pathogen with a major risk factor of prior nasopharyngeal carriage of the organism. Dr. Bruschi concluded, “Based on this epidemiology and the fact that there were no known cases of meningococcal disease among the patients and staff, I conclude that it is much more likely than not that [the employee] did not acquire the fatal meningococcal infection at her place of employment.”

By decision dated May 26, 2016, OWCP denied appellant’s claim finding that the medical evidence of record failed to establish that the employee’s death was causally related to factors of her federal employment.

On April 18, 2017 appellant, through counsel, requested reconsideration of the May 26, 2016 decision. He provided a sworn declaration of facts dated March 30, 2017.⁶

In support of his request, appellant provided an April 10, 2017 report from Dr. Keith Hamilton, Board-certified in infectious disease. Dr. Hamilton reviewed the employee’s medical record and employment duties. He reviewed appellant’s statement that he and the employee had no other persons in their house during the two weeks prior to her death, that he drove and picked her up every day during the weeks before her death, and that the employee had not gone anywhere aside from work and home during the two weeks prior to her death. Dr. Hamilton noted that the employee worked near patients who were being intubated and that she reported often being sneezed

⁶ Appellant noted that the employee began working at the surgery clinic four months prior to her death. He noted that he and the employee lived alone during the two weeks prior to her death. Appellant reported that he drove the employee to and from work during the two-week period prior to her death. He further asserted that during the two-week period prior to her death, the employee went nowhere other than work and home. Appellant noted that the employee worked near patients who were being intubated and that she was often sneezed on at work. The employee had also reported that she had contact with more than 50 different individuals every day at the employing establishment. Appellant concluded that other than at work, the only person that the employee came into contact with during the two weeks prior to her death was him.

on at work. He opined that it was more likely than not that the employee acquired the infection that led to her death at the employing establishment as a direct result of performing her job duties. Dr. Hamilton reported that many people were asymptomatic, but could still spread NM. He found that it was likely that the employee contracted the bacteria from an asymptomatic colleague or patient. Dr. Hamilton noted that in less than 2 percent of cases of NM occurred in outbreak settings and that the remaining 98 percent of cases were sporadic and that many of those occurred without a known contact. He opined that it was unreasonable to expect a claimant to provide a “specific circumstance” of exposure. Dr. Hamilton found that focus should be placed on the likelihood of acquiring an infection in a specific setting and that healthcare workers have 25 times the risk of the general public. He opined that healthcare workers such as the employee involved in aerosol-generating procedures such as intubation had a higher risk of exposure. Dr. Hamilton further opined that the number of contacts in a setting helped to prioritize the likelihood that a person acquired the infection in a particular location and that 5 to 10 percent of adults carry NM without having symptoms. He concluded, “Given that the [employee] was in contact with only one person outside of the healthcare setting (her husband) during the incubation period of 2 [to]10 days, but hundreds of people in the healthcare setting and given that she worked in a higher risk healthcare setting, I can say with a reasonable degree of medical certainty that it was much more likely [the employee] acquired the infection that led to her death at the [employing establishment] than at any other location.”

By decision dated July 14, 2017, OWCP denied modification of the May 26, 2016 decision finding that Dr. Hamilton’s report was speculative as there was no evidence that the employee was exposed to NM at the employing establishment. Appellant appealed this decision to the Board and requested oral argument. On December 20, 2017 the Director of OWCP filed a motion to remand the case without oral argument as OWCP had not followed the Board’s directives in the February 11, 2016 decision. On March 13, 2018 the Board issued an *Order Granting Remand*.⁷

In an April 23, 2018 development letter, OWCP requested additional factual evidence from the employing establishment including the employee’s work duties, exposure to bodily secretion, and the number of patients treated on October 6, 2011.

On April 27, 2018 a representative for the employing establishment, P.M., responded to a request for information by OWCP. She noted that the employee worked in the urology and plastic surgery clinics on October 6, 2011. P.M. listed her duties as obtaining vital signs, administering medication, voiding trials, catheter changes, dilations, and assisting with procedures such as biopsies and suture removal. She concluded that in the two weeks prior to October 6, 2011 appellant could have seen in the range of 100 patients.⁸ P.M. noted that during procedures where there was potential exposure to body fluids, personal protective equipment such as gloves, gowns, face shields, and masks were worn, and that the employee had not generated an exposure report. However, she responded that her responses to the inquiry were “very general, but is all I can give with this timeframe.”

⁷ *Supra* note 4.

⁸ P.M.’s reply noted that while the employee could have seen in the range of 100 Veterans, “due to the amount of time that has passed, I do not readily have on hand the clinic list to see which Veterans she provided care to.”

On June 6, 2018 OWCP composed a new SOAF and included the facts of the employee's work in the urology and plastic surgery clinics and the listed duties. It further noted that in the two weeks prior to her death, the employee treated approximately 100 patients. It noted that personal protective equipment were used and that the employee had not made an exposure report during this period. OWCP noted that no patients or coworkers were diagnosed with NM around the period of the employee's illness and death.

On July 17, 2018 Dr. Lynette H. Posorske, Board-certified in infectious disease, reviewed the medical records and the SOAF. She opined that the employee's death was not related to a workplace exposure or factors either by direct cause, aggravation, precipitation, or acceleration. Dr. Posorske noted that NM was transmitted *via* droplets by a respiratory route. Dr. Posorske reported that most commonly transmission resulted in asymptomatic colonization, with a small number of individuals developing acute infection. She also reported that 98 percent of cases occurred sporadically without a known exposure with up to 10 percent of the adults and adolescents colonized. Dr. Posorske noted that healthcare workers who were performing or assisting in endotracheal intubation, care of an endotracheal tube, mouth-to-mouth resuscitation, or close-in examination of the oropharynx were at high risk. She found that the employee would not have had close face-to-face contact in the process of performing her usual duties and that her exposure to respiratory secretions would be minimal. Dr. Posorske concluded, "Given the sporadic nature of most cases of serious meningococcal infection, it is at least as likely that [the employee's] exposure could have come from an exposure outside the workplace. The type of contact required to acquire the causative organism is that of being around other people, and her specific role in the healthcare setting would not place her at increased risk."

By decision dated July 17, 2018, OWCP denied appellant's claim for death benefits, finding that the employee's death was not employment related as none of the medical reports included a history of a verified specific instance where the employee was exposed to the NM virus while performing her federal job duties.

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.⁹ 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.¹⁰

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, he or she must submit medical opinion, based upon a complete and accurate factual and medical background, which is of reasonable certainty, and supported by medical rationale explaining the nature of the relationship

⁹ 5 U.S.C. § 8133 (compensation in case of death).

¹⁰ *M.L. (S.L.)*, Docket No. 19-0020 (issued May 2, 2019); *W.C. (R.C.)*, Docket No. 18-0531 (issued November 1, 2018); see *Sharon Yonak (Nicholas Yonak)*, 49 ECAB 250 (1997).

between the employee's death and the accepted conditions or employment factors identified by the employee.¹¹

Chapter 2.805.6 of OWCP's procedures provides:

“High-Risk Employment. Certain kinds of employment routinely present situations which may lead to infection by contact with animals, human blood, bodily secretions, and other substances. Conditions such as HIV [human immunodeficiency virus] infection and hepatitis B more commonly represent a work hazard in health care facilities, correctional institutions, and drug treatment centers, among others, than in Federal workplaces as a whole. Likewise, claims for brucellosis, anthrax, and similar diseases will most often arise among veterinarians and others who regularly work with livestock.

“Establishing causal relationship in these types of complex cases usually requires an in-depth discussion of causal relationship by an appropriate specialist (whether it is the claimant's physician or a second opinion specialist.) When writing to a specialist, the [claims examiner] should include a SOAF to provide a complete and accurate factual background for the specialist to render his/her opinion.”¹²

ANALYSIS

The Board finds that appellant has met his burden of proof to establish that the employee's death on October 7, 2011 was causally related to the accepted exposures as a high-risk employee.

The Board previously found that the employee's work as a nurse at the employing establishment routinely presented situations which could lead to infection by contact with human blood, bodily secretions, and other substances. Appellant's employment was thus found to be high-risk employment. The Board previously remanded the claim for OWCP to formulate a new SOAF setting forth the accepted high-risk employment factors and refer the employee's case for an appropriate second opinion medical review to determine if her NM was employment related.

On remand OWCP obtained opinions from Dr. Bruschi and Dr. Posorske as to whether appellant's death was employment related.

In his April 26, 2016 report, Dr. Bruschi opined that the employee's death was not medically related to her employment. However, he premised his opinion on the belief that working in a healthcare setting is not considered to be a risk factor for meningococemia. Dr. Bruschi's opinion thus ignored the Board's prior finding that appellant was employed in a high-risk position and is therefore not based upon a proper factual history. He also discounted causal relationship explaining that there were “no known cases of meningococcal disease among the patients and staff,” but that explanation is unsupported as the employing establishment failed to determine how many patients the employee was in contact with prior to her death and whether they were a carrier,

¹¹ *R.G.*, Docket No. 17-0916 (issued September 6, 2017); *Donna L. Mims*, 53 ECAB 730 (2002).

¹² Federal (FECA) Procedural Manual, Part 2 -- Claims, *Causal Relationship*, Chapter 2.805.6 (January 2013).

noting such investigation would be time consuming. A medical opinion should reflect a correct history and offer a medically sound explanation by the physician of how the specific employment exposure physiologically caused or aggravated the diagnosed conditions.¹³ As such, the opinion of Dr. Brusck lacks probative value on the issue of causal relationship.

In her July 17, 2018 report, Dr. Posorske opined that the employee's death was not related to a workplace exposure or factors either by direct cause, aggravation, precipitation, or acceleration. She explained that NM was transmitted *via* droplets by a respiratory route and that most transmissions resulted in asymptomatic colonization, with a small number of individuals developing acute infection. Dr. Posorske also reported that 98 percent of cases occurred sporadically without a known exposure with up to 10 percent of the adults and adolescents colonized. She noted that healthcare workers who were performing or assisting in endotracheal intubation, care of an endotracheal tube, mouth-to-mouth resuscitation, or close-in examination of the oropharynx were at high risk. However, Dr. Posorske indicated that the employee did not have close face-to-face contact in the process of performing her usual duties for the employing establishment and therefore her exposure to respiratory secretions would be minimal. She concluded, "Given the sporadic nature of most cases of serious meningococcal infection, it is at least as likely that [the employee's] exposure could have come from an exposure outside the workplace. The type of contact required to acquire the causative organism is that of being around other people, and her specific role in the healthcare setting would not place her at increased risk." The Board finds that Dr. Posorske's opinion also failed to accept and follow the Board's prior finding that appellant was employed in a high-risk position by finding she was not at an increased risk. Therefore her opinion on the issue of causal relationship is not based upon a proper factual history and lacks probative value.¹⁴

In support of his claim, appellant submitted an April 10, 2017 report from Dr. Hamilton. Dr. Hamilton considered the high risk nature of the employee's work for the employing establishment, noting that she worked near patients who were being intubated and that she had reported often being sneezed on at work. He opined that it was more likely than not that the employee acquired the infection that led to her death at the employing establishment as a direct result of performing her high risk employment duties. Dr. Hamilton concluded that it was likely that she had contracted the bacteria from an asymptomatic colleague or patient as many carriers are asymptomatic, but can still spread NM. He explained that in less than 2 percent of cases of NM occurred in outbreak settings, but that the remaining 98 percent of cases were sporadic and that many of those occurred without a known contact. Dr. Hamilton provided a rationalized explanation as to why it would be unreasonable to expect a claimant to provide a "specific circumstance" of exposure given a likely sporadic exposure in her or his work and thus indicated that focus should be placed on the likelihood of acquiring an infection in a specific setting. In the setting of her employing establishment, he noted that healthcare workers have 25 times the risk of exposure compared to the general public, healthcare workers performing aerosol-generating procedures have a higher risk of exposure, the number of contacts increases the likelihood of infection, and that 5 to 10 percent of adults carry NM without having symptoms. He concluded, "Given that the [employee] was in contact with only one person outside of the healthcare setting

¹³ See *J.M.*, Docket No. 17-1002 (issued August 22, 2017).

¹⁴ *Id.*

(her husband) during the incubation period of 2 [to] 10 days, but hundreds of people in the healthcare setting and given that she worked in a higher risk healthcare setting, I can say with a reasonable degree of medical certainty that it was much more likely [the employee] acquired the infection that led to her death at the [employing establishment] than at any other location.” The Board finds that Dr. Hamilton’s opinion is sufficient for appellant to meet his burden of proof to establish causal relationship in this case as his opinion is based on a complete and accurate factual and medical background of the claimant and the instances of the progression of her condition, the opinion is set forth with reasonable certainty, he is an infectious disease physician, and his opinion is properly supported by medical rationale explaining the nature of the relationship between her accepted high-risk employment and her ultimate death from NM on October 7, 2011.

As the Board has found that appellant has met his burden of proof to establish causal relationship, this claim shall be remanded for payment of proper compensation benefits.

CONCLUSION

The Board finds that appellant has met his burden of proof to establish that the employee’s death on October 7, 2011 was causally related to the accepted exposures as a high-risk employee.

ORDER

IT IS HEREBY ORDERED THAT the July 17, 2018 decision of the Office of Workers’ Compensation Programs is reversed and the case is remanded for payment of proper compensation benefits.

Issued: March 19, 2020
Washington, DC

Christopher J. Godfrey, Deputy Chief Judge
Employees’ Compensation Appeals Board

Janice B. Askin, Judge
Employees’ Compensation Appeals Board

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