FINAL AWARD ALLOWING COMPENSATION
(Affirming Award and Decision of Administrative Law Judge)

Injury No. 99-171802

Employee: Michael C. Agnew, deceased

Dependent: Logan Zachary Hartman-Agnew, dependent son

Employer: AALCO Wrecking Company, Inc.

Insurer: Granite State Insurance Company

The above-entitled workers' compensation case is submitted to the Labor and Industrial Relations Commission (Commission) for review as provided by § 287.480 RSMo. Having reviewed the evidence and considered the whole record, the Commission finds that the award of the administrative law judge is supported by competent and substantial evidence and was made in accordance with the Missouri Workers' Compensation Law. Pursuant to § 286.090 RSMo, the Commission affirms the award and decision of the administrative law judge dated May 2, 2014. The award and decision of Administrative Law Judge Edwin J. Kohner, issued May 2, 2014, is attached and incorporated by this reference.

The Commission further approves and affirms the administrative law judge's allowance of attorney's fee herein as being fair and reasonable.

Any past due compensation shall bear interest as provided by law.

Given at Jefferson City, State of Missouri, this 21st day of November 2014.

LABOR AND INDUSTRIAL RELATIONS COMMISSION

John J. Larsen, Jr., Chairman

James G. Avery, Jr., Member

Curtis E. Chick, Jr., Member

Attest:

Secretary

Issued by DIVISION OF WORKERS' COMPENSATION

AWARD

Employee: Michael C. Agnew, deceased

Injury No.: 99-171802

Dependents: Logan Zachary Hartman-Agnew, born July 23, 1996

Before the
Division of Workers' Compensation
Department of Labor and Industrial Relations of Missouri
Jefferson City, Missouri

Employer: AALCO Wrecking Company, Inc.

Additional Party: Second Injury Fund

Insurer: Granite State Insurance Company

Hearing Date: February 28, 2013

Checked by: EJK/kr

FINDINGS OF FACT AND RULINGS OF LAW

1. Are any benefits awarded herein? Yes
2. Was the injury or occupational disease compensable under Chapter 287? Yes
3. Was there an accident or incident of occupational disease under the Law? Yes
4. Date of accident or onset of occupational disease: March 26, 1999
5. State location where accident occurred or occupational disease was contracted: St. Charles County, Missouri
6. Was above employee in employ of above employer at time of alleged accident or occupational disease? Yes
7. Did employer receive proper notice? Yes
8. Did accident or occupational disease arise out of and in the course of the employment? Yes
9. Was claim for compensation filed within time required by Law? Yes
10. Was employer insured by above insurer? Yes
11. Describe work employee was doing and how accident occurred or occupational disease contracted: The Employee was working on a roof and fell approximately 25 feet to the ground.
12. Did accident or occupational disease cause death? No Date of death? November 22, 2008
13. Part(s) of body injured by accident or occupational disease: Body as a whole
14. Nature and extent of any permanent disability: Permanent and Total Disability
15. Compensation paid to-date for temporary disability: $286,672.44 (03/27/99 - 11/26/08 - 4 days after date of death)
16. Value necessary medical aid paid to date by employer/insurer: $2,269,197.03

17. Value necessary medical aid not furnished by employer/insurer? None

18. Employee's average weekly wages: $844.00

19. Weekly compensation rate: $562.67/$294.73

20. Method wages computation: By agreement

COMPENSATION PAYABLE

21. Amount of compensation payable:

Permanent total disability benefits from Employer beginning November 23, 2008, for Lifetime of deceased employee's dependent son, at a rate of $562.67 per week, with a $321.53 credit to the Employer/Insurer for 4 days overpay (November 23-26, 2008) Indeterminate

22. Second Injury Fund liability: No

TOTAL: Indeterminate

23. Future requirements awarded: As above

Said payments to begin November 23, 2008, and to be payable and be subject to modification and review as provided by law.

The compensation awarded to the claimant shall be subject to a lien in the amount of 25% of all payments hereunder in favor of the following attorney for necessary legal services rendered to the claimant: Steven V. Stenger, Esq.

FINDINGS OF FACT and RULINGS OF LAW:

Employee:	Michael C. Agnew, deceased	Injury No.: 99-171802
Dependents:	Logan Zachary Hartman-Agnew, born July 23, 1996	Before the **Division of Workers' Compensation** Department of Labor and Industrial Relations of Missouri Jefferson City, Missouri
Employer:	AALCO Wrecking Company, Inc.	
Additional Party:	Second Injury Fund	
Insurer:	Granite State Insurance Company	Checked by: EJK/kr

This workers' compensation case raises several issues arising out of an alleged work-related injury in which the claimant, a laborer, suffered a severe injury when he fell 25 feet from a roof. At the hearing, the dependents of Michael C. Agnew, the deceased employee, appeared by their attorneys, and the employer and insurer appeared by counsel for a hearing for a Final Award. The parties agreed on certain undisputed facts and identified the issues in dispute. No witnesses testified at the hearing. These undisputed facts and issues, together with the findings of fact and rulings of law, are as follows:

UNDISPUTED FACTS:

1. On or about March 26, 1999, AALCO Wrecking was operating under and subject to the provisions of the Missouri Workers' Compensation Act and its liability was insured by Granite State Insurance Co. c/o Chartis Claims, Inc.

2. On or about March 26, 1999, Michael C. Agnew was an employee of AALCO Wrecking and was working under and subject to the provisions of the Missouri Workers' Compensation Act.

3. On or about March 26, 1999, the employee sustained an accident arising out of and in the course of his employment.

4. The employer had notice of employee's accident.

5. Employee's claim was filed within the time allowed by law.

6. The employee's average weekly wage was sufficient to put his compensation rate for temporary total and permanent total disability at the maximum rate for the date of accident of $562.67, and his rate for permanent partial disability is $294.73.

7. The employee's physical injuries are medically causally related to the work accident occurring on or about March 26, 1999.

8. The employer has furnished $2,269,197.03 in medical aid to the employee.

9. The employer has paid disability benefits from March 27, 1999 through November 26, 2008 for 504 4/7 weeks at a rate of $562.67 (maximum rate for TTD/PTD) for a total of $286,672.40, which included 4 days TTD overpayment (November 23-26, 2008).

10. The parties stipulate Michael C. Agnew died on November 22, 2008.

11. If permanent total disability is awarded to employee, the parties stipulate Logan Zachary Hartman-Agnew, born July 23, 1996, is the sole dependent child of Michael C. Agnew, was the sole dependent child of Michael C. Agnew at all relevant times, and is a minor child as of the February 28, 2014 date of this trial.

12. If permanent total disability is awarded to employee, the parties stipulate Michael C. Agnew married Kristen Fulmer Agnew in August 2006 and they were continuously married until his death on November 22, 2008.

13. If permanent total disability is awarded to employee, permanent total disability payments will begin on November 23, 2008 at a rate of $562.67 per week; with a $321.53 credit to the Employer/Insurer for 4 days overpay (November 23-26, 2008).

ISSUES:

1. Whether employee reached maximum medical improvement from the injuries sustained as a result of the March 26, 1999 work injury prior to his death on November 22, 2008?

2. Nature and extent of permanent partial vs. permanent total disability.

3. ~~Reimbursement for unpaid prescription medication expenses.~~ (Exhibit D, Employee's evidence in support of this issue was withdrawn).

4. If employee was rendered permanently totally disabled as a result of the March 26, 1999 work injury,

   a) Whether *Schoemehl v. Treasurer of State of Missouri* and its progeny apply;

   b) Whether employee's November 22, 2008 death was related to the work injury;

   c) Whether Employer/Insurer are precluded from using Employee's death as a basis for compensation, pursuant to RSMo. §287.020.4;

   d) Whether employee has qualified dependent(s) for purposes of *Schoemehl* (and its progeny) benefits.

5. Whether Employer/Insurer have unreasonably defended this claim, pursuant to RSMo. §287.560.

6. Whether Employee has presented a frivolous claim for benefits on behalf of widow, Kristen Fulmer Agnew, pursuant to RSMo. §287.560.

EXHIBITS:

Court's Exhibit:

I. Joint Statement of Undisputed Facts and Issues for Trial

Employee Exhibits:

A. Deposition of Dr. Mark Pelikan, with Exhibits
B. Deposition of Mr. Timothy Lalk, with Exhibits
C. Deposition of Dr. Edwin Wolfgram, with Exhibits
D. (Withdrawn)
E. 10/9/12 correspondence copy to Defense Counsel
F. 10/18/12 correspondence copy to Defense Counsel
G. Itemized expense and attorneys' time billing, related to responding to Defense assertions of cause of death, in violation of RSMo. §287.020.4
H. Medical Records, subdivided A – DD
I. Motion in Limine, Instanter

All exhibits were entered into evidence, with rulings on the objections to be taken with the case. All objections made at the time of depositions were renewed. Employer objected to admissibility of Exhibit C on the basis of hearsay and failure of the medical report to meet the statutory requirements of RSMo. §287. 210.5. All objections are overruled, and the Exhibits are received for whatever evidentiary value they may contribute.

Employer/Insurer Exhibits:

1. Certified record of Division of Workers' Compensation
2. Deposition of Ivra J. Cross
3. Certified Certificate of Death
4. City of St. Peters Police Department, Record
5. Certified records, St. Charles County Medical Examiner's Office
6. Certified records, Francis Howell North
7. Transcript of Records, Logos High School
8. Deposition of Michael Christopher Agnew
9. Marriage Certificate
10. Deposition of Kristin Agnew
11. Deposition of Kathleen Hartman Clark
12. Deposition of Michael W. Agnew (father)
13. Deposition of Donna S. Agnew (mother)
14. Undated note, handwritten
15. Deposition of Dr. Russell Cantrell
16. Deposition of Dr. Wayne Stillings (2/11/2013)
17. Second Deposition of Dr. Wayne Stillings (12/23/2013)

18. Deposition of Donna Abram
19. Records, Mercy Hospital
20. Records, Barnes-Jewish Hospital, inpatient
21. Records, Barnes-Jewish Hospital, outpatient
22. Records, Barnes-Jewish Hospital, pain management
23. Records, Washington University Physicians
24. Records, SSM St. Joseph Hospital West
25. Records, Blessing Hospital
26. Records, The Rehabilitation Institute of St. Louis
27. Records, Dr. Wice
28. Records, Dr. Dave
29. Records, Dr. Field
30. Report of Dr. Tate
31. Report of Dr. Berry
32. Deposition of Dr. Richard Anderson
33. Deposition of Dr. Christina Sadowsky
34. Deposition of Dr. Lawrence Lenke

Employee objected to Exhibits 12, 13, 14, 15-18, and 32-34. All exhibits were entered into evidence, with rulings on the objections to be taken with the case. All objections made at the time of depositions were renewed. Employee objected to the description of Exhibit 14. Experts for both Employee and Employer/Insurer reviewed and relied on the note in forming their opinions. Exhibits 32-34 contain testimony obtained at the request of Employee. All objections are overruled, and the Exhibits are received for whatever evidentiary value they may contribute.

SUMMARY OF FACTS

Injury of March 26, 1999

On March 1, 1999, this employer, AALCO Wrecking, hired the employee, Michael C. Agnew, a 22-year-old laborer. On March 26, 1999, while working in St. Charles County, Missouri, Employee sustained a 20+ foot fall through a steel roof gate. He was emergently transferred to St. John's Mercy Medical Center for immediate life-saving treatment. Having sustained massive injuries, he was taken to the operating room "in extremis" after having been resuscitated in the emergency room. On March 26, 1999, Dr. Sakabu surgically removed his spleen, repaired a scalp laceration, and addressed a left hemathorax (Exhibit 19, pp. 230-232). He was transported to the recovery room in critical condition.

On March 29, 1999, Dr. Martin Wice, examined the employee and found a comminuted fracture of C5 that was stable, a complete T8-9 fracture dislocation and complete T7 paraplegia (Exhibit 19, pp. 160-1). Dr. Backer and Dr. Merenda examined him and planned a surgical fusion, once the procedure was medically safe. He also had rib fractures from T9-T12. He was on ventilator support. He had posttraumatic anemia. Dr. Wice referenced marijuana use in his history. Dr. Wice recommended intensive inpatient multidisciplinary rehabilitation once he was medically and orthopedically stable.

On April 1, 1999, Dr. Merenda performed an open reduction of T8-9 and fracture dislocation, with posterior spinal fusion from T4-T12, using left iliac bone graft (Exhibit 19, pp. 233-234). His post-operative diagnosis was fracture, dislocation T8-9 with complete paraplegia. Employee was transferred to the ICU with prolonged mechanical ventilation and was extubated on April 2, 1999. When he awoke, his complete paraplegia was confirmed. On April 4, 1999, Dr. Thomas Fox found a dorsal dislocation of his left long finger and performed a closed reduction of the finger and placed him in a splint (Exhibit 19, pp. 162-3). On April 6, 1999, a vena cava filter was placed to prevent pulmonary embolism, due to a very high risk of deep venous thrombosis (Exhibit 19, pp. 235).

On April 6, 1999, Dr. Qasim examined the Employee for depression and agitation (Exhibit 19, pp. 164-5). Dr. Qasim noted he was quite anxious and angry. He was teary-eyed and initially fairly cooperative, but became more irritated and agitated. He opined that his intellect was average, but also suggested a history of learning disability. Employee denied seeing a psychiatrist in the past or needing one at present. He admitted to drinking beer and smoking marijuana almost daily. Dr. Qasim's impression was adjustment disorder with mixed emotions and depressive disorder. He recommended continuing Xanax. Dr. Qasim noted he was taking morphine, but claimed it did not help. Dr. Qasim felt his emotional anxiety was playing a role. He cautioned him on the use of pain medications due to their potential side effects.

On April 12, 1999, St. John's discharged the employee to the Rehabilitation Hospital (Exhibit 19, pp. 147-8). The final discharge diagnoses included: complete T8-9 paraplegia, fracture/dislocation of the spine T8-T12, fracture of C5 with spinous process fractures at T7 and T9, respiratory failure, pneumonia, concussion, right upper lobe and left lower lobe atelectasis, rib fractures on the right at 10 and 11 and bilaterally 9-12, left hemathorax, splenic laceration with hemorrhagic anemia, scalp lacerations, dislocated left finger, adjustment disorder and depression. Dr. Sakabu noted "a severe emotional disturbance which may have been further complicated by his post concussive illness." He was transferred to the rehabilitation division.

Post-Injury Treatment, 1999 – 2008

On May 10, 1999, Employee was transferred from the rehabilitation hospital back to St. John's for surgery. Dr. Merenda performed a posterior arthrodesis of T12-L4, with posterior instrumentation and right iliac bone graft (Exhibit 19, pp 79-80). On May 14, 1999, the employee was readmitted for additional rehabilitation. He developed a C. diff infection. His neurologic status remained stable. He developed good self-care skills to an independent level, and was capable of doing his own bowel and bladder routine. Dr. Wice prepared a discharge summary on June 4, 1999 noting efforts were made to pursue vocational rehabilitation, but he refused the offer. It was felt further inpatient rehabilitation would not be fruitful. He was discharged to home under the supervision of his parents.

On October 5, 1999, Employee came under the care of Dr. Russell Cantrell for a second opinion regarding treatment options for muscle spasms in his lower abdomen, lower back and both lower extremities. His current treatment regimen included bladder catheterization every 6 hours, suppositories and digital stimulation for bowel movements and recurrent urinary tract infections. Other complications by that time included deep vein thromboses in his lower extremities, primarily in his left and right calves and femoral veins. On January 7, 2000, he

returned to St. John's and Dr. Merenda surgically removed some loose hardware (Exhibit 19, pp. 14).

On August 7, 2000, Employee completed his Application for Certification of High School Equivalence. The Missouri Department of Education granted him until January 1, 2002 to complete the five tests (Exhibit 18, Exhibit 2). On January 4, 2001, the Missouri Department of Elementary and Secondary Education approved Employee's application for Special Accommodations for his GED testing. He was provided extended time, one test per day, a private room, and supervised frequent breaks (Exhibit 18, Exhibit 2).

On August 21, 2000, he had a Baclofen pump placed. The pump was surgically removed following a staph infection on September 21, 2000. A second Baclofen pump was surgically placed on November 13, 2000.

The employee consulted Dr. Wice, of St. John's Mercy, for ongoing rehabilitation medicine from the initial injury through January 23, 2001 (Exhibit 27). On examination at that time, the employee's affect was flat and he exhibited great anger and frustration. His medications at the time included Prozac, Elavil, and Macrobid. He planned to move to a wheelchair accessible home in the next month. The severe lower extremity spasticity and pain were intolerable to Employee. Dr. Wice recommended increasing Baclofen as needed and starting Neurontin.

On March 5, 2001, Employee was readmitted to St. John's Mercy for replacement of a Baclofen pump that was malfunctioning. Following the replacement, it was verified the pump system was operating, but it provided very little improvement. A radiologist located a large L5-S1 disk herniation and felt it could be a pain generator. On March 13, 1999, he was taken to the operating room for a left L5-S1 microdiscectomy (by Dr. James Coyle) (Exhibit 19, pp. 369). Postoperatively he had significant relief of the spasms in his legs.

On May 8, 2001, vocational case manager Fran Zedalis of Concentra Managed Care Services met with Employee (Exhibit 18, Exhibit 6). She noted he was still treating and not at maximum medical improvement. She took a vocational and educational history. He expressed interest in joining a wheelchair softball team, and enjoyed attending his son's activities. He was able to drive and had an equipped van. He reported completing his own daily living activities, except lawn care. Employee gave Ms. Zedalis an impression of a very positive attitude towards rehabilitation. He was anxious to reenter the workforce. He articulated a long term goal of becoming a child psychologist. Ms. Zedalis felt he was able to return to work in several capacities. She also felt he would benefit emotionally and mentally from reentering the work force.

On May 21, 2001, Employee reported improvement in his lower extremity spasticity to Dr. Cantrell (Exhibit 15, pp. 16). Neurontin was effectively reducing his spasms and pain complaints. He reported living independently and anticipated a new wheelchair soon. Dr. Cantrell made some recommendations for further comfort modifications, and opined he could return to sedentary activities, with breaks every two hours for catheterization and stretching. Employee planned to attend classes. On July 16, 2001, Dr. Cantrell noted sedentary work restrictions would likely be permanent.

On August 8, 2001, Dr. Cantrell reexamined him for back pain and spasticity in his lower extremities (Exhibit 15, pp. 19). Dr. Cantrell noted he was "very groggy" and suspected it could have been the result of Valium, or the combination of Valium and Vicodin (Exhibit 15, pp. 19-20). Dr. Cantrell anticipated maximum medical improvement in six weeks. On September 4, 2001, Dr. Cantrell again expressed concern regarding Employee's presentation of lethargy and sedation (Exhibit 15, pp. 21). He recommended lab studies, a metabolic panel and drug screen. Employee denied use of recreational drugs to Dr. Cantrell.

On September 6, 2001, Dr. Cantrell referred Employee to Dr. Bakul Dave for treatment of his muscle spasms (Exhibit 28). Dr. Dave recommended Botox injections under fluoroscopic guidance in the left iliopsas muscle. On September 10, 2001, Dr. Dave injected Botox in several different muscles. On October 5, 2001, Employee returned to Dr. Dave reporting pulling and spasms to the left side of his leg. He reported pain 8/10. Additional injections were provided, but he was to follow up as needed.

On November 12, 2001, Dr. Cantrell examined Employee. Employee gave Dr. Cantrell a letter that outlined his residual symptoms including lumbosacral pain, radiation of pain into his right leg, and pain in his left flank. He discussed concerns about returning to work or school and caring for his son (Exhibit 15, pp. 25). Dr. Cantrell reviewed his progress. He had recently undergone a colonoscopy to investigate the source of rectal bleeding. No obvious source was located. His examination revealed increased bilateral lower extremity tone. But, this was an improvement over the initial examination. Dr. Cantrell noted several months' improvement in spasticity and sensation, without any functional change. Employee reported functional decline, but could not explain his decline on a basis of his spinal cord injury.

At the November 12, 2001 examination, Dr. Cantrell discussed a positive drug screen indicating marijuana use. Employee attributed it to "eating poppy seed salad dressing." Dr. Cantrell explained the purpose of the drug screen was to assess his level of sedation. He suspected his level of sedation was not solely related to prescription medication side effects. Dr. Cantrell remained suspicious of the sedation he witnessed was secondary to recreational drug use even after Employee's attempted explanation. Dr. Cantrell testified "poppy seed ingestion on a bagel, in salad dressing would not cause a test to be positive for marijuana" (Exhibit 15, pp. 55).

Dr. Cantrell determined Employee had reached maximum medical improvement with permanent restrictions placing him in the sedentary work category (Exhibit 15, pp. 27). Dr. Cantrell testified that at that point in time, he didn't think any intervention, given his status, would lead to improvement in his overall functional outcome (Exhibit 15, pp. 51). He explained it was anticipated he would require continued medical supplies for bladder management and medications for spasticity (Exhibit 15, pp. 52).

On November 15, 2001, Employee was admitted to St. Joseph Hospital West for self-inflicted stab wounds and Benzodiazepine overdose as a result unrelenting pain (Exhibit 24, p. 3). He stabbed himself in the abdomen four times and took up to forty (40) Valium tablets. On November 15, 2001, Dr. Charles Hartman surgically repaired his small bowel and mesenteric bleeding (Exhibit 24, pp. 15). He was transferred to the recovery room in stable condition, but was later transferred to the ICU. After several days of pneumonia, elevated white cell count and

elevated temperatures, a consultation with Dr. Lillard was ordered. He was intubated for respiratory failure and ARDS (acute respiratory distress syndrome). He was considered to be septic, but an immediate source was not identified.

Psychiatry refused to evaluate him at St. Joseph Hospital West. On postop day 20, December 5, 2001, he was transferred to St. Joseph Health Center for psychiatric evaluation due to a suicide attempt. He was transferred in satisfactory and stable condition. Employee left a handwritten note to his son around the time of the suicide attempt in 2001 (Exhibit 14). Employee wrote (in part), "I cannot take the pain any longer. Please no (sic) that I will be in no more pain…will be out of pain all at once…The spazmans (sic) have take over my whole body as well as pain…I'm sorry…I also tried."

On December 6, 2001, Dr. Richard Anderson accepted Employee for treatment at St. Joseph Heath Center (Employee Exhibit H, Sub H). He took a history of a 25 year old with a psychiatric history of some adjustment problems when he was a pre-teenager, and he was treated without medication. He had no psychiatric issues until a 1999 work injury, which resulted in paraplegia. Shortly before his self-inflicted stab wounds, he was told there was little else to offer in terms of his pain or muscle spasms. During hospitalization, he was started on Paxil. He reported his mood improved. He said he no longer had thoughts of wanting to hurt himself, and his only goal was to mitigate the severe pain. He also reported taking significant amounts of narcotic analgesics at the time, which may have affected his judgment. He restated plans to return to school. He had recently purchased a home and van. Dr. Richardson's assessment was work-related injury with paraplegia, chronic pain syndrome, status post abdominal wounds, self-inflected, because of major depressive disorder and as a direct result of his work-related injury and its concomitant disability pain syndrome.

On December 16, 2001, he saw Dr. Swarm for pain management at Barnes Jewish (Exhibit 22). Dr. Swarm noted he was "at best a fair historian." He recommended follow up with Dr. Anderson, discontinuing Gabapentin and Fentanyl and continuing Paxil. Dr. Swarm continued to follow him, intermittently, through June 3, 2008.

On December 16, 2001, he also presented to the Barnes-Jewish emergency room due to severe pain and was admitted (Exhibit 20, pp. 823-5). He was having right lower extremity, back and perianal pain for two weeks. During his admission, he was seen by the paraplegia psychiatrist, the physical therapist, occupational therapy, and rehabilitation therapist. His pain medications were adjusted regularly. He was offered a place at The Rehabilitation Institute, but refused. It was also noted he had low testosterone. A CT of the lumbar spine showed loosening of a screw in the lumbar spine; however orthopedics did not have a recommended intervention at that time. Upon discharge on December 21, 2001, he was scheduled to follow up with the Medicine Clinic for his low testosterone, Dr. Anderson in psychiatry and Dr. Lenke in orthopedic surgery.

On January 15, 2002, Employee had an initial vocational evaluation with specialist, Donna Abram (Exhibit 18, Exhibit 3). He complained of pain upon arrival. The interview was stopped about 5 minutes later. Ms. Abram's recommendations included determining if his medical status had changed from Dr. Cantrell's opinion of maximum medical improvement. She

also recommended a neuropsychological evaluation. She planned to complete her assessment and assist him with obtaining his GED.

Donna Abram met with him again on February 8, 2002. He appeared "drugged". He told Ms. Abram Drs. Sadowsky and Lenke indicated all possible treatment options had not been explored to alleviate his pain. He reported his pain level was so severe it was interfering with all aspects of his life and left him depressed. He had only been relatively pain free for a couple of months when he first moved into his house. His pain returned because "his body had become acclimatized to the Neurontin." During the interview, Ms. Abram discussed an opportunity at Crossroads program to work as a counselor, due to his personal experience with a chemical problem. He took offense to the comment and denied a chemical dependency issue. Employee felt he could not fully participate in vocational retraining until his pain was under control.

On February 15, 2002, Employee consulted Dr. Beverly Field, Washington University Department of Psychiatry, for evaluation related to chronic back and lower extremity pain. Employee dated his problems back to March 1999. He had not worked since his injury and was receiving social security disability benefits. He reported working towards his GED and retraining with computers. He reported buying a house and vehicle with hand controls. He reported being unable to live independently because he cannot drive or transfer himself due to pain. During the evaluation, Employee's father provided much of the information. Employee appeared sedated. He was "skeptical but feeling more hopeful." He returned to church. He reported severe insomnia that had improved with medication. He reported dozing off and on all day long. He denied current suicidal ideation. His psychiatric history included a suicide attempt in November 2001, seeing Dr. Anderson while hospitalized, and a current prescription of Prozac from his primary care physician.

Dr. Field noted significant symptoms of depression, but stated the symptoms could be attributable to increased pain and medications. She suggested he contact Paraquad as a resource. She briefly discussed psychological techniques for pain management. Her DSM-IV Diagnosis was Axis I: Major Depression, partial remission; Axis II: no diagnosis; and Axis III: Chronic low back, hip, buttock and lower extremity pain (Exhibit 29). Dr. Field saw him 8 times between February and June, 2002.

On April 2, 2002, Employee met again with Donna Abram. She noted he was "very drowsy". He only stayed for 45 minutes, and was unable to complete any further testing. The vocational file was closed because he appeared to have "regressed from Dr. Cantrell's treatment."

On April 10, 2002, Employee saw Dr. Lenke, an orthopedic surgeon at Washington University, for evaluation of his neuromuscular scoliosis with progressive back pain and deformity. He described a worsening of his thoracolumbar scoliosis following removal of the left-sided rod. He described non-union and unfused segments with decompensation to the left. This caused problems with sitting, balance transfers, and sacral decubitus (Exhibit 23, pp. 25). Dr. Lenke's diagnoses included: paralytic scoliosis with pseudoarthrosis and marked pelvic obliquity, narcotic addiction, and skin ulceration (Exhibit 23, pp. 27). Dr. Lenke planned to revise the posterior instrumentation into the pelvis and then fuse anteriorly to make sure his entire lumbosacral spine gets solidly fused.

On July 3, 2002, Dr. Cantrell performed a records review to comment on need for additional treatment (Exhibit 15, pp. 27). He described Employee's condition over the past six or seven months had worsened. A spine surgeon was recommending spinal stabilization surgery to correct what had been found to be hardware failure and paralytic scoliosis. Dr. Cantrell testified there had been "an interval increase in his scoliosis" and failure of the prior hardware (Exhibit 15, pp. 30-1). Dr. Cantrell testified the condition diagnosed and treatment recommended by Dr. Lenke was not present at his last physical examination in November 2001. Dr. Cantrell testified Employee was not at maximum medical improvement at that point in time due to his agreement with Drs. Merenda and Lenke that he needed additional surgical treatment (Exhibit 15, pp. 31).

On July 18, 2002, Dr. Dowling, department of neurological surgery at Washington University, examined Employee for consideration of a spinal cord stimulator. Dr. Dowling took a history of severe pain despite treatment. He noted a suicide attempt with stab wounds in November 2001 (Exhibit 23, pp. 28). He denied smoking or drinking. On examination, Dr. Dowling noted he dozed off during the visit (Exhibit 23, pp. 29). Dr. Dowling felt he had a combination of distal spinal cord injury pain and some degree of visceral pain. He recommended moving forward with surgery planned with Dr. Lenke.

Employee contacted vocational specialist, Donna Abram, on August 2, 2002 for additional assistance. He was alert, but could not sit straight in the chair and was unable to complete testing. He wanted to use the recovery time after surgery to work towards his GED.

On August 21, 2002, Dr. Lenke performed a posterior spinal fusion for paralytic scoliosis. He removed the Isola instrumentation from T4 to L4; confirmed solid fusion from T4 to T9, pseudoarthrosis of T9-10, T10-11, T11-12, and solid fusion from T12 to L3, with pseudoarthrosis at L3-4; a halo was placed with intraoperative halo-femoral traction and left femoral traction pin placement; osteotomies were performed at T10-11, T11-12 and T12-L1 also at L2-3 and L3-4; segmental spinal reinstrumentation from T4 to the sacrum with multiple fixed screws, stainless steel CD Horizon system and four cross-links and two rods; bilateral iliac ring screws for sacral fixation; posterior revision of the thoracic fusion from T9 through T12-L1; revision of the posterior lumbar fusion at L2-3 and L3-4; and primary lumbar fusion at L4-5 and L5-S1 with right iliac bone graft (Exhibit 23, pp. 35-6; Exhibit 20, pp. 730-33). His postoperative course was complicated by a decrease in mental status and increase in respiratory distress (Exhibit 20, pp. 735-8). He was transferred to the surgical intensive care unit for observation and oxygen supplementation. His pain medications and fluids were adjusted. The remainder of his hospital course was further complicated by continued issues with pain management. Pain Service was thoroughly involved. He was discharged on September 3, 2002 to an extended care facility for further assistance with physical and occupational therapy (Exhibit 20, pp. 735-8).

On November 20, 2002, Dr. Lenke returned to the operating room at Barnes Jewish to anteriorly fuse T10 or T11 to the sacrum to make sure he gets fused and has fusion from the prior pseudoarthrosis. Dr. Lenke performed an anterior approach five-level lumbar fusion (L1-2 through L5-S1); thoracic fusion of T12-L1; and placed titanium mesh kidney bean cages at all 5 lumbar levels (Exhibit 23, pp. 42; Exhibit 20, pp. 700). He was discharged to rehabilitation on November 27, 2002 (Exhibit 20, pp. 704-6).

On January 16, 2003, Dr. Lenke felt he was stable enough (5 months postoperatively) to start aggressive physical therapy. (Exhibit 23, pp. 48). He continued to have spasms and pain, but had taken himself off Methadone and his pain seemed to be getting better.

He was admitted to The Rehabilitation Institute of St. Louis from January 20, 2003 through March 14, 2003 (Exhibit 26). During his admission, he continued to have severe spasticity in his lower extremities. He had difficult neuropathic pain. During his hospital course he had three UTIs. He underwent several Botox injections. He participated in an intensive activity-based rehabilitation program and daily occupational therapy. He showed good improvement of his functional status by the time of discharge. He was to continue with outpatient rehabilitation.

On January 28, 2003, Donna Abram documented renewed attempts to assist Mr. Agnew, particularly with securing a laptop computer for studying (Exhibit 18, Exhibit 3).

On May 13, 2003, Dr. Sandra Tate performed an IME at the request of AIG. She was asked to review Dr. Lenke's August 21, 2002 operative report, correspondence and office records of Dr. Sadowsky and reports of Dr. Cantrell. Dr. Tate felt he had too much spasticity to benefit from further Botox injections. She felt Botox-B may be a possibility. The use of 4AP did not have sufficient clinical support to offer benefit to Employee. She felt he could benefit from a Quickie Titanium wheelchair, and a standing frame to prevent neurogenic osteopenia. She was hopeful replacement of the Baclofen pump would help with his spasticity. She felt he had reached maximum medical improvement for his spinal cord injury, however she offered he would require significant ongoing medical care for maintenance including: bowel and bladder evaluations, medication, UTI prevention medication, physical therapy, and further wheelchairs (Exhibit 30).

On May 14, 2003, Dr. Lenke reexamined him (9 months postoperatively). He was doing very well and was sitting up nicely, but had a fair amount of spasm. His Baclofen pump was disconnected during surgery, and at one-year post op, he would have it reconnected (Exhibit 23, pp. 49).

He was admitted to Barnes Jewish on May 16, 2003 for chest pain. A CT scan of the chest revealed a pulmonary embolism in the right middle lobe artery. On the date of discharge, he was insistent on leaving. Anticoagulation medication was thoroughly reviewed and he was discharged May 19, 2003 (Exhibit 20, pp. 669).

On September 3, 2003, Dr. Dowling surgically repaired the intrathecal Baclofen pump with replacement of the spinal catheter (Exhibit 20, pp. 655). He returned to Barnes Jewish on October 14, 2003 due to no perceived benefit of the pump. Dr. Dowling returned to the operating room to perform a T12 laminectomy for direct insertion of a spinal subarachnoid catheter for the intrathecal Baclofen pump. During surgery, it was noted the catheter could not be placed at L4-5 or L3-4 likely due to scarring from his prior trauma (Exhibit 20, pp. 639-40).

Due to losing benefit from the pump in December, on January 23, 2004, Employee returned to the operating room with Dr. Dowling for revision of the intrathecal catheter (Exhibit 20, pp. 618-19).

On March 9, 2004, Employee was admitted to Barnes Jewish Hospital for severe rectal pain. During the admission, he was placed on high doses of Dilaudid for pain control. On March 11, 2004, he was found unresponsive, with a pulse and respirations. He was resuscitated and intubated bedside. He was transferred to ICU for hypoxic respiratory failure. He was successfully extubated, but developed pneumonia on the left side. It was noted "the patient has a high tolerance for pain medications." He was restarted on Prozac for depression and trazadone for insomnia. He was discharged to home on March 26, 2004 (Exhibit 20, pp. 549-52). On May 14, 2004, he presented to the Barnes Jewish emergency room with continuous UTI pain after six days of a ten-day dose of antibiotics (Exhibit 20, pp. 516-7). The antibiotic course was altered, and he was discharged.

On June 23, 2004 (upon Dr. Sadowsky's departure from the area), Employee was referred to Dr. Juknis, a Spinal Cord Injury Fellow in the Division of Rehabilitation Medicine (Exhibit 23, pp. 174). Dr. Juknis noted he was taking Trazadone and Prozac for depression. His prior psychiatrist reportedly did not want to see him, and she recommended further management through Barnes. She further recommended gait training and a home exercise program. He followed up regularly with Dr. Juknis through late 2006.

On August 27, 2004, Employee underwent surgery for removal of a bladder stone and bladder augmentation procedure with Dr. Brandes (Exhibit 20, pp. 490-1). He was subsequently admitted to Barnes on September 1, 2004 for a high fever and swelling at the incision cite. He had developed a Staph infection. He was admitted from September 2-8, 2004. He was discharged with a Foley catheter and Foley drain (Exhibit 20, pp. 461-2).

On October 25, 2004, Employee returned to Dr. Swarm for follow up (he had not been seen since February 2002). He provided an interim history of complications and surgeries. He was not on any opioid analgesics at present. Dr. Swarm recommended evaluation by Dr. Field.

On November 8, 2004, Employee returned to Barnes, upon transfer from St. Joseph Hospital, for further surgical evaluation of ongoing bladder complications (Exhibit 20, pp. 409). Dr. Venkatesh performed a laparotomy with repair of the bladder rupture, peritoneal lavage and retention suture of the abdomen.

On March 9, 2005, Dr. Swarm noted he had tried several drugs, without change in his pain level. Employee was frustrated by the severe pain. On May 6, 2005, Dr. Swarm refilled his spinal pump with Baclofen. Later in May, Dr. Swarm added Clonidine, but on June 10, 2005, he was admitted for low blood pressure as a result of mixing Clonidine and Baclofen. On June 15, 2005, Dr. Lenke surgically removed bilateral iliac screws and cross connector that had been causing pain (Exhibit 23, pp. 53; Exhibit 20, pp. 383). On July 6, 2005, Dr. Swarm noted his blood pressure issue was under control, but he had to discontinue Abilify (which was working) due to concern of adult-onset diabetes.

In August and September 2005, he developed hematoma and inflammation in his right leg, which required several hospital visits. On November 1, 2005, he was admitted to Barnes for another bladder surgery. On November 2, 2005, Dr. Brandes performed a cystoscopy, urinary clot evacuation and bladder irrigation (Exhibit 20, pp. 309-10). On December 9, 2005, his Baclofen pump was replaced again by Dr. Dowling as an outpatient at Barnes Jewish (Exhibit 21, pp. 541).

On January 21, 2006, he returned to Barnes, via transfer from St. Joseph Hospital West, for surgical treatment of fluid in his belly. On January 22, 2006, Dr. Brandes performed extensive lysis of adhesions, resection of necrotic bladder, reconstruction and repair of the augmentation cystoplasty, placement of a suprapubic tube and ureteral stricture dilation with abdominal and pelvic wash out. (Exhibit 23, pp. 162-3; Exhibit 20, pp. 255-7).

On February 21, 2006, Dr. Cantrell examined Employee for the first time since 2001 (Exhibit 15, pp. 31-2). Dr. Cantrell reviewed his interim medical history. Dr. Cantrell opined that the pulmonary embolism and blood clots, hospitalizations of November 2005, and anticoagulation therapy were related to the 1999 work injury (Exhibit 15, pp. 38). He recommended Employee remain under the care of a physiatrist to monitor complications of the spinal cord injury. He also recommended Employee locate a primary care physician for unrelated conditions, like his hypercholesterolemia.

On March 14, 2006, Employee woke up with severe abdominal pain, fever and chills. He was transferred from an outside hospital to Barnes Jewish for further care with Dr. Brandes (Exhibit 20, pp. 197-9). Dr. Brandes performed an exploratory laparotomy, repair and mobilization of bladder rupture, extensive adhesiolysis and suprapubic tube placement.

In July 2006, Dr. Cantrell issued an opinion that a referral to the Mayo Clinic was unnecessary due to the caliber of care Employee was receiving in St. Louis, through Washington University (Exhibit 15, pp. 38).

In August 2006, Employee married Kristen Agnew, an alleged dependent. Kristen Agnew testified in 2010 (Exhibit 10) that she believed Employee started using cocaine in October 2006. He also told her he used marijuana occasionally before they met. She recalled an overdose in November or December 2006, and felt there could have been other times.

On November 22, 2006, Employee presented to St. Joseph Hospital emergency department for complaints of low back pain (Exhibit 23, pp. 308). He told triage, “I look at my whole bottle of 200 pills of Valium and want to take them all sometimes, but I won’t.” The nurse noted Employee was upset because he only received 3 mg of Dilaudid, states he gets 2 mg IV every 30 minutes at Barnes and is leaving AMA. It was suggested the patient “has become addicted to his meds” and needed a follow up with Dr. Swarm today. Due to a blood pressure of 92, no additional pain medication was administered.

On November 26, 2006, he was involuntarily admitted to the Psychiatric Department, under the service of Dr. Thomas Richardson (Exhibit 20, pp. 175-7). Dr. Richardson spoke to his family and reviewed medical records. This was Employee’s first psychiatric admission to

Barnes Jewish. He described that "things have gotten out of control due to pain." Dr. Richardson took a history of a 29 year old paraplegic with chronic pain, history of cocaine abuse, and pseudo seizures. He reportedly left against medical advice from an outside hospital on November 20, 2006 when his pain was not addressed. His father described suicidality with a plan to "overdose on crack." Employee denied prior psychiatric history, and asked only to address his pain. Employee threatened to leave against medical advice. Dr. Richardson noted a 2006 emergency room visit for delirium, and 2002 suicide attempt, when Employee stabbed himself "secondary to pain". He told Dr. Richardson "I don't like psychologists", and was vague regarding his medical compliance.

Employee reported to Dr. Richardson he was often in trouble as a child, and was expelled from junior high. He was a "mob member" by 17. He had recently married and was living with his wife. He used alcohol and valium for sleep. He told Dr. Richardson he has smoked two packs per day since he was 12. He used cocaine recently, and had a history of marijuana use. He recently became Christian and was offered a head pastor position at a church before his pain escalated. Dr. Richardson noted a family history of alcoholism (grandfather and father) and suicide (grandfather). Dr. Richardson's impression was depression, not otherwise specified, cocaine, opioids, benzodiazepines and alcohol abuse. He noted suicidal ideation and attempt to overdose on cocaine.

He was admitted to 15-500 for safety reasons, with elopement and assault precautions. Dr. Richardson planned to restart Cymbalta, initiate thiamine and folate, and consult the pain management team. He also recommended a consultation with Chemical Dependency. Dr. Richardson ordered clonidine for opioid withdrawal symptoms (Exhibit 23, pp. 60-2). Dr. Richardson's psychiatric assessment was: Axis I, depression, not otherwise specified, possibly secondary to cocaine abuse and history of polysubstance abuse; Axis II, antisocial personality disorder; Axis III, T2-T8 paraplegia, neuropathic pain, history of DVT, recurrent UTI, history of low back pain, bladder augmentation and repair and spinal fusion; Axis IV, recent marriage, chronic health problems, and financial; Axis V, GAF 20 to 30 (Exhibit 23, pp. 130-2). Employee claimed to have been clean since 1999. However, his current presentation was precipitated by him buying a quantity of cocaine and stated he started using again approximately four months prior. He admitted to a suicide attempt several years ago. Dr. Richardson recommended involuntary hospitalization. Employee denied almost all symptoms of depression, suicidal ideation or psychosis. He realized he needed to enter a drug rehab. Overall, Dr. Richardson's prognosis was guarded.

On December 7, 2006, Dr. Robert Swarm, Chief of Pain Management at Washington University, saw him for the first time since July of 2005. His current medications included Cymbalta and Gabapentin. Employee described getting injections of Hydromorphone (Dilaudid) on several occasions through the emergency room, which provided temporary relief. He sought an opioid. Dr. Swarm expressed concern over use of opioid analgesics that could quickly lead to daily use. He cautioned routine opioid use could create tolerance and ultimately prevent long-term benefit, and could actually result in worsening of the pain. He also noted the adverse effects of constipation and addiction.

Dr. Swarm discussed Employee's substance abuse. Employee denied this; however, Dr. Swarm noted "it is clear that he has had abuse." He reported cocaine use several years ago, and acknowledges relapse of cocaine use this past summer. Employee noted "miraculous pain control associated with cocaine use." He was adamant that he used cocaine as a way to get pain control (Exhibit 23, pp. 16-19). Employee's mother was present during the examination.

Dr. Swarm expressed concern about his lack of follow up after discharge from the Psychiatric admission. Employee said he would follow up with Dr. Anderson, but did not have an appointment. Dr. Swarm noted he "continued to cling to the idea that his recent use of cocaine was reasonable in an attempt for pain control." (Exhibit 23, pp. 16-19). Dr. Swarm recommended an evaluation at the Mayo Clinic for further pain and spasticity treatment. Employee rejected the idea of an examination with Dr. Field.

On February 13, 2007, he presented to the emergency room at St. Joseph Hospital West after involvement in a motor vehicle accident. He was the driver. He was going 35-45 miles per hour when he struck an object. He was not restrained and described a moderate amount of vehicular damage. He arrived on a backboard, and was admitted for observation due to a closed head injury and lumbar strain.

On September 17, 2007, Employee presented to the Wound Care Clinic at Blessing Hospital in Quincy, Illinois. He recently developed a decubitus ulcer of the coccyx (Exhibit 25, pp. 343). It was noted he has suffered with depression ever since his injury. He was followed by wound care management at this facility through May 2008. On October 17, 2007, he presented to the emergency room at Blessing Hospital with a 104^{o} temperature and an inflamed right side. He was given Dilaudid, x-rays were taken and a blood draw was performed. He left against medical advice. By the time the physician contacted him with test results, he had already returned to St. Louis and was admitted to the hospital.

On October 23, 2007, he was admitted to Barnes Jewish and provided a history of fevers of 104 to 105 degrees over the past five days (Exhibit 20, pp. 129-34). He had presented to Barnes Jewish St. Peters on October 21, 2007, but left against medical advice. His urinary tract infection was treated with antibiotics. A cystourethrogram did not show any further bladder leakage. Additionally, his sacral decubitus ulcer was examined and his medications were continued. He was discharged on October 26, 2007.

On October 31, 2007, he presented to the emergency room at Blessing Hospital stating he needed pain medication and did not have an appointment with Dr. Tahir until Wednesday. He was provided with Lortab.

On November 25, 2007, he presented to the Barnes Jewish emergency room (Exhibit 21, pp. 345). Nursing notes indicate he was there two (2) nights prior with the same complaints. He reported severe back pain. He said he "could take 20 Percocet and it wouldn't help me." After medication administration, he could not keep his eyes open and his speech was slurred. He told the nurse "tell the doctor I want 4 mg of pain medication this time instead of 3 mg." Two nights previously, on the 23^{rd}, he signed out against medical advice after "falling asleep mid-sentence." He refused to go to x-ray until he got another dose of medication.

On November 28, 2007, he returned to Barnes Jewish emergency room (Exhibit 21, pp. 321). He appeared drowsy, but yells out in pain with movement. He became defensive and angered when staff asked about his last dose of pain medication. He demanded more pain medication approximately two (2) minutes after Dilaudid was given. He cursed at staff. When he was told only one dose of medication was ordered, he demanded to see the doctor. Employee was falling asleep when the doctor presented for assessment. When aroused, he yelled again in pain and demanded more medication. He transferred himself to his wheelchair, dressed himself, and refused to wait for AMA forms.

On December 3, 2007, Employee presented to St. John's emergency room with complaints of increasing back pain. His diagnosis was consistent with UTI (Exhibit, pp. 312). He sought and was given Dilaudid (Exhibit 19, pp. 300). He returned on December 10, 2007, and was given Dilaudid (Exhibit 19, pp. 316). He signed out against medical advice, despite concern regarding his safety operating a motor vehicle (Exhibit 19, pp. 324). Dr. Sosna noted difficulty in treating Employee due to multiple hospitalizations and multiple visits to emergency rooms, mainly under the Barnes system (Exhibit 19, pp. 331).

Dr. Tad Berry, Pain Management Services, was consulted for a pain management second opinion on December 7, 2007 (Exhibit 31). Dr. Berry noted he had not seen Dr. Swarm in approximately one year. He noted Employee to be in no obvious distress and animated during conversation. He had no evidence of infection on examination. He recently attempted to taper the Baclofen, but had increased spasticity. He reported doing better over the past year, until two or three months ago when he started to have more problems. Dr. Berry recommended he contact Dr. Swarm and they would discuss a plan. Employee discussed social issues of a pending divorce, and he recommended those issues be addressed by a psychiatrist. He denied depression.

On December 13, 2007, he saw Dr. LaBore, Associate Professor of Orthopedics at Washington University, for further evaluation of his present complaints (Exhibit 19, pp. 13-4). Dr. LaBore took a history that his spasticity was difficult to control, but stable. Employee reported a recent onset of thoracolumbar back and flank pain. On examination, he had sacral decubitus. His pain was reproduced with flank percussion on the left and right. Dr. LaBore diagnosed thoracolumbar back and flank pain, ongoing infection as evidenced by an elevated white count and positive urinalysis. He wanted to rule out pyelonephritis and hardware failure. Dr. LaBore ordered CT scans and follow up with an infectious disease specialist. Regarding his work status, he felt he was chronically disabled and on Medicare. On December 17, 2007, Dr. LaBore issued an Addendum. He recommended follow up for his UTI, but made no orthopedic recommendations.

He returned to St. John's emergency room on December 30, 2007 with complaints of mid-back pain. He was admitted to rule out a hardware-related problem (Exhibit 19, pp. 381). A CT scan of the lumbar spine showed fracture of the right L5 pedicle screw, with mild lucency of the interbody fusion device at L4-5. It was recommended he follow up with Dr. Lenke in two days. IV Dilaudid was discontinued, and he was discharged with oral Dilaudid on January 2, 2008. He presented for the fourth time in one month's time to St. John's emergency room on January 3, 2008 (Exhibit 19, pp. 404). He was provided IV Dilaudid. Upon discharge, he was instructed to follow up with Dr. Lenke.

On January 15, 2008, Dr. Lenke issued a letter to providers and Employee (Exhibit 23, pp. 56). He described Employee's complaints of low back pain as "rubbing and popping in his lumbar area." He does not have much lumbar sensation. He has a broken L5 screw (chronic), but it is not causing any clinical problems and it is not the source of his complaints. Thoracic spine radiology looks fine. He does not have a pulmonary embolism. Dr. Lenke recommended continued pain management and follow up with physiatry, but no further spine surgery. He recommended follow up every 5 years from a spine surgery perspective. He returned again to St. John's emergency room on January 25th and 28th, 2008 for back pain. He was provided IV Dilaudid on both occasions (Exhibit 19, pp. 439, 451). On February 28, 2008, he returned to Dr. Lenke due to continued complaints involving his thoracic spine. Dr. Lenke felt he may have an inflammatory condition, as Aleve was relieving his symptoms, but did not recommend any additional treatment (Exhibit 23, pp. 57).

On March 21, 2008, he presented to the Blessing Hospital emergency room with complaints of increased pain. He reported "his home Dilaudid is not helpful." He reported having extensive work up in St. Louis where he recently moved from (Exhibit 25, pp. 298). He presented to the emergency room at Blessing Hospital again on April 14, April 23, April 24 and April 29, 2008 for pain medication. He received Dilaudid at every visit. On April 30, 2008, was admitted to Blessing Hospital, but signed out against medical advice because of a family incident (Exhibit 25, pp. 188). His patient profile included a history of suicidal thoughts and past attempted suicide (Exhibit 25, pp. 181). He returned later that day for continued back pain. On May 10, 2008, he presented to the Blessing Hospital emergency room for right shoulder pain. When the nurse attempted to give him oral narcotics, he refused and requested an IV instead. The request was denied by the physician. He would not review the discharge instructions with the nurse and met his wife in the lobby to go home. On May 16, 2008, he returned to the Blessing Hospital emergency room with complaints of back pain at 3:00 in the morning. He was tearful and depressed, which was noted to be his normal presentation. He was given Dilaudid and told to follow up with his primary physician.

Employee lived in Quincy, Illinois with his wife, Kristen Agnew, from August 2007 until May 2008 (Exhibit 10, pp. 9, 12). She worked full time as a medical laboratory technician at Blessing Hospital (Exhibit 10, pp. 21). Mrs. Agnew testified she moved back to Quincy in 2006, in part, due to her husband's drug use (Exhibit 10, pp. 30). She testified he may have started using cocaine again in October 2006 (Exhibit 10, pp. 28). During the time she knew him, she tried to get him to enter rehabilitation treatment five or six times (Exhibit 10, pp. 31). Mrs. Agnew testified she drove him, more than once a month, to the emergency room at Blessing Hospital to obtain IV Dilaudid (Exhibit 10, pp. 36-7). She said "he was an addict" (Exhibit 10, pp. 45). She felt it started in October 2006, and he never stopped using from that moment on (Exhibit 10, pp. 45). She testified Blessing Hospital "black flagged him" and he was not allowed to come to the emergency room anymore to get Dilaudid (Exhibit 10, pp. 47).

On June 3, 2008, he returned to Dr. Swarm at the Pain Center (he was last seen December 7, 2006) (Exhibit 23, pp. 21). Employee reported ongoing difficulty with severe right shoulder pain and mid thoracolumbar back pain. He described the pain as "terrible." He had an extensive work up to be sure infections were not contributing to this pain. Dr. Lenke had not recommended any additional spine surgery, and Dr. Dowling confirmed correct placement of his Baclofen pump. He told Dr. Swarm he moved back in with his parents in St. Peters. He returned

from Quincy, Illinois where he was living with his wife. He sought pain medication, and described his prescription from his doctor in Quincy had run out. Employee's son was present at the appointment, so Dr. Swarm did not discuss his cocaine use. He did restate his concern over long-term opioid analgesic use. Employee was not under the care of a psychiatrist as he did not feel he needed psychiatric care. Dr. Swarm provided a 30-day supply of Oxycodone, and reviewed his "opioid guidelines." Employee became irritated at the requirement and decided against receiving any opioid analgesics from Dr. Swarm. He left the pain center abruptly. No further appointments were made, and no arrangements were made for psychiatric care. Dr. Swarm again stated he would benefit from ongoing psychiatric care.

The same day he left Dr. Swarm without a prescription for an opioid analgesic, June 3, 2008, he presented to St. John's emergency room with complaints of back pain that started a few days go. He stated he slipped out of bed and might have hurt it (Exhibit 19, pp. 461). He stated pain medication was not providing any relief. He was given IV Dilaudid. On July 1, 2008, he returned to St. Johns' emergency room with complaints of back pain. He did not appear to be in distress (Exhibit 19, pp. 479). He requested IV Dilaudid, and Dr. Emerson denied his request. He asked to see another physician. Employee refused further care or treatment and left against medical advice (Exhibit 19, pp. 478).

On August 19, 2008, he was admitted to Barnes Jewish for fever and chills (Exhibit 20, pp. 72-3). Progress notes indicate over the evening, Employee became verbally abusive, demanding multiple doses of narcotics. His urine drug screen was positive for cocaine. When initially approached, he denied cocaine use and later said he had eaten some cocaine he found in a drawer (Exhibit 20, pp. 43). He refused to go to the operating room. He threatened to sue for malpractice, but refused care. Employee's father was present. He asked to leave against medical advice. On August 19, 2008, he underwent a lumbar spine CT with contrast that detected a phlegmon surrounding the hardware at L4-5 (Exhibit 20, pp. 62). Due to a positive cocaine screen, Dr. Lenke waited until August 22, 2008 to proceed with surgery. Dr. Lenke surgically removed the infected hardware and aspirated the purulent material in his lumbar spine (Exhibit 20, pp. 69-70). Dr. Lenke performed wound exploration, fusion mass exploration of L3 to S1, instrumentation removal at L5-S1 and placement of antibiotic beads (Exhibit 23, pp. 87-8).

Dr. Jonas Marschall was consulted for antibiotic treatment for the spinal infection (Exhibit 23, pp. 110-12). The aspirated material was identified as Corynebacterium and Staphylococcus aureus. Dr. Marschall noted only a portion of the fusion rod was shortened and a couple of screws were removed, but much hardware remains and will not be taken out. Dr. Marschall recommended continuing Vancomycin for at least six weeks, and adding Rifampin. He recommended extended antibiotic treatment in the form of chronic suppressive therapy. He further recommended follow up with wound care for his sacral decubitus ulcer. On August 29, 2008, he was discharged to home.

On September 8, 2008, Employee was re-admitted to Barnes Jewish for follow up of antibiotic bead placement (Exhibit 20, pp. 9-10). Dr. Lenke returned to the operating room to explore the posterior spinal fusion from L4 to S1 and irrigation and debridement of the spine. He confirmed pseudoarthrosis at L4-5. He removed posterior spinal instrumentation from L5 to S1 on the right (including a portion of the right L5 pedicle screw) and performed a revision posterior fusion from L4 to L5 without instrumentation. The antibiotic beads were removed and the wound was closed. The discharge summary of September 12, 2008 listed his principal and

secondary diagnoses as spine infection and pseudoarthrosis of L4-5, with previous instrumentation and fusion. His secondary diagnoses included thoracic paraplegia with paralytic scoliosis and instrumentation and fusion for scoliosis deformity, history of deep vein thrombosis and substance abuse disorder (Exhibit 20, page 9). The discharge summary, completed by Dr. Charles Crawford, reviewed his hospital course. The report states he became noncompliant with instructions the night of surgery. He tried to disconnect himself to leave the room. He threatened to leave against medical advice, despite warnings that it was unsafe to do so. On postoperative Day 1, he requested to be taken off of patient-controlled medications so he could leave his room. Doctors recommended against this, but he did so anyway. During his stay, he intermittently demanded intravenous Dilaudid for pain, despite not appearing in pain on physical exam. He exhibited continued noncompliance with nursing and physician requests. At the time of discharge, his wound was inspected and it was clean, without drainage. Against advice, he was allowed to go home with Home Health Care on September 12, 2008 (Exhibit 20, pp. 10).

On October 10, 2008, Dr. Marschall recommended continuing Vancomycin for two more weeks and return to the clinic. He recommended Bactrim and Doxycycline for chronic suppressive therapy. On November 14, 2008, Employee presented for wound care for his pressure ulcer (Exhibit 23, pp. 126-7). He was to follow up in six to eight weeks.

Death on November 22, 2008

On November 22, 2008, Employee died of acute intoxication with difluoroethane and cocaine (Exhibits 3). The St. Charles County Medical Examiner, Dr. Mary E. Case, prepared a Post-Mortem Examination report (Exhibit 5). The manner of death could not be determined. Blood toxicology results were positive for the presence of difluoroethane, Benzodiazepines, Bupropion, Acetaminophen, Gabapentin, Diazepam, Nordiazepam, Cocaine and Cocaine metabolites. Urine test results also showed the presence of Hydrocodone. The Toxicology summary report indicated a toxicologically significant amount of Gabapentin present in his blood (Exhibit 5).

His body was found in a Wal-Mart parking lot on Jungerman Road in St. Peters, Missouri at 3:09 a.m. (Exhibit 4). His vehicle had been parked in front of the business running for a long period of time. The St. Charles Police Department investigated the sudden death. The investigation revealed Employee had purchased dust remover, a 12 ounce can, and electronic wipes. He paid for the purchase with a personal check, and received $20.00 cash back. A Wal-Mart employee assisted him with his purchases and recalled Employee made sure the dust remover had a red straw taped to the side.

The investigating officer, Officer Snavely, recalled a prior “missing person case” concerning Employee on November 6, 2008. Employee made a statement to a friend that “everyone would be better off without him.” His family and friends feared he may harm himself. Employee returned home the following day, and Officer Snavely interviewed him. He told the officer he sometimes thought about committing suicide due to the constant pain he has from injuries related to the fall. However, due to his Christian beliefs he cannot kill himself or he would suffer the consequences of suicide in the afterlife.

Due to his history with the family, Officer Snavely informed Employee's parents of his passing. He obtained a medical history form and current medication list from Employee's father. He related that he had been hospitalized as recently as September 2008 due to complications related to a Staph infection brought about by lumbar hardware in his back. His current medication list included: Cymbalta, Keppra, Gabapentin, Warfarin, Cephalexin, and Bupropion.

On February 2, 2009, Officer Snavely prepared a supplemental report after he reviewed the Medical Examiners report. He recalled Employee's van had a can of clean safe dust spray, which is commonly used for "huffing." The spray can was on the seat where his head came to rest. He previously told the officer he would occasionally use heroin and cocaine to alleviate the constant pain he suffered and prescription drugs did not help. Officer Snavely did not find any indications of cocaine in the vehicle at the time of death. St. Charles Police Department closed its investigative file.

Witness Testimony

Michael C. Agnew

The employee, Michael C. Agnew, testified by deposition on August 5, 2002 (Exhibit 8). A question regarding recreational drug use was certified, but never answered under oath. He testified he had a six year old son, and paid $300 a month in child support. He was receiving Social Security Disability and Medicare. He testified Effexor and Prozac caused sedation. He was also taking Morphine. He testified he attempted suicide on November 15, 2001, when he took 75 Valiums, stabbed himself four times in the stomach, and left a suicide note. He denied any prior or subsequent suicide attempts. He testified Dr. Cantrell had told him he was as good as he was going to get. He testified he stopped smoking July 11, 2002. Prior to that, he smoked a pack a day since high school.

He testified his father was retired, and both parents helped him with certain activities. They helped dress him, change bandages, and assist with medication administration. His parents cooked for him, or he microwaved his own meals. Drs. Sadowsky, Anderson and Carpenter were prescribing medications at that time. He performed self-catheterization every 6 hours and a bowel routine every other day. He testified he was confined to a wheelchair or bed. He did not stand at all. He had light sensation in his left leg, but no movement in his legs. His scoliosis caused problems with his upper extremities in that he had to use his arm to balance. He had pain in his buttocks and hips. He denied headaches, dizziness, and difficulty with vision or hearing.

He completed 10th grade, and could not recall why he left. He had enrolled in the "My Skills Tutor" to get his GED. He spent 15 hours at the community college for testing and was spending time daily preparing for the GED test. Prior to March 26, 1999, he broke his arm, had a facial laceration and a right Achilles tendon repair. Prior to working for Aalco Wrecking, he worked for Missouri Pipe as a pipe layer and skid loader operator. He worked for Safety Construction using hand tools and shovels. He worked for Albericci as a union laborer, and belonged to Local #110. Prior to joining the union, he installed fences and worked at a carwash.

Kristen Agnew

Kristen Agnew, Employee's widow, testified by deposition on January 11, 2010 (Exhibit 10). She was not married to Employee on March 26, 1999, the date of injury. They met in 2006 on the Internet, and were married in August 2006. She moved to Wentzville and in with Michael one month after they married. She testified his home was foreclosed on in 2007, and she moved back to Quincy, Illinois. Employee lived with her from August 2007 until May 2008. He moved back to St. Peters and in with his parents in May 2008. He lived with his parents until his death in November 2008. She was stepmother to Logan, Employee's son, but did not adopt him. She was never a legal guardian of Logan. Kristen testified he volunteered with the youth at church. Some days he was interested in getting his degree, and some days not.

Regarding his death in 2008, she did not have an opinion as to the cause of his death. She did not believe he committed suicide. She denied he left a suicide note, and did not bring any such statements pursuant to Subpoena Duces Tecum. She was aware of Employee's drug use. She believes he started using cocaine in October 2006 because he told her. He told her of his substance abuse history, but described it as "on and off". She believes he started using again in October 2006. He also used marijuana every once in a while before she met him. She did not have any idea that he was using difluoroethane or "huffing". She testified Employee had a friend that did it. She denied he ever had legal or criminal trouble as a result of his drug use.

She moved back to Quincy in 2007 due to the employee's drug use. She tried to get him to go to drug treatment five or six times, but he fought it every time. She did not think his parents were aware of his drug use. She testified most of his drug use occurred while she was at work or at night while she was asleep. She testified he probably took more of his prescription medication than was medically prescribed. She testified he was addicted to his pain medication. She would drive him to the emergency room to obtain pain medication, specifically Dilaudid. She would take him to the Blessing Hospital emergency room more than once a month.

Prior to his death in 2008, she recalled one other overdose in November or December 2006. She felt there could have been other times, but none that she recalled. She denied he ever received any psychological treatment or was diagnosed with any mental health conditions. She testified he would use any excuse, a different one every time, as to why he was using drugs.

Kathleen Hartman Clark

Mrs. Clark, mother of Logan Agnew, testified on June 25, 2013 pursuant to Subpoena Duces Tecum for Deposition (Exhibit 11). She was asked to produce any written or recorded communication relied upon in her interview with Dr. Wolfgram and other documentation of her parental relationship to Logan Agnew. She did not bring any documents with her. She was married one time, and remains married to Mr. Clark. She lives with her husband and only child, Logan Agnew, in Fenton, Missouri. She graduated from Nerinx Hall in 1994, attended Central Missouri State for one year, and then attended Sanford Brown. She works full-time as an executive assistant. She testified Logan receives Social Security benefits from Michael Agnew, approximately seven hundred dollars a month. He has received those benefits since Employee's death. Her relationship to Employee was that of girlfriend.

Mrs. Clark met Employee in 1995 after she graduated high school. They were both working at Waterway carwash. She was 18 years old. They started dating in 1995, but broke up shortly after Logan was born in July 1996. She testified "they were not healthy together" and he "was physical" with her.

When Mrs. Clark met Employee in 1995, Employee smoked cigarettes. She saw him smoke marijuana and snort cocaine. She smoked marijuana with Employee weekly. She denied seeing him use any other drugs, illegal drug, off-use prescription drugs or other illicit substances. She personally saw him use cocaine twice. She had suspicions but never confirmed heroin use. After they broke up in 1996, she did not have any further suspicions of drug use. Between 1996 and 1999, she had no knowledge of any drug use. She had no knowledge of any drug rehabilitation. She did not know if he did any drugs at any point after the 1999 work injury. She did not develop any suspicions of drug use after the work injury in 1999.

Mrs. Clark was unaware of the 2001 hospitalization from the self-inflicted stab wounds and overdose of Vicodin. She was kept advised, but never got details about Employee's medical condition. Employee would tell her how much pain he was in, and that it was "extreme."

Mrs. Clark testified Employee is the biological father of Logan Agnew. Mrs. Clark estimated that Employee started paying child support when Logan was a few months old and paid $250-300 per month until he passed in 2008. He was occasionally late with payments. Employee and Mrs. Clark had a voluntary custodial arrangement. Mrs. Clark had custody during the week, and Employee would have Logan every other weekend. She did not know why Employee's name was not originally listed on the birth certificate. Logan is a senior at Rockwood Summit High School, an average student, and plans to join the Marines. He works at Valley Park Elevator during school and summers. Mrs. Clark testified she spoke to Dr. Edwin Wolfgram earlier in 2013, prior to her deposition.

Michael W. Agnew

Mr. Agnew, Employee's father, testified on November 8, 2013 (Exhibit 12). He denied attorney representation in this matter, or that he spoke to any of his son's attorneys. However, he admitted to understanding his grandson stood to receive a monetary gain if his attorneys were successful. He denied being told what to say. He is Logan Agnew's grandfather. He described Employee as a fair student. Employee had been diagnosed with attention deficit disorder in fifth grade. He tried Ritalin, but took him off of it. He denied Employee ever attended special education classes. He was also diagnosed with a behavioral disorder, but was unclear on what that meant. After he quit high school at Francis Howell, he entered Logos School. He testified Employee was financially dependent upon him and his wife for support up until 1999. He never obtained his GED. Mr. Agnew never suspected his son was using drugs. At no point prior to November 22, 2008, was Mr. Agnew aware of any cocaine use. Mr. Agnew denied any knowledge of drug use on the part of his son, except for those medications prescribed by his doctors.

After the 1999 work injury, Mr. Agnew stayed with his son, attended doctor's appointments and learned about taking care of him. From 1999 to 2001, he was in a lot of pain,

"everything they gave him failed." Mr. Agnew was not aware of any drug use between 1999 and 2001. Mr. Agnew testified his son stabbed himself in 2001 to make the pain go away. When he was living in the handicap accessible home, he was able to make his own meals, do his own wash, and help his son take a bath. Between 2001 and 2006, he testified he read a lot, got involved with the church, and became neighborly. He made bird houses and feeders in his woodworking shop. He volunteered, but never worked for pay. He wanted to find a job. Also between 2001 and 2006, he described Employee had "good days, bad days", but also said "every day was bad." He described his spasms would make his whole body shake. His upper extremities were good; he did woodworking and worked out with weights.

Donna S. Agnew

Mrs. Agnew, Employee's mother, also testified on November 8, 2013 (Exhibit 13). She has worked as a procurement coordinator at Boeing for forty-five years. She testified Employee was a normal child, an average student. She testified he had attention deficit disorder. He would go to a resource room in school for testing. She testified he dropped out of high school his first semester of sophomore year. She testified Employee struggled in school because of his learning disability. His learning process was different. School was a battle. He also had behavioral issues and trouble sitting still. During high school, she never suspected he was using drugs. She denied ever finding drugs. She denied Employee ever saw a therapist prior to 1999. In 1999, Employee was living with his parents at the time of the injury. He was also dependent upon his parents for food and support.

Between 1999 and 2001, she testified the muscle spasms controlled him. She testified he stayed home a lot and it took a while for him to allow his friends to accept him. She testified she helped him with his medications. The insurance company gave him $80,000 to put towards a handicap accessible home. When he lived in the home alone, his parents did grocery shopping, and had dinner with him. But she felt he never really had the chance to be alone because of the surgeries. She testified that between 2001 and 2006 he was pretty much under constant medical care.

Mrs. Agnew testified her understanding of Employee's 2008 death was that his heart stopped. She testified he had just had surgeries to remove a screw and infection. Mrs. Agnew denied ever seeing her son use cocaine. She never witnessed her son using difluoroethane. She denied having any knowledge of drug use.

Evaluations and Opinions Offered by Employee

Dr. Mark Pelikan

Dr. Pelikan, a family physician and doctor of osteopathic medicine, performed a records review, because Employee passed before he could perform a physical examination. He prepared an eight-page report in 2012. He was provided some records documenting the treatment of Employee. Dr. Pelikan testified Employee reached MMI in 2001 and that any treatment he received after that date was "merely comfort, restorative type care, supportive care" (Exhibit A, pp. 20). He agreed Employee was met with setbacks and surgeries through at least 2006. He

further conceded the surgeries Employee underwent after November 2001 would not be considered merely comfort and restorative measures.

He did not recall a positive drug screen in 2001 for marijuana. Dr. Pelikan also testified the non-union of the thoraco-lumbar junction diagnosed in 2002 by Dr. Merenda possibly could have been present in November 2001. However, he admitted he was not aware of any medical records discussing thoracolumbar scoliosis or kyphoscoliosis prior to November 12, 2001. Dr. Pelikan testified Employee's actions on November 15, 2001 would medically be considered a suicide attempt due to the self-inflicted stab wounds to the abdominal area.

Dr. Pelikan did not recall the 2002 surgery performed by Dr. Lenke involving all levels of the spine from T4 to the sacrum. Dr. Pelikan agreed on cross examination that the complications associated with T7 paraplegia followed Employee until his death in 2008. He testified he did not review any records indicating prescription drug dependency. He noted in 2006, Employee had a urine screen positive for cocaine, and was diagnosed with depression secondary to cocaine abuse. He denied reviewing any record diagnosing depression from anything other than polysubstance abuse. Dr. Pelikan did not review any records, physical or psychiatric, between 2006 and 2008. Dr. Pelikan testified Employee was permanently and totally disabled from any type of work based on his injuries. He testified Employee's death was not a suicide. He testified he did not find any link between the work injuries and drug use.

Timothy Lalk

Timothy Lalk, a vocational expert, testified on January 10, 2013. He was unable to conduct an interview of Employee and had to rely on records to prepare his vocational assessment report. Mr. Lalk did not think Employee could secure and maintain employment from November 2001 to his death in November 2008. He testified that due to the treatment he received during that time period, he would not have been able to work. He underwent multiple procedures and was hospitalized on multiple occasions. Mr. Lalk testified the additional treatment was substantial. He was unable to work or even pursue retraining during the time period of 2001 to 2008.

Mr. Lalk testified the most salient information he was able to gather for his report were the records of Donna Abram, and the psychological and psychiatric evaluations. He agreed that despite Employee's condition appearing relatively stable in 2001, he continued to be met with setbacks and surgeries through 2006. He agreed that in 2006, Employee articulated a plan to overdose on cocaine. He reported miraculous pain control with cocaine.

Mr. Lalk did not review any treatment records, physical or psychiatric, between 2006 and the Employee's death in 2008. He was not provided with any records documenting his level of functioning for purposes of vocational evaluation between 2006 and 2008.

Based on his educational and vocational history, Employee could have returned to the work force. He was a young worker. Only Dr. Cantrell and Dr. Lenke provided opinions regarding physical restrictions. Based on Dr. Cantrell's restriction of sedentary work, he could have done some type of work, unless, he had some intellectual deficiencies or emotional difficulty. Mr. Lalk testified a GAF score of 20-30 would suggest the person could not function

in a job, school or social setting. Mr. Lalk opined that the employee was permanently and totally disabled as a result of the symptoms and limitations related to the back and spinal cord injury of March 26, 1999.

Dr. Edwin Wolfgram

Dr. Wolfgram, a psychiatrist, but not a toxicologist, reviewed records from Employee's attorney and interviewed Kathleen Hartman, Logan Agnew's mother and Employee's girlfriend from 1995-1996. He did not interview Employee, because he was deceased by the time Dr. Wolfgram was involved in the case.

Dr. Wolfgram prepared an undated three-page report at Employee's request. He was not asked to provide a psychiatric diagnosis, and did not provide one in his report. He did not document Employee's prescription medication list at any point in his report. He was not asked to address the extent of Employee's psychiatric disability. However, he testified Employee had a "substance related disorder, not otherwise specified", DSM-IV 292.9. He described the category as a "catchall" to be used at different times in different ways.

Dr. Wolfgram interviewed Ms. Hartman on an unspecified date and time. He considered her to be a "pivotal part" of his report and conclusions. None of the notes from his interview are documented in the report. He described Ms. Hartman's interview as being of particular importance because she had "an acquaintance" with him. Dr. Wolfgram knew her relationship with Employee was that of boyfriend/girlfriend from 1995 until July 1996. They never married, lived together or got back into a romantic relationship. He admitted her knowledge of Employee's drug use was limited to her personal experience with him from 1995 to 1996. However, he explained he wanted to gain some understanding from her as to what sort of person Employee was.

Dr. Wolfgram testified that the history Ms. Hartman provided to him regarding Employee's early drug use vastly differed from her deposition testimony suggesting he "used marijuana on a couple of occasions and snorted cocaine two times." He testified that the latter description would only be considered "use" not abuse of drugs. Dr. Wolfgram did not interview Employee's widow, his wife from 2006 through 2008 or Employee's parents.

Dr. Wolfgram testified that Employee reached MMI in 2001. He considered that a point at which no clinical change was expected. He opined that Employee was disabled as a result of the work injury. Dr. Wolfgram testified to a "self-inflicted" wound in 2001, but he reviewed no records of an "actual direct suicide attempt". He did, however, note Employee's thoughts of suicide. Dr. Wolfgram did not think the 2001 self-inflicted stab wounds and overdose qualified as a "suicide attempt." Rather, he described it as a "manipulative event." Dr. Wolfgram disagreed with Dr. Anderson's 2002 testimony and medical connection made between Employee's paraplegia, chronic pain syndrome, significant narcotic medication that was insufficient to control pain and depression as a result of the pain. Dr. Wolfgram testified Dr. Anderson was "totally naïve and it's a total misstatement of the facts."

Dr. Wolfgram opined that the work injury did not cause Employee's death. He testified that he died of "a toxic substance to include cocaine and trifluoroethane" (sic). He testified that

the injury did not cause the use of the substances, but that drugs were a factor in his death. He testified that Employee had an early use of illicit substances as a teenager, and this was the force that drove his entire existence even through his death. Dr. Wolfgram denied reviewing any reference to abuse or misuse of his prescription drugs. He testified that people who have used illicit drugs regularly demand excessive amounts of prescription drugs. "They're constantly asking for more…you simply cannot use pain-relieving medications because they become addicted to it." He testified Employee's difficulties created a predisposition to turn to drugs. He relied on Ms. Hartman's interview, who he described as "no angel" because she too used drugs. The doctor's information regarding Employee's drug use before the accident, earlier in life, was discovered through his interview with Ms. Hartman.

Dr. Wolfgram testified the predictability of use of illicit drugs by someone after a severe injury would depend on the person and their background. He testified in practice he is careful about using prescription medications, mood-altering medications, on people with a history of addiction. He opined that Employee had such a history. Dr. Wolfgram did not review any medical records, psychiatric records or drug rehabilitation records documenting a drug problem prior to the 1999 work injury. Dr. Wolfgram did not review any legal documents suggesting involvement in illegal drug activity before 1999. Dr. Wolfgram suggested, based on his review of records, that Employee's social difficulties and adjustment problems were indicative of drug use prior to 1999.

Dr. Wolfgram summarized his own opinion as "the crux of the case is the long shirt sleeve." Dr. Wolfgram testified Ms. Hartman "knew" he was a hardcore addict. He never wore short sleeves to hide "vena punctures." Dr. Wolfgram testified he was into intravenous drug use. He was under the control of drugs and all subsequent conditions and illnesses are a reflection of his substance related issues. Dr. Wolfgram testified that Dr. Richardson, in 2006, was on the right track to recommend drug rehabilitation. Dr. Wolfgram testified the treating physicians were preoccupied with the spine injury and the drug issue wasn't picked up. Dr. Wolfgram did not feel his 2008 death was a suicide, rather an attempt to obtain the exhilaration and effect of toxic substances.

Evaluations and Opinions Offered by Employer/Insurer

Richard Anderson, M.D.

Dr. Anderson testified (Exhibit 32) on July 24, 2002 regarding the November 15, 2001 suicide attempt. Dr. Anderson examined Employee for the first time on December 6, 2001, as a treating physician. He considered it a "serious suicide attempt." He testified self-inflicted stab wounds are extremely extraordinary and unusual. Employee told him the self-injury was the result of unremitting pain. Dr. Anderson diagnosed him with chronic pain syndrome, with continued symptomatology requiring significant narcotic analgesia. He had significant and worsening depression from the pain syndrome and paraplegia, and on November 15, 2001, as a result of that depression he became acutely suicidal. Dr. Anderson testified his depression and anxiety about the ongoing need for treatment and uncertainty about the outcome were related to the injury, as was the need for Prozac and Effexor. Dr. Anderson felt he required psychiatric treatment as a result of the work injury. Dr. Anderson took a history of adjustment problems in school prior to 1999, but did not review any psychiatric treatment records from before 1999. Dr.

Anderson did not feel he required any psychiatric restrictions in pursuing vocational rehabilitation.

Christina L. Sadowsky, M.D.

Dr. Sadowsky testified (Exhibit 33) on July 31, 2002. She treated Employee from February 5, 2002 through July 22, 2002 on referral from Dr. Swarm. She testified Baclofen is a non-spasticity agent and a pump delivers the medicine continuously and constantly into the spinal canal, where the medication is needed. She took down his description of his pain on February 5, 2002 as "tremendous, stabbing, burning" pain in the low back and bilateral lower extremities and groin. He told her about increased sweating associated with the pain, which Dr. Sadowsky called "autonomic dysreflexia" commonly associated with spinal cord injuries. She testified the spasticity, pain and constipation are related effects of the work injury. She testified he would require additional treatment into the future for these conditions. She did not feel he was able to work due to his intractable pain and the side-effects from the medication required to treat it; however his limited mobility would allow him to work a desk job. She attempted to reduce the amount of medication he was taking, because she thought Employee was addicted to the drugs and had developed a physical addiction. However, she did not feel he had a psychological addiction to his pain medication at that time.

Lawrence Lenke, M.D.

Dr. Lenke, an orthopedic spine surgeon, testified (Exhibit 34) on July 31, 2002 about the recommended spine surgery to provide balance to his pelvis and spine support. He first examined Employee on April 10, 2002. Dr. Lenke planned to remove the current instrumentation system, explore his fusion and re-fuse all levels of the spine down to the pelvis. Dr. Lenke related the very involved recommended surgical procedure to the 1999 work injury. He felt it could take a year to recover from surgery. Dr. Lenke required Employee to stop smoking prior to surgery.

Russell C. Cantrell, M.D.

Dr. Cantrell treated the claimant for his spinal injury and reviewed records regarding prior suicide attempts on at least two occasions, in 2001 and 2006. Dr. Cantrell opined that the drug use starting in 2006, according to the records of Dr. Richardson and Dr. Swarm. Dr. Cantrell testified Dr. Swarm's records show a history of cocaine use associated with the work injury. Employee told Dr. Swarm he was using cocaine for its "miraculous pain control," but there was no evidence of consistent illicit drug use for extended periods of time (Exhibit 15, pp. 69-70, 74). Ultimately, Dr. Cantrell opined there was a causal connection between Employee's use of cocaine and his injury because he wasn't suffering any chronic pain symptoms prior to his injury.

Dr. Cantrell also testified at the time of his death, he had prescription medications in his system, including Hydrocodone, Buproprion, Diazepam and Nordiazepam. Employee was taking those medications as a result of the 1999 work injury. Dr. Cantrell explained there are known side effects of prescription medications, but that there are fewer studies that have been done on illicit drugs. There is certainly an understanding in the medical community that illicit drugs can have interactions with prescription drugs, but this interaction is not usually formally studied. Dr.

Cantrell testified it was very possible the prescription medications in his system interacted with, in an adverse way, the illicit drugs to contribute to his death. Noting specifically, Hydrocodone, or other narcotics can have respiratory suppression effects.

Dr. Cantrell testified the toxicology report showed, in addition to difluoroethane and cocaine, Employee had Hydrocodone, Buproprion, Diazepam and Nordiazepam in his system. He testified the latter medications were all prescription medications that were prescribed to treat the effects of the March 26, 1999 work injury. Dr. Cantrell testified to the adverse reactions and known side effects of illicit drugs and prescription medications. He testified it was "very possible" the prescription medications Employee was on at the time of his death contributed to or interacted with, in an adverse way, the illicit drugs to contribute to Employee's death on November 22, 2008 (Exhibit 15, pp. 46).

Leading up to his death, Employee's lumbar spine complaints in 2007 and 2008 were "severe." He repeatedly presented to various emergency rooms due to his persistent pain. Dr. Cantrell described his August 19, 2008 CT scan as abnormal, and his urine screen as positive for cocaine. On August 22, 2008, a wound exploration procedure was performed to remove hardware and address a wound infection. Dr. Cantrell testified infected hardware is a serious cause of back pain. Following surgery, he underwent suppressive therapy to prevent the recurrence of infection. Dr. Cantrell testified the infection and surgery required to treat it on August 22, 2008 were related to his 1999 work injury (Exhibit 15, pp. 43). The infectious disease consultation and follow up by Dr. Marschall were also related to the 1999 work injury, as were the October 29 and 31, 2008 consultations with Dr. Kau.

Dr. Cantrell testified that in November 2008 Employee was still actively under care. His surgical wound had likely healed, but he was still requiring suppressive antibiotic therapy from the spine infection. He further testified that Employee would not have had the opportunity to complete treatment prior to his death on November 22, 2008. Dr. Cantrell testified Employee's death on November 22, 2008 was causally related to the work injury and complications that he suffered (Exhibit 15, pp. 50).

Wayne A. Stillings, M.D.

Dr. Stillings, Assistant Professor of Clinic Psychiatry at Washington University School of Medicine, testified Employee's death on November 22, 2008 was substantially and prevailingly causally related to the March 26, 1999 work injury. Based on a review of medical records and witness testimony, Dr. Stillings diagnosed chronic and severe pain disorder associated with both psychological factors and a general medical condition (the 3/26/99 work injury), and chronic and severe Major Depressive Disorder due to the March 26, 1999 work injury.

Dr. Stillings testified as a result of his catastrophic injury, Employee was bound to bed or a wheelchair, which provided limited mobility. He did not adjust to that very well. As a result of the work injury, Employee had severe chronic, unremitting, incurable and basically intractable pain (Exhibit 16, pp. 9). Dr. Stillings astutely highlighted the initial diagnosis of a traumatic brain injury, which he testified contributed to his major depressive disorder. Dr. Stillings testified he attempted suicide in 2001 by overdosing on twenty-times the average dose of Valium and stabbed himself in the abdomen. Dr. Stillings highlighted Dr. Anderson's 2002 opinion of a

direct causal link between the 1999 work injury and its associated pain. Dr. Stillings agreed with Dr. Anderson.

Dr. Stillings also reviewed a note (Exhibit 14) and opined that his reference to "pain" meant both physical and emotional. Dr. Stillings testified major depressive disorder is often a causative factor in suicides, and it's not to be minimized in this case. Dr. Stillings opined that he started using cocaine in 2006 as a result of the work injury. Dr. Stillings was aware of Employee's remote, recreational drug history of "teenage playing around with substances" and occasional marijuana use (Exhibit 16, pp 18-9). Dr. Stillings opined that even if the evidence showed some prior substance abuse, that the work injury would still be the prevailing factor in his subsequent drug use. Dr. Stillings opined that his parents were in the dark about his drug use (Exhibit 17, pp. 11).

Dr. Stillings disagreed with the opinions of Dr. Wolfgram. Dr. Stillings opined that it was uncommon and inconsistent with standard principles of forensic psychiatry to prepare a forensic psychiatric report without a diagnosis (Exhibit 17, pp13). Dr. Wolfgram did not attribute any psychiatric conditions or disabilities to the 1999 work injury. He essentially opined that the 1999 work injury had nothing to do with his use or abuse of drugs and/or death in 2008. Dr. Stillings opined that the evidence was "overwhelmingly compelling" in this case demonstrating Employee's severe psychiatric problems directly causally related to the work injury (Exhibit 17, pp. 15-6). Dr. Stillings testified that from the time of his suicide attempt in 2001 to the time of his death in 2008, his psychiatric condition declined.

Further, Dr. Stillings testified that within the medical community use of illicit drugs, like cocaine, for palliative purposes is really common. Not only palliative for the physical injuries, but psychologically too. He testified his physical and psychological conditions were interminably tied together, citing the common sense principal of "the mind and the body." Dr. Stillings testified it is highly doubtful that someone who suffered the injuries and complications that Employee suffered would not develop some form of psychiatric disability as a result.

Donna K. Abram

The defense's vocational expert, Donna Abram, was able to interview the Employee and review his medical records. She contended that Employee could have "possibly" been placed in employment, even with the extremely serious and numerous physical injuries and complications that he suffered. However, she also testified that the claimant's employability had very apparent constraints based upon the facts. For instance, she testified that Employee "had periods that were very good and there were periods that were very bad, and they fluctuated and the length of time fluctuated…" (Ex. 18, p. 43.) (Ex. 18, p. 45.) Ms. Abram also testified that, from her review of the medical records, she believed Employee's level of functioning "continued to switch from functioning to nonfunctioning throughout his life," and that the waxing and waning of function level "would be a definite hindrance to placeability and it would make it almost impossible for him to maintain a job." (Ex. 18, p. 53-54.) She also testified that when she last saw Employee in 2002, he was not employable or suitable for vocational rehabilitation. She testified that she did not think there would be any significant treatment after the 2001 MMI that would change Employee's level of functioning "in any important way." Finally, she testified that it would be almost impossible for Employee to maintain a job. (Ex. 18-5, p. 31.) Although she actually

worked with Employee for eight months in 2002, she testified that she was not able to continue working with him because of his medical status—that he was not a good candidate for vocational rehabilitation at that time. (Ex. 18, p. 39-40.) Her later opinion that "vocational rehabilitation could have been very appropriate" was given 12 years after she had last seen Employee. (Ex. 18, p. 41.) Ms. Abram testified:

> With pain control, it is possible that he would have been placeable. From a vocational perspective, I cannot state to what level "possibly" being placeable would change into "probably" placeable. There are too many factors that I did not have the opportunity to assess due to his death. I regret I cannot provide a more definitive opinion as to whether or not it would have been likely that he would have returned to work." (Ex. 18-5, p. 10.)

Donna Abram opined that the Employee's lack of pain control affected his ability to return to work. She testified it was a very significant factor in his vocational picture. When he felt he didn't have pain control, he increased his medication and increased his recreational drugs. It appeared his pain control made it impossible for him to focus on anything other than his pain so that all of his life surrounded his pain level and what he felt he could or couldn't do (Exhibit 18, pp.36).

LEGAL BACKGROUND

Prior to January 9, 2007, the dependents of a deceased employee could recover death benefits and burial expenses from the employer only if the employee was fatally injured, or subsequently dies as a result of injuries sustained due to a work-related accident or occupational disease. RSMo §287.240 (emphasis added). Section 287.240 provides an employer shall pay to the total dependents of the employee a death benefit based on employee's average weekly wages during the year immediately preceding the injury that resulted in the employee's death. §287.240.2, RSMo. 2000. Section 287.020.4 sets forth the definition of death:

> "Death" when mentioned as a basis for the right to compensation means only death resulting from such violence and its resultant effects occurring within three hundred weeks after the accident; except that in cases of occupational disease, the limitation of three hundred weeks shall not be applicable.

Section 287.020.4 does not create any right to collect death benefits under workers' compensation, unless the death occurs within 300 weeks of the accident. *Id.* Section 287.120 of the Workers' Compensation Act states that every employer subject to the provisions of the Act shall be liable to furnish compensation for personal injury or death of an employee by accident arising out of and in the course of the employment. RSMo, §287.120.1. Where an employee's death occurs more than 300 weeks after his work-related accident, the purported dependents of that employee cannot recover workers' compensation death benefits. RSMo, §287.020.4; *Greenlee v. Dukes Plastering Service*, 75 S.W.3d 273, 277-278 (Mo.banc. 2002).

Since the Employee's injury in this case occurred on March 26, 1999, and he passed away on November 22, 2008, approximately 504 weeks after the initial injury, the plain language of Section 287.020.4 bars employee's dependents from recovering death benefits and burial

expenses. *Id.* Employer/Insurer paid all benefits due and owing to the date of death. However, the Claimant is not seeking death benefits.

The Claimant's theory for recovery is for lifetime permanent total disability benefits pursuant to *Schoemehl v. Treasurer of the State of Missouri*, 217 S.W.3d 900, 902 (Mo.banc. 2007), in which our Supreme Court held that an injured employee's wife, as his sole dependent, was entitled to recover the accrued and unaccrued permanent total disability benefits awarded to her husband after his death from causes unrelated to his work injury, for the remainder of her lifetime. *Schoemehl*, 217 S.W.3d 902 (emphasis added). In *Strait v. Treasurer*, 257 S.W.3d 600, 602-603 (Mo.banc. 2008), the Supreme Court held that the rule of law enunciated in *Schoemehl* only applied where the injured employee died while his or her workers' compensation claim was pending before the Division, the Commission, or on appeal before an appellate court. *Strait* ruled that *Schoemehl* only applied on a prospective basis to cases that were pending at the time the *Schoemehl* Opinion was issued on January 9, 2007. *Id.*

On June 26, 2008, the Missouri Legislature passed House Bill 1883. The express language contained in House Bill 1883 stated that it was the intent of the legislature to reject and abrogate the holding in *Schoemehl* and all cases citing, interpreting, applying, or following *Schoemehl*. House Bill 1883 amended Sections 287.020, 287.200, and 287.230, which the Supreme Court relied on in rendering its Opinion in *Schoemehl*. Since House Bill 1883 contained an emergency clause, it became effective on June 26, 2008, the date of its passage.

In *Bennett v. Treasurer of the State of Missouri*, 271 S.W.3d 49 (Mo.App.W.D.2008), the Court of Appeals held that recovery under *Schoemehl* was limited to claims for permanent total disability benefits that were pending between January 9, 2007, the date when the Supreme Court issued its Opinion in *Schoemehl*, and June 26, 2008, the effective date of House Bill 1883. Within this context, a workers' compensation claim for permanent total disability benefits is "pending" when it is before the Division, the Commission, or is on appeal to the Court of Appeals or Supreme Court. *Bennett*, 271 S.W.3d at 53; *Strait*, 257 S.W.3d at 602. Thus, *Schoemehl* does not apply to claims for compensation that were not pending, and were closed prior to the issuance of the Supreme Court's decision on January 9, 2007.

The operative timeline in this case is that Employee's original Claim for Compensation was filed on March 13, 2000 for injuries to the body as a whole, temporary total disability benefits and medical care (Exhibit 1). House Bill 1883 became effective on June 26, 2008. Employee died on November 22, 2008. See Exhibit 3. The Amended Claim for Compensation alleging permanent total disability benefits was filed on May 7, 2009 (Exhibit 1).

In order to recover, the Claimant in this case must prove: (1) The employee attained maximum medical improvement and (2) was permanently and totally disabled; (3) That there are surviving dependents as of the time of his death who qualify as "dependents" for purposes of *Schoemehl* and its progeny; (4) That the *Schoemehl* doctrine temporally applies to this case; and (5) that the Employee's death did not ensue for any cause resulting from the work injuries. Both parties have also filed competing Motions for Costs.

ISSUE 1: Did employee reach a point of maximum medical improvement from the March 26, 1999 work injury?

The Missouri Court of Appeals recently addressed this issue in Miller v. Treasurer, Slip Op. (Mo. App. E.D. March 25, 2014), and held that the level of permanent disability associated with an injury cannot be determined until it reaches the point of maximum medical improvement ("MMI"). Hoven v. Treasurer of State, Custodian of Second Injury Fund, 414 S.W.3d 676, 678 (Mo. App. E.D. 2013) citing Cardwell v. Treasurer of Missouri as Custodian of the Second Injury Fund, 249 S.W.3d 902, 910 (Mo. App. 2008). The issue of whether further medical improvement can be reached is essential to determine when a disability becomes permanent, and accordingly, when payments for PPD should be calculated. Id. "Permanent disability is determined and provided only after temporary disability compensation is discontinued." Cardwell at 909, citing Schuster v. State Division of Employment Security, 972 S.W.2d 377, 381 (Mo. App. E.D. 1998).

Temporary total disability benefits are owed until the claimant can find employment or the condition has reached the point of maximum medical progress. Vinson v. Curators of Univ. of Missouri, 822 S.W.2d 504, 508 (Mo. App. 1991). In 2001, workers' compensation laws were broadly interpreted in a liberal manner in favor of the employee, and questions regarding the right of the employee to benefits must be resolved in the injured employee's favor. Minnick v. South Metro Fire Prot. Dist., 926 S.W.2d 906, 909 (Mo. App. 1996).

The Employee had reached MMI as of November 12, 2001 when Employer's authorized physician and medical expert, Dr. Russell Cantrell, placed him at MMI. (Ex. 15-3.). Subsequent reports dated July 3, 2002, February 21, 2006, and April 12, 2006 do not retract the MMI opinion; on the contrary, they indicate continuing deterioration of Employee's conditions. Dr. Cantrell's final report (issued December 19, 2013, several years after Employee's death) confirmed that MMI was reached as of November 12, 2001. (Ex. 15-3.) When asked on cross-examination whether the MMI date for the 1999 work accident was November 12, 2001, Dr. Cantrell responded:

> Yes. In other words, at that point in time, I didn't think that any intervention that I could do or that could be done by others, given his status at that point in time, would lead to any improvements in his overall functional outcome. (Ex. 15, p. 51.)

Dr. Cantrell also testified that MMI does not necessarily mean there would not be any additional treatment "down the road." (Ex. 15, p. 52) When asked if deterioration could happen even after MMI, he responded:

> Yeah. I think Mr. Agnew might be a good example of that where he developed failure of his spinal hardware that led to a paralytic scoliosis, and that, in turn, led to the need for future spinal surgery. You don't necessarily anticipate that happening, but it's a possibility. (Ex. 15, p. 52.)

Although Employee continued to receive medical treatment after 2001 and up through the date of his death, this fact does not preclude or in any way contradict the fact that he had reached

MMI as of November 12, 2001 for the injuries sustained on March 26, 1999. Given the severity and extent of Employee's work-related injuries, it is reasonable to conclude that Employee would have required continuing treatment after MMI in 2001 and for the rest of his life. It is also reasonable to conclude that Employee would have developed various conditions and complications due to the nature and extent of his work injuries, even after he had reached MMI in 2001, for which he may not have been "MMI" *for those particular conditions or complications*; although his overall condition was not going to drastically improve from his status in November 2001. MMI is not a function of any particular condition or complication, but rather of the overall condition of injuries sustained by the work accident. It is clear that the Employer's own authorized treating physician and medical expert witness confirmed that Employee reached MMI as of November 12, 2001.

Employee's medical expert, Dr. Mark Pelikan, reviewed the comprehensive medical records but was not able to examine Employee (as the review was after Employee's death). Dr. Pelikan agrees with Dr. Cantrell that Employee had reached MMI as of November 12, 2001. (Ex. A-B.)

Dr. Sandra Tate examined Employee on May 13, 2003, and opined that Employee reached maximum medical improvement.

> However, in regard to his actual injury, it has been well over two years, and it is my opinion that he is at maximum medical improvement for his spinal cord injury. However, these types of injuries require ongoing medical care for maintenance which includes bowel and bladder evaluations, medications to control spasticity, and bowel and bladder, and for urinary tract infection prevention. The patient also may need physical therapy evaluations on an intermittent basis. He also will need further wheelchairs, but usually a wheelchair should be able to last an individual anywhere from three to five years, depending on the activity of that individual. See Exhibit 30.

Dr. Tate's opinion did not contemplate the additional complications, involved surgeries and hospitalizations Employee would endure through 2008.

The evidence compels a finding that Employee had reached MMI as of November 12, 2001 and that treatment for any subsequent conditions or complications would be expected due to the nature and extent of the serious injuries sustained.

The defense argues in its well written and well researched brief that the claimant never attained maximum medical improvement, because the claimant had continuing care for his severe injuries from the accident and requested and received temporary total disability benefits until his death. However, Missouri Law recognizes that medical care is authorized after the claimant attains MMI, if warranted.

> "The worker's compensation act permits the allowance for the cost of future medical treatment in a permanent partial disability award." Sharp v. New Mac Electric Cooperative, 92 S.W.3d 351, 354 (Mo. App. S.D. 2003). There is no requirement for a claimant to prove specific medical treatment will be required in order for payment of future medical expenses to be made available. Id. What is

required is proof there is a "reasonable probability" that additional medical care will be needed to treat the work-related injury. Id.

In addition, our statutes provide temporary total disability benefits for a maximum of 400 weeks. The fact that the employer continued to pay temporary total disability benefits well after 400 weeks reflects that the claimant's condition was permanently and totally disabled after he attained maximum medical improvement and is to be credited to any permanent disability benefits due.

The weight of the evidence and the clear forensic evidence from Dr. Cantrell and Dr. Tate compel this conclusion.

ISSUE 2: Whether Employee was permanently and totally disabled?

Missouri courts have routinely required that the permanent nature of an injury be shown to a reasonable certainty, and that such proof may not rest on surmise and speculation. Sanders v. St. Clair Corp., 943 S.W.2d 12, 16 (Mo.App. S.D. 1997). A disability is "permanent" if "shown to be of indefinite duration in recovery or substantial improvement is not expected." Tiller v. 166 Auto Auction, 941 S.W.2d 863, 865 (Mo.App. S.D. 1997).

The standard for determining whether Claimant was permanently and totally disabled is whether the person is able to compete on the open job market, and the key test to be answered is whether an employer, in the usual course of business, would reasonably be expected to employ the person in his present physical condition. Joultzhouser v. Central Carrier Corp., 936 S.W.2d 908, 912 (Mo.App. S.D. 1997). "Total disability" is defined as the inability to return to any employment and not merely the inability to return to the employment in which the employee was engaged at the time of the accident. Section 287.020.7, RSMo 2000. The test for permanent total disability is whether, given the claimant's situation and condition, he or she is competent to compete in the open labor market. Sutton v. Masters Jackson Paving Co., 35 S.W.3d 879, 884 Mo.App. 2001). The question is whether an employer in the usual course of business would reasonably be expected to hire the claimant in the claimant's present physical condition, reasonably expecting the claimant to perform the work for which he or she is hired. Id.

Employee's extensive and severe injuries, treatment, complications, and complaints are compelling evidence of total disability. Employer continued to provide total disability benefits for seven years after its own authorized physician placed Employee at MMI. The Employer provided funds for Employee to purchase a new home in order to accommodate his disabilities and limitations.

Employee's parents testified as to the near-constant care and assistance Employee needed with everyday activities. Employee's mother testified how she had to stimulate her son's bowel movements (Ex. 13, p. 49), that "spasms always controlled Mike" (Ex. 13, p. 52), and that Employee would "limit how many people he came in contact with" because of his physical mobility problems (Ex. 13, p. 52). Employee's father stated that Employee's pain "stayed the same pretty much" throughout the years after 2001. (Ex. 12, p. 47.) His mother stated that even in the new home with accessibility accommodations, Employee did not really live completely

independently. When asked if Employee was able to live in the house and take care of his needs, she replied:

> But we got Mike's groceries. You know what I'm saying? We did his groceries. I did his house cleaning. We'd go have dinner with him. You know, his dad stayed with him for—I don't know—seven or eight months after his surgeries. And there were so many times—so many surgeries. I don't know that Mike really ever had the opportunity to be by himself because of the surgeries. And again, his dad and I did his bowel routines. You know, we were out there every other night. (Ex. 13, p. 40, 41.)

Employee's father testified that he would stay with Employee five days a week, around the clock, to assist him, and Employee's mother would stay with him the other two days. (Ex. 12, p. 24.) Employee's father also testified that Employee would fall out of his wheelchair often. He described one incident where he (the father) was not present, and Employee's mother had to back-up a van onto the lawn and Employee pulled himself and crawled onto a wheelchair lift. (Ex. 12, p. 41.) Employee's father further testified, "And I was called home many a times when he was in my living room…And he would be bad—he would be laying on his back because he fell out of a chair or something." (Ex. 12, p. 41.)

The defense argues that a discussion of permanent disability would be premature, and based solely on conjecture and surmise because Employee never reached a point of maximum medical improvement. If the claimant never attained maximum medical improvement from the March 26, 1999 work injury, a determination of the extent of his permanent disability would be conjecture and speculation. Therefore, the defense contends that the claimant is unable to meet his burden of proof to a reasonable probability that Employee was permanently and totally disabled prior to his death in 2008. Further, the defense argues that Employee also required near-constant care for basic personal needs and activities of daily living. No employer would be able to provide the kind of accommodations that Employee would require and meet his daily needs. His physical limitations were matched by severe ongoing symptoms that were themselves extremely limiting and prevented him from finding and maintaining employment. However, this point was discussed above and found that the claimant had reached maximum medical improvement.

The forensic evidence has multiple views on whether the Employee was employable. Dr. Cantrell opined that the claimant could perform sedentary employment:

> Although it is my understanding that Mr. Agnew did not pursue or obtain any gainful employment after release from me at maximum medical improvement in November of 2001, it remains my opinion that given his diagnosis of a T6 incomplete spinal cord injury, Mr. Agnew would have been capable of functioning at a sedentary level. (Ex. 15-A.)

Dr. Cantrell testified "chronic pain" would not, in and of itself, preclude employment. Even addicts are not necessarily precluded from employment until it reaches a point that it adversely affects their work.

The defense vocational expert, Donna Abram, was able to interview the Employee and review his medical records. She contended that Employee could have "possibly" been placed in employment, even with the extremely serious and numerous physical injuries and complications that he suffered. However, she also testified that the claimant's employability had very apparent constraints based upon the facts. For instance, she testified that Employee "had periods that were very good and there were periods that were very bad, and they fluctuated and the length of time fluctuated…" (Ex. 18, p. 43.) (Ex. 18, p. 45.) Ms. Abram also testified that, from her review of the medical records, she believed Employee's level of functioning "continued to switch from functioning to nonfunctioning throughout his life," and that the waxing and waning of function level "would be a definite hindrance to placeability and it would make it almost impossible for him to maintain a job." (Ex. 18, p. 53-54.) She also testified that when she last saw Employee in 2002, he was not employable or suitable for vocational rehabilitation. She testified that she did not think there would be any significant treatment after the 2001 MMI that would change Employee's level of functioning "in any important way." Finally, she testified that it would be almost impossible for Employee to maintain a job. (Ex. 18-5, p. 31.) Although she actually worked with Employee for eight months in 2002, she testified that she was not able to continue working with him because of his medical status—that he was not a good candidate for vocational rehabilitation at that time. (Ex. 18, p. 39-40.) Her later opinion that "vocational rehabilitation could have been very appropriate" was given 12 years after she had last seen Employee. (Ex. 18, p. 41.) Ms. Abram testified:

> With pain control, it is possible that he would have been placeable. From a vocational perspective, I cannot state to what level "possibly" being placeable would change into "probably" placeable. There are too many factors that I did not have the opportunity to assess due to his death. I regret I cannot provide a more definitive opinion as to whether or not it would have been likely that he would have returned to work." (Ex. 18-5, p. 10.)

On the other hand, Timothy Lalk, another vocational counselor, reviewed the claimant's medical and vocational records after death and opined that Employee was "unable to secure and maintain employment" in 2001 and remained so through his death in 2008. (Ex. B-2, p. 28.)

> Because his symptoms and limitations prevented him from not only working at a sedentary level of physical exertion but also prevented him from pursuing a training program, it is my conclusion that Mr. Agnew was totally disabled from the time of his injury through 11/22/08. As long as his symptoms and limitations persisted, he would remain totally disabled. If it is a medical decision that his condition was permanent from 11/21/01 [sic] through 11/22/08 then I would conclude from a vocational rehabilitation perspective that he was permanently and totally disabled. (Ex. B-2, p. 28.)
>
> As I have outlined above, the symptoms and limitations described in the medical records due to the injury of 3/26/99 prevented him from competing for, finding and maintaining employment in the open labor market from the time of his injury through the date of 11/21/01 [sic], when Dr. Cantrell placed him at maximum medical improvement and on to his death on 11/22/08. (Ex. B-2, p. 28.)

Based on the weight of the factual and forensic evidence, Employee was not able to find or maintain employment in the open labor market and was therefore permanently and totally disabled.

ISSUE 3: Dependency under *Schoemehl*

Employee amended the original Claim for Compensation on May 7, 2009 to allege permanent total disability and list dependents, Kristen J. Agnew (wife) and Logan Agnew (son). The Amended Claim for Compensation was silent as to whether the injury resulted in death. A Suggestion of Death and Substitution of Parties was filed concurrently on behalf of Kristen J. Agnew and Logan Agnew. Kristen J. Agnew married Michael C. Agnew in August 2006 (Exhibit 9, 10), seven years after the work injury.

Ivra J. Cross, State Registrar for the Missouri Bureau of Vital Records, testified regarding the Birth Certificate of Logan Agnew (Exhibit 2). The original birth certificate of Logan Zachary Hartman-Agnew did not list the Father's Name. It was later amended by Paternity Affidavit on June 12, 2003 (Exhibit 2, p. 14). By Paternity Affidavit, the father's name, father's date of birth and father's birth place were amended in 2003 (Exhibit 2, p. 11). The Father's Name listed on Logan Agnew's birth certificate is Michael C. Agnew, date of birth May 11, 1976.

Under Missouri Workers' Compensation Law §287.240(4), the word 'dependent' is defined to mean a relative by blood or marriage of a deceased employee, who is actually dependent for support, in whole or in part, upon the Employee's wages at the time of the injury. "As such any 'dependent' would have to be born and dependent at the time of the injury." *Schoemehl*, 217 S.W.3d at 902. The plain language of the statute "states an employee's dependents are determined 'at the time of the injury' and includes as a dependent a [child] of an injured worker." *Gervich v. Condaire, Inc.*, 370 SW3d 617, 622 (Mo. Banc 2012). Therefore, when an injured worker dies, dependent status is determined at the time of the injury, not the time of death." Id.

On the date of Employee's work accident, March 26, 1999, he was unmarried and had one child. By Paternity Affidavit filed with the State of Missouri, on June 12, 2003, the birth certificate of Logan Zachary Hartman-Agnew, born July 23, 1996, was amended to document Michael C. Agnew as father.

Logan Agnew is now, and was at the time of the work injury of March 26, 1999, the sole total dependent of Employee Michael C. Agnew. Under *Schoemehl*, Logan Agnew is the only dependent entitled to future benefits, if any are awarded.

ISSUE 4: Temporal application of the Schoemehl Doctrine

In *Bennett v. Treasurer of the State of Missouri*, 271 S.W.3d 49 (Mo.App.W.D.2008), the Court of Appeals held that recovery under *Schoemehl* was limited to claims for permanent total disability benefits that were pending between January 9, 2007, the date when the Supreme Court issued its Opinion in *Schoemehl*, and June 26, 2008, the effective date of House Bill 1883. Within this context, a workers' compensation claim for permanent total disability benefits is "pending" when it is before the Division, the Commission, or is on appeal to the Court of

Appeals or Supreme Court. *Bennett*, 271 S.W.3d at 53; *Strait*, 257 S.W.3d at 602. Thus, *Schoemehl* does not apply to claims for compensation that were not pending, and were closed prior to the issuance of the Supreme Court's decision on January 9, 2007.

The operative timeline in this case is that Employee's original Claim for Compensation was filed on March 13, 2000 for injuries to the body as a whole, temporary total disability benefits and medical care (Exhibit 1). House Bill 1883 became effective on June 26, 2008. Employee died on November 22, 2008. See Exhibit 3. The Amended Claim for Compensation alleging permanent total disability benefits was filed on May 7, 2009 (Exhibit 1).

On this point, *Schoemehl* temporally applies to this case. Employee filed his Claim for Compensation, and it was received by the Division of Workers' Compensation on February 17, 2000. Therefore his claim was pending between the January 9, 2007 *Schoemehl* decision and the June 26, 2008 statutory abrogation date. The defense argues in its brief that the amended claim was filed nearly one year after the window closed and that *Schoemehl* cannot apply without a claim for permanent total disability pending prior to June 26, 2008. On the other hand, the claimant could not have amended the claim alleging that he was the employee before the now deceased Employee's death. The amended claim relates to the same event or transaction as the original claim and to the same state of facts. It would appear that either the amended claim relates back to the original claim or that the original claim is sufficient to constitute the claim upon which to render compensation in this case from a temporal aspect.

ISSUE 5: Was Employee's Death Related to the Accident?

The critical issue and most difficult question in this case is whether the Employee died as a result of the accident or the effects of the accident. By virtue of the claimed benefits, Employee must meet his burden of proof not only for permanent total disability, but also for lifetime benefits as a result of an unrelated death. In *Schoemehl*, the Supreme Court held the right to compensation for the permanent total disability of an injured employee, who dies from causes unrelated to their work injury, survives to the dependents of the injured employee. *Schoemehl*, 217 S.W.3d at 901-902. There was no discussion as to when the death occurred or number of weeks from the date of injury. The inquiry focused on whether the injured worker died from causes unrelated to the work injury. Where this is the case, the worker's dependents assume his or her place and become the "employee" for purposes of receiving permanent total disability benefits. *Id. Schoemehl* required that permanent total disability benefits be paid not only during the lifetime of the injured employee, but also over the lifetime of any of the employee's surviving dependents. *Schoemehl*, 217 S.W.3d at 903, 135.

In *Schoemehl*, the parties stipulated Employee died of a cause unrelated to his work injury. *Id.* at 635. This appears to be a novel issue, because no claims for *Schoemehl* benefits presented to the Supreme Court have addressed relatedness of the death as an issue. The Court came close to addressing the issue in *Taylor v. Ballard R-II School District*, 274 S.W.3d 629 (Mo.App. W.D.2009). The employer argued that *Schoemehl* was not dispositive due to a significant factual difference and alleged that Taylor's death was related to her work injury. Procedurally, the Western District could not reach the issue in *Taylor*, because Employer's appeal asked the court to revisit a question of fact. Due to a determination by the Labor and Industrial Relations Commission finding the work injury did not cause the employee's death, the

court was prohibited from reaching the issue. The issue of death related to the work injury in the context of *Schoemehl* benefits is a novel issue of law.

The Court recently contemplated the impact of determining relatedness of death to the work injury in *Spradling v. Treasurer of Missouri* 413 S.W.3d 126 (Mo.App. S.D. 2013), in which a concurring opinion lamented "that our constitutional obligation to follow *Schoemehl*, **…** now requires this Court to affirm what I consider to be the unreasonable result of awarding lifetime benefits to surviving dependents where the employee's death was *unrelated to* the work injury, when the surviving dependents would have only received benefits during the time of their dependency if the employee's death had been *caused by* the work injury." *Id*. at

Both parties in this case seek to impose limitations on the opposing party based on Section 287.020.4, which states, "'Death' when mentioned as a basis for the right to compensation means only death resulting from such violence and its resultant effects occurring within 300 weeks after the accident; except that in cases of occupational disease, the limitation of 300 weeks shall not be applicable." The claimant argues that the cause of Employee's death is moot and the issue of death causation is precluded as a matter of law, pursuant to the "300-week rule of the Workers' Compensation Act." The claimant relies on *Greenlee v. Dukes Plastering Service*, 75 S.W.3d 273, 278 (Mo. banc 2002), in which the Missouri Supreme Court heard a case in which the widow of an employee who had sustained a head injury claimed that the employee developed psychological problems which lead to his suicide, therefore his death was related to and caused by the work accident. The Court held that there was simply too much time between the work accident and the death to support a causal connection, and that the legislature had a rational basis for adopting the"300-week rule:"

> Death benefits under worker's compensation are only available if an employee dies from injuries sustained on the job either in an accident or through the contraction of an occupational disease. Where death occurs at or near the time of an accident, the connection between the accident and the death is readily identifiable and competent evidence can be introduced to establish causation. As time passes, however, the connection between a work accident and a subsequent death becomes unclear as other factors can intervene and contribute to an employee's death. *Greenlee v. Dukes Plastering Service*, 75 S.W.3d 273, 278 (Mo. banc 2002).
>
> The connection between a work accident and death after such a lapse in time could rationally be determined to be too tenuous to allow. Despite any incidental inequality that might result, we cannot say that the three hundred-week requirement is an irrational restriction. The three hundred-week requirement of Section 287.020.4 does not violate equal protection. *Id*.

The case is not directly on point, because the *Greenlee* case involved death benefits not the permanent total benefits sought by the claimant in this case. On the other hand, Employer argues that Claimant seeks recovery based on the death of Employee and that the death was over 300 weeks from the date of the accident. Therefore, Employer concludes that the employee is barred from recovery under the 300 week rule. However, the claimant here seeks permanent total disability benefits, because he is the "employee" in this case is not seeking death benefits. Thus,

he is seeking to recover benefits based Employee's permanent total disability not on Employee's death "as a basis for the right to compensation."

Unfortunately, the 300-week rule does not dispose of this case in favor of either party and a protracted review of the factual and forensic evidence is required. Both parties have submitted competent forensic experts that have offered qualified opinions on the question. Employer argues in its well written brief, "Employee's physical pain continued undiminished from the time of his original injury, renewed at every complication. His physical and psychological pain caused him to seek alternate pain remedies, including cocaine. A combination of his prescribed medications and illicit drug use ultimately lead to his death in 2008." The defense bases its position on forensic medical conclusions from Dr. Cantrell and Dr. Stillings that Employee's death resulted from an overdose of both cocaine and difluoroethane which was a suicide causally related to his work injury and the complications he suffered from chronic long-term uncontrolled pain and spasticity from the time of his injury to his death in 2008.

On the other hand, Claimant argued in a well written brief that Employee died of acute intoxication of cocaine and difluoroethane based on forensic medical opinions from Dr. Wolfgram and Dr. Pelikan with medical records that suggests that Employee had a history of using illegal drugs prior to the work accident and that he was an established drug user well before, and independent of, the work accident. Dr. Swarm, at the BJC Pain Management Center (December 7, 2006 note), diagnosed a "history of cocaine abuse" and noted that Employee reported cocaine use several years before the work accident. (Exhibit B-2, page 16, and Exhibit 22.) In addition, Employee was in a relationship with Kathleen Hartman, the mother of their child, Logan Hartman-Agnew, prior to the work accident. She testified that she met Employee in 1995 when they were both 18 and 19 years old and that their relationship ended a few months after their son was born in 1996. (Ex. 11, p. 20-21.) Ms. Hartman also testified that when she met Employee in 1995, he was using drugs, and she personally witnessed him using marijuana and cocaine in 1995 and 1996. (Ex. 11, p. 25-26.) She admitted using marijuana with Employee on a weekly basis in 1995-96. (Ex. 11, p. 28-29.) She also suspected Employee was using other drugs, possibly heroin. (Ex. 11, p. 27.) On the other hand, Ms. Hartman is the mother of the Employee's only dependent in this case. However, the defense produced no contrary evidence relating to the claimant's pre-existing condition.

The defense presented a document that it contended was a suicide note prepared by the now deceased Employee, but offered no foundation to support the legitimacy of the document, not even a handwriting analysis. See Exhibit 14. Without additional foundation to support the relationship of the document to the decedent, the document has limited credibility and weight.

The facts suggest that the Employee died of acute intoxication of cocaine and difluoroethane. See Exhibit 3. The Employee had a history of cocaine abuse that predated the work-related accident in 1999. The Employee had a medical plan for medical regulation of pain. The use of cocaine was not part of any medical plan for treatment of the Employee's pain from the accident. The conclusion is that the Employee had a pre-existing history of cocaine abuse that appears to have continued and resulted in the Employee's demise. This assumes that long-term use of cocaine can result in increased demand for the substance and interfere with more reasoned instructions to refrain from use of cocaine. In addition to these assumptions, the medical examiner's conclusions also weigh heavily in this result.

Costs

If the division or commission determines that any proceedings have been brought, prosecuted or defended without reasonable ground, it may assess the whole cost of the proceedings upon the party who so brought, prosecuted or defended them. Section 287.560, RSMo 2000. The courts have set forth the standard for determination.

> The record unequivocally demonstrates that the employer has offered absolutely no ground, reasonable or otherwise, for its refusal to pay the … benefits it clearly owed. The record also reflects that no basis for such a refusal could be offered, for the statute is clear and the facts supporting the obligation are uncontested. Stillwell v. Universal Const. Co., 922 S.W.2d 448, 457 (Mo.App. W.D. 1996).

The defense contends that placing the deceased employee's after acquired spouse on the claim constitutes prosecution of a claim without reasonable grounds. The deceased employee's after acquired spouse did not recover, but the other named dependent did recover. The total amount of benefits awarded in this case is the same regardless of the number of qualified dependents. Furthermore, the legal analysis would be the same regardless. Finally, the additional time and attorney's fees expended by Employer in addressing whether one or two dependents are qualified to recover under *Schoemehl* is negligible, if not absent altogether—and Employer has not submitted any evidence which would itemize, describe, or explain such fees or costs. The claim is certainly not prosecuted without reasonable ground, and the claim presents novel questions arising out of the particular factual pattern, according to the defense brief.

The claimant suggests that the claim was defended without reasonable grounds:

> As previously stated, the cause of Employee's death cannot be used by the Employer in an attempt to avoid any liability that would be due under *Schoemehl*, pursuant to the "300-week rule" in RSMo Sec. 287.020.4. Although it was not the responsibility of the Employee to notify the Employer of this statutory preclusion in the controlling law, Employee's Counsel did in fact give written notice to Employer's Counsel in a certified letter dated October 9, 2012, and again by in another letter on October 18, 2012. See Claimant's Brief.

Certainly, the evidence in this case shows that the defense compelled the claimant to strictly show each and every element necessary to prevail. The defense certainly had every right to contest the eligibility of the deceased employee's after acquired spouse to recover and prevailed on that issue. This section requires that the claim be defended without reasonable ground. At this point, one cannot determine the ultimate outcome, because the claim presented novel questions that may or may not support this opinion on appeal. The claimant's attorneys expended 141.4 hours of legal time at $195.00 per hour ($27,793.00) for Attorney Fees and $14,472.18 for legal expenses including deposition and expert witness fees, for a total of $42,265.18 to prepare this case for the hearing. See Exhibit G. The Motions for Costs are denied.

SUMMARY

Employee Michael Agnew sustained serious injuries in a compensable work accident on March 26, 1999. He reached maximum medical improvement as of November 12, 2001. At that time, he was, and remained until his death, permanently and totally disabled. On the March 26, 1999 date of accident, Employee had a dependent son, Logan Hartman-Agnew. Employee's Claim for Compensation was filed on February 17, 2000 and was pending during the operative period of *Schoemehl* as the controlling law (between January 9, 2007 and June 26, 2008).

Employee died on November 22, 2008, of acute intoxication of cocaine and difluoroethane. The accident in 1999 was not a substantial factor causing the Employee's fatal acute intoxication of cocaine and difluoroethane.

Since Employee's claim was pending during the operable period of *Schoemehl*, and since he had a dependent son on the date of accident, *Schoemehl* and its progeny apply, and Employee's dependent son is entitled to receive permanent total disability benefits, past and future, as the Employee in this case for the remainder of the dependent son's lifetime.

Both Motions for Costs are denied. The attorneys for both parties submitted unusually well written, well reasoned, and exceptionally insightful briefs and should be commended for their professionalism.

Made by: s/s EDWIN J. KOHNER
EDWIN J. KOHNER
Administrative Law Judge
Division of Workers' Compensation