

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

Injury No.: 07-130590

Employee: Kristine Gibbons
Employer: St. Louis University Hospital
Insurer: American Home Assurance Company
Additional Party: Treasurer of Missouri as Custodian
of Second Injury Fund

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 June 19, 2012, and awards no compensation in the above-captioned case.

The award and decision of Administrative Law Judge John K. Ottenad, issued June 19, 2012, is attached and incorporated by this reference.

Given at Jefferson City, State of Missouri, this 10th day of January 2013.

LABOR AND INDUSTRIAL RELATIONS COMMISSION

V A C A N T
Chairman

James Avery, Member

Curtis E. Chick, Jr., Member

Attest:

Secretary

AWARD

Employee: Kristine Gibbons

Injury No.: 07-130590

Dependents: N/A

Employer: St. Louis University Hospital

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

Additional Party: Second Injury Fund

Insurer: American Home Assurance Company
C/O Specialty Risk Services, LLC

Hearing Date: January 18, 2012
Record Closed on February 17, 2012

Checked by: JKO

FINDINGS OF FACT AND RULINGS OF LAW

1. Are any benefits awarded herein? No
2. Was the injury or occupational disease compensable under Chapter 287? No
3. Was there an accident or incident of occupational disease under the Law? No
4. Date of accident or onset of occupational disease: (alleged) March 15, 2007
5. State location where accident occurred or occupational disease was contracted: St. Louis City
6. Was above employee in employ of above employer at time of alleged accident or occupational disease? Yes
7. Did employer receive proper notice? No
8. Did accident or occupational disease arise out of and in the course of the employment? No
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: Claimant was employed as a care partner for Employer and allegedly injured her low back while trying to help restrain a very combative patient, while they were trying to place a central line in her right leg.
12. Did accident or occupational disease cause death? No Date of death? N/A
13. Part(s) of body injured by accident or occupational disease: (alleged) Body as a Whole—Lumbar Spine
14. Nature and extent of any permanent disability: N/A
15. Compensation paid to-date for temporary disability: \$0.00
16. Value necessary medical aid paid to date by employer/insurer? \$0.00

Employee: Kristine Gibbons

Injury No.: 07-130590

- 17. Value necessary medical aid not furnished by employer/insurer? N/A
- 18. Employee's average weekly wages: \$509.96
- 19. Weekly compensation rate: \$339.97 for TTD/ \$339.97 for PPD
- 20. Method wages computation: By agreement (stipulation) of the parties

COMPENSATION PAYABLE

21. Amount of compensation payable:

Claim denied	\$0.00
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22. Second Injury Fund liability:

Claim denied by virtue of having no compensable primary injury	\$0.00
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<u>TOTAL:</u>	<u>\$0.00</u>
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23. Future requirements awarded: None

Said payments to begin immediately 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: Thomas J. Gregory.

FINDINGS OF FACT and RULINGS OF LAW:

Employee:	Kristine Gibbons	Injury No.: 07-130590
Dependents:	N/A	Before the
Employer:	St. Louis University Hospital	Division of Workers'
Additional Party:	N/A	Compensation
Insurer:	American Home Assurance Company	Department of Labor and Industrial
	C/O Specialty Risk Services, LLC	Relations of Missouri
		Jefferson City, Missouri
		Checked by: JKO

On January 18, 2012, the employee, Kristine Gibbons (Claimant), appeared in person and by her attorney, Mr. Thomas J. Gregory, for a hearing for a final award on her claim against the employer, St. Louis University Hospital, and its insurer, American Home Assurance Company C/O Specialty Risk Services, LLC. The employer, St. Louis University Hospital, and its insurer, American Home Assurance Company C/O Specialty Risk Services, LLC, were represented at the hearing by their attorney, Mr. Hugh S. O’Sullivan. The Second Injury Fund is a party to this case and was represented at the hearing by Assistant Attorney General Da-Niel Cunningham.

To allow the parties time to prepare and file their proposed awards or briefs in this matter, the record did not technically close until February 17, 2012. Although we did not go back on the record or take any further evidence in this matter after the initial hearing date, the record was, then, closed on that date and the briefs were submitted by the parties on February 27, 2012, after an extension beyond the initial due date for the briefs was requested and granted.

At the time of the hearing, the parties agreed on certain stipulated facts and identified the issues in dispute. These stipulations and the disputed issues, together with the findings of fact and rulings of law, are set forth below as follows:

STIPULATIONS:

- 1) On or about March 15, 2007, Kristine Gibbons (Claimant) allegedly sustained an accidental injury.
- 2) Claimant was an employee of St. Louis University Hospital (Employer).
- 3) Venue is proper in the City of St. Louis.
- 4) The Claim was filed within the time prescribed by the law.

- 5) At the relevant time, Claimant earned an average weekly wage of \$509.96, resulting in applicable rates of compensation of \$339.97 for total disability benefits and \$339.97 for permanent partial disability benefits.
- 6) Employer has not paid any benefits to date.

ISSUES:

- 1) Was there an accident under the statute?
- 2) Did the accident arise out of and in the course of employment?
- 3) Are Claimant's injuries and continuing complaints, as well as any resultant disability, medically causally connected to her alleged accident at work?
- 4) Did Claimant provide Employer with proper notice of the injury under the statute?
- 5) Is Claimant entitled to payment for past medical expenses in the stipulated amount of \$10,516.58?
- 6) Did Claimant ever request medical treatment from Employer in connection with her alleged injury at work?
- 7) Is Claimant entitled to future medical treatment as a consequence of her alleged accidental injury at work?
- 8) Is Claimant entitled to the payment of temporary total disability benefits for a period of time to be determined?
- 9) What is the nature and extent of Claimant's permanent partial or permanent total disability attributable to this alleged accidental injury?
- 10) What is the liability of the Second Injury Fund?

EXHIBITS:

The following exhibits were admitted into evidence:

Employee Exhibits:

- A. Medical treatment records of Dr. E. Charles Robacker
- B. Medical treatment records (outpatient physical therapy) of St. Elizabeth's Hospital
- C. Medical treatment records (inpatient hospitalization from May 28, 2008 to June 2, 2008) of St. Elizabeth's Hospital

- D. Medical treatment records (inpatient hospitalization from July 1, 2009 to July 6, 2009) of St. Elizabeth's Hospital
- E. Medical treatment records of Chestnut Health Systems
- F. Itemized list of, and copies of, medical treatment bills for this alleged injury
- G. Deposition of Dr. David Volarich, with attachments, dated December 4, 2009
- H. Deposition of Dr. Wayne Stillings, with attachments, dated December 16, 2009
- I. Deposition of Mr. James England, with attachments, dated September 21, 2010

Employer/Insurer Exhibits:

- 1. Certified medical records of St. Louis University Hospital's Employee Health Department
- 2. Deposition of Dr. Stacey Smith, with attachments, dated July 14, 2011
- 3. Deposition of Dr. Sherwyn Wayne, with attachments, dated July 22, 2011
- 4. Deposition of Mr. James Stenger, with attachments, dated October 25, 2011
- 5. Deposition of Ms. Mary Beth Deines, with attachment, dated November 4, 2011
- 6. Deposition of Mr. Aaron Herr dated January 16, 2012

Second Injury Fund Exhibits:

Nothing offered or admitted at the time of trial

Notes: 1) Unless otherwise specifically noted below, any objections contained in the exhibits are overruled and the exhibits are fully admitted into evidence in this case.

2) Some of the records submitted at hearing contain handwritten remarks or other marks on the exhibits. All of these marks were on these records at the time they were admitted into evidence and no other marks have been added since their admission on January 18, 2012.

EVIDENTIARY RULINGS:

In the deposition transcript and at the trial when Employer offered Exhibit 5, the deposition testimony of Ms. Mary Beth Deines, into evidence, Claimant objected to the admission of the attached exhibit, and any testimony regarding or based on that deposition exhibit.

The attached exhibit to that deposition, marked at the deposition as Exhibit A, is an undated, handwritten note allegedly concerning Claimant and her alleged injury at work. Ms. Deines identified the note as being in her handwriting, but she was unable to determine when she allegedly wrote the note. She surmised that she must have written the note in 2007, but could not determine exactly when. She could not certify whether she created this note all at one time, or added multiple entries over time. It was not even clear where this note was kept over the years, whether in Ms. Deines' files or in Claimant's personnel file. However, regardless of which file it

may have been kept in, there were no other file contents offered or disclosed to help authenticate this document. In reviewing the handwritten note, not only is there no date and no indication of where it may have been kept over the years, but there is also no clear indication that this note concerns Claimant, as opposed to any other employee. I could not find anywhere in the handwritten note where Claimant was named as the individual about which this note was written.

On the basis of all these factors, Claimant's objections regarding the admissibility of this handwritten note (Exhibit A attached to Exhibit 5) and any testimony referencing the note itself, are **SUSTAINED**. The note and only the testimony of Ms. Deines regarding the note are not admitted into evidence in this case, and will not be considered when reaching my conclusions in this matter. However, the rest of the testimony of Ms. Deines regarding her personal recollections and interactions with Claimant, as well as her testimony about her duties and position of responsibility at Employer, are properly admitted into evidence in this case.

FINDINGS OF FACT:

Based on a comprehensive review of the evidence, including Claimant's testimony, the medical records and bills, the medical/psychiatric opinions and testimony, the vocational opinion and testimony, and the testimony of the other witnesses, as well as based on my personal observations of Claimant at hearing, I find¹:

- 1) **Claimant** is a 47-year-old woman, who testified that she last worked for St. Louis University Hospital (Employer) as a care partner from April 2006 until February 2008. In her position as a care partner, Claimant was responsible for assisting patients (cleaning them or turning them), taking blood pressure, working with catheters, drawing blood and taking vital signs. She said that she basically did everything except administer medications.
- 2) Claimant testified that she left high school in the eleventh grade, but later obtained a GED. She began a course of study at Sanford-Brown to become an LPN, but she never completed the program and earned no certificates or degrees. She indicated that she dropped out of the program when her house burned down.
- 3) In terms of work history, Claimant testified that prior to her work as a care partner for Employer, she has worked in various positions, including the following: A server or bartender at various restaurants or bars; taking care of patients in their homes for a home health care company; putting soles on military boots at a shoe factory; and stocking shelves and waiting on customers at a small store.
- 4) Claimant testified at hearing that she had symptoms of low back pain that caused her to seek medical treatment prior to her alleged accident at work in 2007. She said that she could not remember when the episodes of back pain started, but she estimated it was "probably a couple" years before she started working for Employer. She agreed that it may have been back to 1998 or 1999. She acknowledged that she took pain

¹ Only those facts relevant to the determination of this case, and upon which I am basing my rulings of law in this matter, are included in this findings of fact.

medications for her back complaints and that she received an injection in 2003. Claimant testified that in 2006, her low back complaints worsened in frequency and intensity, requiring her to seek increased pain medications and visits with Dr. Robacker. She said that her back pain increased as a result of lifting the patients at work for Employer prior to her alleged injury in 2007.

- 5) In addition to her prior low back complaints, Claimant testified that she also received treatment for depression and various other psychiatric conditions prior to her alleged injury at work in 2007. Claimant said that she had problems with depression in childhood, but she never received any treatment for it. She was first prescribed medications for depression (postpartum depression) after the birth of her second daughter in 1988. She said she began treating with Dr. Robacker in 1999 for prenatal examinations for the daughter she gave up for adoption, and received various medications from him over the years for various psychiatric diagnoses, including depression and bipolar affective disorder.
- 6) Claimant testified that prior to her alleged injury in 2007, she was never hospitalized for her psychiatric issues and she never had any suicide attempts. She said that she was able to function with her psychiatric issues, but she would have moments of crying and not feeling great that caused her to miss some time from work. She said that she lost jobs over the years because of missing work attributable to the depressive symptoms.
- 7) Claimant testified that she also had a history of cocaine use in the past. She said that she used cocaine on a daily basis during periods of time from 1988 to 1992, when she was 24 to 28 years old. She testified that she had not used cocaine for a couple years before her alleged injury in 2007. She said that she just quit and switched her job, friends and everything to stop the cocaine use.
- 8) Medical treatment records from her personal treating physician, **Dr. E. Charles Robacker** (Exhibit A), document the extensive treatment he provided for Claimant's various conditions from 2000 through the time of her alleged injury in 2007 and for a number of years thereafter. In a note dated May 19, 2000, Claimant reported increasing back pain, which had been present for several years, for which he began prescribing Vicodin. The note from September 25, 2000 contained a complaint that her depression was worsening. She also admitted her history of cocaine use and that she had used only two weeks prior to that examination. It was at that point that Dr. Robacker began prescribing psychiatric medications. In the years that followed, she was basically maintained on some type of psychiatric medication, although the medications prescribed were changed and various diagnoses were offered, ranging from depression to manic depression to bipolar affective disorder to anxiety. The records note additional cocaine use in January 2002. On June 26, 2002, the records indicate that she was seen with complaints of paresthesias of the face and left lower leg. On August 5, 2003, she again complained of back pain and was sent for an injection to St. Elizabeth's Hospital. On November 14, 2003, she was treated for chest pain. On February 26, 2004, Claimant reported back pain from a recent fall, for which Dr. Robacker began prescribing Flexeril and Ultram.

- 9) In early 2006, Dr. Robacker (Exhibit A) began prescribing Darvocet and in a note dated March 22, 2006, recorded Claimant's complaints of acute low back pain with radiation into the left leg. X-rays of the lumbar spine showed only minimal degenerative changes with no acute abnormality. In the months that followed, even into late 2006, Claimant received a number of refills for Darvocet.
- 10) Prior to beginning her employment for Employer, Claimant had a pre-employment physical performed at **St. Louis University Hospital's Employee Health Department** (Exhibit 1) on May 10, 2006. In the medical history section of the examination, which Claimant apparently filled out and signed, she denied any current complaints or any history of mental trouble, chest pain, back pain, back injury, lumbar strain or recreational drug use. In terms of medications, she only listed Lamisil and hydrocodone for a tooth removal, which she was no longer taking.
- 11) Claimant testified at trial that she had just come on duty on March 15, 2007 and she was helping to restrain a very combative patient, who was having a central line placed in her right leg, when she injured her back. She said that she remembered twisting and turning to the left and she heard something pop. She did not know if he kicked or not, but she was trying to restrain his left leg by the hip or knee and there were two others trying to restrain him, with six doctors working on him. She said that she felt pain on the left side of her low back. She continued working for a few hours, then started hurting worse and had to go home. Claimant testified that she told a co-worker, Lynetta, who was standing by her when it happened, "I don't think that was good." Employer's records confirm that Claimant left early, however, the reason in the records that Claimant apparently provided for why she needed to go home was, "FAMILY EMERGENCY" (Exhibit 4).
- 12) Claimant said that she told her supervisor, Kathy or Diane, that her back was hurting and she needed to go home. She admitted that she did not tell them it was work-related and she did not tell them about any alleged accident. In fact, she did not report the alleged injury to anyone she considered to be a supervisor on March 15, 2007.
- 13) Claimant testified that she did not really miss any work at first. She called the doctor for some muscle relaxers and tried to work. She said that she had a sharp, shooting pain that caused problems lifting and walking. However, her work records indicate that not only did she work her regular 12-hour shifts on March 20, 21 and 22, 2007, but she also worked an extra 12-hour shift on March 18, 2007 (Exhibit 4), before she missed any time from work following this alleged injury on March 15, 2007. Even after she started missing work, none of the entries in Employer's time records give any indication that she reported a work injury or that her absence was related to a work injury (Exhibit 4).
- 14) Claimant testified that she saw Dr. Robacker on March 27, 2007, told him about the injury and started missing time from work. She said that she called into the sick line at work and left messages that she would not be able to come to work, but she did not describe in detail what had happened. However, on cross-examination, Claimant

asserted that when she called the sick line, she would tell them that she was not coming in because of her problems from her low back resulting from the work injury. However, Employer's time records (Exhibit 4) contain absolutely no indication that she ever reported any work-related injury or problems as the reason for her need to be off work.

- 15) Claimant said that when she began missing days, sometime in early April 2007, she tried to talk to Tammy, her supervisor, but learned that she had been fired. In fact, Tammy had been fired on March 5, 2007, over a week prior to Claimant's alleged injury on March 15, 2007. Claimant then learned that her new supervisor was Aaron, and tried to contact him in early April to report her injury. She said that she did not talk to him directly, but rather left a message explaining what had happened and asking what paperwork she needed and the procedures for being off work. Claimant testified that she never received a return phone call from Aaron. She said that she did talk to a supervisor and asked about coming back to light duty, but the supervisor told her, "no," that she needed a release to full duty before she could come back. She did leave him another message in April when she was ready to return to work full duty. Even after she returned to work in April, she said that she never talked to Aaron at all about the alleged incident or her lost time. She also never filed anything in writing with Employer to notify them of the alleged injury at work.
- 16) **Aaron Herr**, who was employed by Employer as a nursing manager at or around the time of Claimant's alleged injury on March 15, 2007, testified for Employer by deposition. Mr. Herr testified that he was given administrative oversight to supervise nursing on 5-North, the floor Claimant worked on, on an interim basis in early March 2007, when the prior nursing manager for that floor departed. Mr. Herr explained the process for reporting work injuries and seeking medical treatment, once a work injury is reported to a supervisor. While Mr. Herr recalled Claimant's name, he did not recall her ever reporting a work-related back injury to him, whether by phone or in person. He admitted that he had voicemail in his office and noted that if someone called to report a work injury via telephone message, he would have contacted them to have them come in to fill out the appropriate paperwork and to get the injury evaluated. If, instead of reporting a work injury, he had received a call reporting an unrelated personal injury, he would have told them they needed a release to work without restrictions before they could come back to work.
- 17) Medical treatment records from **Dr. E. Charles Robacker** (Exhibit A) confirm that Claimant called and obtained a refill of Flexeril on March 17, 2007, but the records do not give a reason for the prescription. The records also document her visit on March 27, 2007, when she first reported "a 24 hour course of back pain (mid to lower), which was present for two days, but increased over the prior 24 hours." The history indicates that she initially had pain in all of her back for 1.5 weeks, related to restraining a patient at work 2 weeks prior. The pain was radiating into the left leg. Her current medications were listed as Darvocet and Flexeril. He took her off work for a couple days and prescribed Vicodin. By April 4, 2007, she was noted to be doing better with regard to her back pain. In a note given to Claimant, apparently for her work, dated April 5, 2007, Dr. Robacker indicated that Claimant has been treating

since March 25, 2007 for chest and back pain. He thought she could return to full-duty work on April 10, 2007. There was no reference to any work injury contained in that work excuse note.

- 18) Dr. Robacker sent Claimant for outpatient physical therapy at **St. Elizabeth's Hospital** (Exhibit B) and then later indicated that as of May 16, 2007 she could return back to regular duties at work. In the months that followed, Claimant had an MRI of the lumbar spine that showed some mild disc bulges and mild degenerative changes. She was kept on various medications, given physical therapy, injections, a TENS unit and kept off work for various periods of time.
- 19) Claimant agreed that Ms. Mary Beth Deines became the manager in late June or early July 2007. Claimant testified that she reported the injury to Ms. Deines, but she did not remember when that may have occurred. She agreed that it could have occurred as late as February or March of 2008, which was near the end of her FMLA benefits. Other than the telephone call to Mr. Herr and the conversation with Ms. Deines, Claimant denied that she ever told anyone else that she considered to be a supervisor about her alleged work injury on March 15, 2007.
- 20) **Mary Beth Deines** (Exhibit 5) testified by deposition on Employer's behalf. She admitted that she became the nurse manager of the floor where Claimant worked in Employer's hospital in early June 2007. She took over that position from Aaron Herr, the interim manager on that floor before her. She testified that during her orientation period with Aaron, she went through files and familiarized herself with the staff. She said that she never learned about any work injury that Claimant allegedly sustained on the floor during that process. Further, although Claimant continued to work under her for a number of months, Ms. Deines denied that Claimant ever reported a work injury to her, ever requested or required any work restrictions, or ever requested a referral for medical treatment for an alleged work-related back injury.
- 21) **James Stenger** (Exhibit 4) also testified by deposition on Employer's behalf. He has been employed as a nurse manager and staffing and float pool manager for Employer since January of 2005. In that position, he is very familiar with Employer's record keeping practices pertaining to attendance and work status. His review of Employer's records in that regard, revealed no indication that Claimant ever reported a work injury or reported back pain or problems from a work injury as the reason she needed to take off work in the months following the alleged accident on March 15, 2007.
- 22) Claimant testified that the pain just got too bad in February 2008 and she just could not keep working. She said that she got more injections, was hospitalized for back pain in 2009 at **St. Elizabeth's Hospital** (Exhibit D) and continues to see Dr. Robacker monthly for her pain pills. Claimant said that he prescribes Lortab, Percocet and tramadol.
- 23) The deposition of **Dr. David Volarich** (Exhibit G) was taken by Claimant on December 4, 2009 to make his opinions in this case admissible at trial. Dr. Volarich is an osteopathic physician, who is board certified in occupational medicine, nuclear

medicine and as an independent medical examiner. He examined Claimant one time on December 11, 2008, at the request of her attorney, and provided no medical treatment. He issued his report on that same date. Claimant provided Dr. Volarich with a history of the alleged injury on March 15, 2007 and she complained of low back pain radiating down the right leg greater than left, all the way to the feet. Dr. Volarich performed a physical examination, but was unable to fully and accurately determine her strength and reflexes, because of her breakaway (Claimant manipulating the test by not giving full effort) response. Dr. Volarich diagnosed and rated lumbar conditions, both attributable to the alleged injury on March 15, 2007 and to her pre-existing conditions. He placed work restrictions on her, but did not opine that she was permanently and totally disabled.

- 24) The deposition of **Dr. Wayne Stillings** (Exhibit H) was taken by Claimant on December 16, 2009 to make his opinions in this case admissible at trial. Dr. Stillings is a board certified psychiatrist, who examined Claimant one time on June 15, 2009 at the request of Claimant's attorney, but provided no medical treatment to Claimant. He issued his report on the same date of his examination. Claimant's history of injury, as contained in Dr. Stillings' report, is that she was kicked in the groin and knocked backwards, while restraining a combative patient. He also took a history of her pre-existing psychiatric treatment and her psychiatric treatment following the alleged injury on March 15, 2007. He diagnosed a number of psychiatric conditions, some of which he attributed to the alleged injury on March 15, 2007, and others of which pre-existed that date. Relying on her history, complaints, the medical records, her examination and her testing results, Dr. Stillings also offered ratings of disability for those various conditions and opined that she was permanently and totally disabled based on the combination of those disabilities.
- 25) The deposition of **Mr. James England, Jr.** (Exhibit I) was taken by Claimant on September 21, 2010 to make his opinions in this case admissible at trial. Mr. England is a certified vocational rehabilitation counselor. He met with Claimant one time on January 28, 2010, at the request of her attorney, to conduct a vocational rehabilitation evaluation. He issued his report dated February 1, 2010. Based on her history, complaints, medical treatment, educational background, vocational history, and based on the restrictions of Drs. Volarich and Stillings, and her description of her day-to-day functioning, he opined that absent significant improvement, she was likely to remain totally disabled from a vocational standpoint.
- 26) The deposition of **Dr. Sherwyn Wayne** (Exhibit 3) was taken by Employer on July 22, 2011 to make his opinions in this case admissible at trial. Dr. Wayne is a board certified orthopedic surgeon. He examined Claimant one time on May 26, 2009 at Employer's request, but he provided no medical treatment. Based on the history, his physical examination of Claimant and his review of the medical records, he diagnosed chronic subjective lower back pain syndrome, which was present for several years before and subsequent to the March 15, 2007 incident. He did not believe her medical findings support the extent of her ongoing subjective complaints. He believed she had multilevel, early, lumbar degenerative disc and joint disease, complicated by her mental health issues. He opined that she was capable of working based on her

physical condition, but she needed psychiatric clearance to return to her job. He did not believe there was any discrete injury attributable to (medically causally related to) the alleged March 15, 2007 event.

- 27) The deposition of **Dr. Stacey Smith** (Exhibit 2) was taken by Employer on July 14, 2011 to make her opinions in this case admissible at trial. Dr. Smith is a board certified psychiatrist. She examined Claimant one time on April 29, 2010 at Employer's request, and provided no medical treatment. She issued her report dated December 21, 2010 following her evaluation of Claimant, her review of the medical records and the testing performed by Dr. Richard Wetzel. Dr. Smith diagnosed pre-existing somatization disorder and pre-existing cocaine dependence. She saw no need for psychiatric treatment related to the alleged events on March 15, 2007, nor did she believe Claimant had any permanent partial psychiatric disability related to the alleged accident on that date. Dr. Smith explained in detail why she believed the somatization disorder diagnosis, and not a diagnosis of chronic pain syndrome with secondary depression, was the appropriate diagnosis in this case.
- 28) In terms of her current complaints, Claimant testified that she can no longer sleep on her left side at all. She said that she has problems sitting and walking and that she spends most of the day laying down. She said that although the pain was in her right leg earlier, now she has pain and problems "strictly" in the left leg. Then a few questions later, she agreed that she did also have radiation down the right leg occasionally. She described the pain as a constant ache that travels down the left leg to the foot. She said that she can only sit for a half an hour before she has to stand and that she can only walk maybe a half of a block.
- 29) I observed over the course of the hearing that Claimant basically sat absolutely still, without shifting or displaying any outward signs of discomfort, until she was asked the question about how long she could sit before she had to stand up. At that very point, she stood up for about a minute and then promptly sat back down. After taking a break at the conclusion of direct, Claimant then remained seated, again basically still without shifting or outward signs of discomfort, for almost an hour of cross-examination.
- 30) Claimant also testified that her depression worsened after her alleged 2007 injury. She said that she tried to commit suicide in 2008 and 2009 by taking overdoses of her medications. She said that the loss of income, loss of her job, and feelings of hopelessness led to her suicide attempts. She was hospitalized from May 28, 2008 until June 2, 2008 at **St. Elizabeth's Hospital** (Exhibit C) because of one of the suicide attempts. The notes indicate her low back problems basically started with her alleged work injury in 2007 and that she started using cocaine again. She also said that although she was treated for depression and bipolar disorder in the past, it was worse since her alleged injury. Claimant testified that she is now receiving regular psychiatric treatment, including therapy once a month and medications, Cymbalta and Abilify. She said that she thinks she has the thoughts of suicide under control, but she still has depression, crying spells and feelings of hopelessness.

- 31) Claimant admitted that since her alleged injury in 2007, she also has had relapses of cocaine use in 2008 and 2009. After some cocaine use in 2009, Claimant began to receive treatment at **Chestnut Health Systems** (Exhibit E) for crack and cocaine use that she had been using off and on for 20 years.
- 32) Claimant testified that she has never received any Workers' Compensation benefits and the medical bills for her treatment for this alleged injury contained in Exhibit F have not been paid. She admitted that despite allegedly leaving the message for Aaron on his voicemail that she had been hurt at work, she never asked him or anyone else at Employer to send her to a doctor or provide medical treatment.
- 33) On cross-examination, Claimant admitted that she had prior low back problems, but initially she said she could not recall if she had left leg complaints or not. Upon being presented with entries from Dr. Robacker, Claimant admitted she must have had those complaints. She also admitted that after her visits for low back and left leg complaints in March 2006, she was given pain medication and she further admitted that she continued to receive prescriptions for Darvocet and Naprosyn all the way up until her alleged March 15, 2007 injury, but she denied that she was actually taking any of the medications at the time of that alleged injury. She did not recall how long it had been that she stopped taking the medications, but she insisted that she was not taking them at the time of her alleged March 2007 injury. On cross-examination from the Fund and questions from the Court, Claimant confirmed quite clearly that although she filled that prescription in November 2006, she did not take the pills, because she said she could not take those pills and work. However, on additional cross-examination from Employer, Claimant then testified that she may have taken those pills on and off, but it was not something she used every day. Claimant admitted that both of her suicide attempts in 2008 and 2009 corresponded with a recurrence of her cocaine use. She admitted that she never told Employer about the prior low back or the recreational drug use when she was hired.

RULINGS OF LAW:

Based on a comprehensive review of the evidence, including Claimant's testimony, the medical records and bills, the medical/psychiatric opinions and testimony, the vocational opinion and testimony, and the testimony of the other witnesses, as well as based on my personal observations of Claimant at hearing, and based on the applicable laws of the State of Missouri, I find the following:

The first three issues can be addressed at the same time since they are inter-related in this case.

Issue 1: Was there an accident under the statute?

Issue 2: Did the accident arise out of and in the course of employment?

Issue 3: Are Claimant's injuries and continuing complaints, as well as any resultant disability, medically causally connected to her alleged accident at work?

Considering the date of the alleged injury, it is important to note that the new statutory provisions are in effect, including **Mo. Rev. Stat. § 287.800 (2005)**, which mandates that the Court "shall construe the provisions of this chapter strictly" and that "the division of workers' compensation shall weigh the evidence impartially without giving the benefit of the doubt to any party when weighing evidence and resolving factual conflicts." Additionally, **Mo. Rev. Stat. § 287.808 (2005)** establishes the burden of proof that must be met to maintain a claim under this chapter. That section states, "In asserting any claim or defense based on a factual proposition, the party asserting such claim or defense must establish that such proposition is more likely to be true than not true."

Under **Mo. Rev. Stat. § 287.120.1 (2005)**, every employer subject to the Workers' Compensation Act shall furnish compensation for the personal injury of the employee by accident arising out of and in the course of employee's employment. According to **Mo. Rev. Stat. § 287.020.2 (2005)**, accident is defined as "an unexpected traumatic event or unusual strain identifiable by time and place of occurrence and producing at the time objective symptoms of an injury caused by a specific event during a single work shift." Further, under **Mo. Rev. Stat. § 287.020.3(1) (2005)**, "An injury by accident is compensable only if the accident was the prevailing factor in causing both the resulting medical condition and disability. 'The prevailing factor' is defined to be the primary factor, in relation to any other factor, causing both the resulting medical condition and disability." Finally, under **Mo. Rev. Stat. § 287.020.3(2) (2005)**, an injury is deemed to arise out of and in the course of the employment only if the accident is the prevailing factor in causing the injury and it does not come from a hazard or risk unrelated to the employment to which workers would have been equally exposed outside of and unrelated to the employment.

Claimant bears the burden of proof on all essential elements of her Workers' Compensation case. *Fischer v. Archdiocese of St. Louis-Cardinal Ritter Institute*, 793 S.W.2d 195 (Mo. App. E.D. 1990) *overruled on other grounds by Hampton v. Big Boy Steel Erection*, 121 S.W.3d 220 (Mo. 2003). The fact finder is charged with passing on the credibility of all witnesses and may disbelieve testimony absent contradictory evidence. *Id.* at 199.

In order to meet her burden of proof on the presence of an accident, whether it arose out of and in the course of employment and on medical causation, Claimant needed to present credible testimony on her own behalf and also credible medical evidence to support her claim.

Considering the evidence listed above, I find that Claimant has failed to meet her burden of proving the presence of an accident, which arose out of and in the course of her employment for Employer and which produced injuries that were medically causally connected to that accident.

First, I find that Claimant failed to offer credible or reliable testimony on her own behalf on these issues. While Claimant did consistently describe an incident while she was trying to restrain a patient, the other details of the alleged accident varied slightly throughout her testimony and her descriptions of the alleged accident to the various medical providers. At trial, she said that she twisted and turned to the left and heard a pop in her back, but was not sure if she was kicked or not. However, to Dr. Stillings, she reported that she was kicked in the groin and knocked backwards. While this may seem like a minor discrepancy, it is amplified by the fact that the employment records contain absolutely no history of any work injury on March 15, 2007. In fact, those records indicate that she left early on that date for a family emergency. Even going forward from that date, for any days she may have missed from work in the months that followed, there is absolutely no indication that a work-related back injury, or any work-related injury for that matter, was ever discussed or reported. While Claimant alleges she reported it by phone to Aaron Herr and in person to Mary Beth Deines, their credible testimony does not support Claimant's assertions in that regard.

In addition to these discrepancies, I find that Claimant's descriptions of the alleged physical problems and complaints she developed on account of the alleged accident are not consistent throughout the medical records/reports or her testimony. At times, she reported left leg symptoms that occurred immediately after the alleged incident (Dr. Robacker's records) and at other times, she reported right leg symptoms were more prominent after the alleged accident (Dr. Volarich's report). At trial, she first testified that she had complaints in both legs, but by the time of trial "strictly" left leg complaints remained, until a number of questions later, when she changed that testimony to indicate that she also still had some right leg complaints.

Her lack of credibility with regard to her physical complaints was magnified both by some of the findings from the doctors and also by her presentation at the time of trial. Dr. Wayne most succinctly stated, what seemed to be suggested by the nature of the examination findings from some of the other physicians, that her medical findings did not support the extent of her ongoing subjective complaints. Her lack of credibility with regard to her physical examination findings and her attempt to "manipulate" the test results was also demonstrated in her own rating physician's report, when Dr. Volarich noted his inability to accurately measure her strength and reflexes on account of her breakaway response. Additionally, at trial, despite her testimony to the contrary, I observed over the course of the hearing that Claimant basically sat absolutely still, without shifting or displaying any outward signs of discomfort, until she was asked the question about how long she could sit before she had to stand up. At that very point, she stood up for about a minute and then promptly sat back down. After taking a break at the conclusion of direct, Claimant then remained seated, again basically still without shifting or outward signs of discomfort, for almost an hour of cross-examination.

Finally, I find that her attempts to minimize whatever pre-existing issues and problems she may have had, while trying to maximize the effect of the last alleged injury, left me again concluding that she was simply not credible. Despite the long history in the medical treatment records of back problems with complaints going into the left leg, Claimant could not recollect prior left leg problems until she was presented with Dr. Robacker's records that confirmed same. Additionally, her conflicted testimony over whether or not she was actually taking the prescribed medications from Dr. Robacker for her back leading up to the time of her alleged March 15, 2007

injury, was simply not believable. In essence, she first suggested that she filled the last prescription in November 2006, but did not take the pills, and then later in her testimony changed that to, she may have taken some of the pills, but was not taking them every day.

Last but certainly not least, I find that her credibility was negatively impacted by her failure to be open and honest with the doctors and with Employer at the time of her pre-employment physical in 2006, before she began working for Employer. On May 10, 2006, in the medical history section of the examination, which Claimant apparently filled out and signed, she denied any current complaints or any history of mental trouble, chest pain, back pain, back injury, lumbar strain or recreational drug use. In terms of medications, she only listed Lamisil and hydrocodone for a tooth removal, which she was no longer taking. Based on her own testimony and the medical treatment records in evidence, she did have a prior history of, and in some respects was still at that time receiving treatment for, mental trouble, chest pain, back pain, back injury, lumbar strain and recreational drug use. Quite simply, she was not truthful with Employer or the doctors at the time of this examination, and that lack of truthfulness adds to the already extensive list of items that negatively impacted her credibility in this case.

Based on all of these factors, I find that I cannot rely on Claimant's testimony or statements in support of her own case, because her testimony is not credible or reliable. Additionally, I find that Dr. Volarich, Dr. Stillings and Mr. England relied heavily on Claimant's statements, descriptions and complaints in reaching their own conclusions in this case. Therefore, to the extent that they relied on Claimant's accounts, which I have already found were not credible, in reaching their own conclusions, I find that their opinions and conclusions are also flawed and cannot serve as the basis for an award of compensation in this case.

Accordingly, based on Claimant's failure to produce any competent, credible or reliable testimony on her own behalf and based on all of Claimant's expert opinions in this case being similarly flawed for having relied on Claimant's less than credible statements in reaching their opinions and conclusions in this matter, I find that Claimant has failed to meet her burden of proof that she sustained an accident, arising out of and in the course of her employment, with any complaints or disability medically causally connected to that alleged accident. As such, Claimant's Claim for Compensation in this matter is denied on these bases.

Issue 4: Did Claimant provide Employer with proper notice of the injury under the statute?

Under **Mo. Rev. Stat. § 287.420 (2005)**, "No proceedings for compensation for any accident under this chapter shall be maintained unless written notice of the time, place and nature of the injury, and the name and address of the person injured, has been given to the employer no later than thirty days after the accident, unless the employer was not prejudiced by failure to receive the notice."

Case law has held that the purpose of this section is to give an employer the timely opportunity to investigate the facts surrounding an accident, and if the accident occurred, the chance to provide the employee with medical treatment in order to minimize the disability.

Willis v. Jewish Hospital, 854 S.W.2d 82 (Mo. App. E.D. 1993) *overruled on other grounds by Hampton v. Big Boy Steel Erection*, 121 S.W.3d 220 (Mo. 2003). However, if the employee failed to give timely written notice of the injury, that failure may be circumvented if the failure to give timely written notice did not prejudice the employer.²

Courts have held that the most common way for an employee to establish lack of prejudice is for the employee to show that the employer had actual knowledge of the accident when it occurred. If employer does not admit actual knowledge, then it is up to the employee to produce substantial evidence that the employer had actual knowledge. If employee produces such evidence, the employee has made his prima facie showing of the absence of prejudice and the burden shifts to employer to now show that employer, was, in fact, prejudiced. However, if the employee does not show written notice or actual knowledge, then the burden rests on the employee to supply evidence that no prejudice to the employer resulted. If no such evidence is provided, then it is presumed that employer was prejudiced by the lack of notice, because it was not able to make a timely investigation. *Soos v. Mallinckrodt Chemical Co.*, 19 S.W.3d 683 (Mo. App. E.D. 2000) *overruled on other grounds by Hampton v. Big Boy Steel Erection*, 121 S.W.3d 220 (Mo. 2003).

I find that there is absolutely no dispute in the evidence that Claimant did not timely provide written notice of her alleged accident and injury to Employer under the provisions of Section 287.420. The first written notice to Employer that an alleged injury occurred at work was Claimant's Claim for Compensation filed in early 2008. I find that Claimant was well past the 30-day notice requirement under the statute at the time that she notified Employer in writing about her alleged accident.

Since Claimant did not provide timely written notice of her accident to Employer, the inquiry then shifts to whether that failure can be circumvented or excused by showing that the failure to give timely written notice did not prejudice Employer. In that respect, I find that Employer has not admitted having any actual knowledge of the accident at the time it occurred. I further find that Claimant has not produced any competent, credible or substantial evidence that Employer had actual knowledge of the alleged March 15, 2007 accident either.

Despite Claimant asserting that she left one voicemail message for Aaron Herr and she had one conversation with Mary Beth Deines regarding her alleged work injury, her assertions in that regard are rebutted by the credible testimony of those witnesses, indicating they do not remember her ever reporting any such injury to them. Her assertions are similarly rebutted by Employer's timekeeping and personnel records, which contain absolutely no indication that Employer was ever made aware that Claimant allegedly suffered an accident on March 15, 2007 or that she was missing work because of that alleged injury. Instead those records contain entries indicating she missed work or left early for a family emergency or for sick (other) or sick (non-work related injury).

² Prior to the 2005 amendments to the Workers' Compensation Statute, in addition to employer not being prejudiced by the lack of such notice, Section 287.420 also allowed for the failure to give timely written notice to be excused if the employee made a showing of good cause for the failure to give such notice. The cases dealing with the issue of notice all dealt with both whether there was good cause for the lack of timely notice and whether employer was not prejudiced by that lack of notice. However, the good cause provision was removed from Section 287.420. Therefore, the failure to give timely written notice can now only be excused if that failure did not prejudice employer.

Based on the evidence in the record described above, I find that Claimant failed to timely report the alleged injury within the 30-day statutory period. Since Claimant did not provide timely written notice and did not produce substantial evidence to prove Employer had actual knowledge of the accident at the time it occurred, the burden rests on Claimant to supply evidence that no prejudice to the employer resulted by the failure to provide notice. Claimant could prove the lack of prejudice if she could show that Employer knew she was injured and knew that the injury was work related. However, Claimant did not provide any such proof in this case. While I believe, based on Claimant missing time from work and seeking treatment with a doctor for her back, that Employer may have known she had back problems, I find no credible evidence in the record to support the contention that Employer knew, or should have known, that her back problems were work related.

As such, I find that Employer had absolutely no opportunity to timely investigate or to provide timely medical treatment to minimize the disability that Claimant might otherwise have on account of this alleged accident.

Therefore, with no timely written notice and no actual knowledge of the alleged accident on March 15, 2007, and based on Employer's inability to timely investigate and inability to control medical treatment to attempt to lessen Claimant's disability in this matter, I find that Claimant has not produced any competent or substantial evidence to show that Employer was not prejudiced by the failure to receive timely notice of the alleged accident.

Accordingly, I find that Claimant's Claim for Compensation for this alleged accident cannot be maintained since Employer was never provided with proper notice of the accident as called for in Section 287.420. Claimant's claim for benefits is denied on this separate and independent reason.

As Claimant's Claim for Compensation has already been denied based on the above findings on the first four issues in this case, the rest of the issues presented at hearing are moot and will not be further addressed in this award. In addition to the specific denial of Claimant's Claim against Employer, since Claimant has failed to meet her burden of proving a compensable Claim against Employer, therefore, her Claim against the Second Injury Fund similarly fails, and is denied.

CONCLUSION:

Claimant failed to produce any competent, credible or reliable testimony on her own behalf and all of Claimant's expert opinions in this case are similarly flawed for having relied on Claimant's less than credible statements in reaching their opinions and conclusions in this matter. Therefore, Claimant has failed to meet her burden of proof that she sustained an accident, arising out of and in the course of her employment, with any complaints or disability medically causally connected to that alleged accident. As such, Claimant's Claim for Compensation in this matter is denied on these bases. Additionally, Claimant's Claim for Compensation for this alleged accident cannot be maintained since Employer was never provided with proper notice of the accident as called for in Section 287.420. Claimant's claim for benefits is denied on this separate and independent reason.

As Claimant's Claim for Compensation has already been denied based on the above findings on the first four issues in this case, the rest of the issues presented at hearing are moot and will not be further addressed in this award. In addition to the specific denial of Claimant's Claim against Employer, since Claimant has failed to meet her burden of proving a compensable Claim against Employer, therefore, her Claim against the Second Injury Fund similarly fails, and is denied.

Made by: _____

JOHN K. OTTENAD
Administrative Law Judge
Division of Workers' Compensation