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Issue Date: 09 November 2012

Case No.: 2009-LHC-00822

OWCP No.: 05-128251

In the Matter of:

SONYO V. TILLET-BOND,
Claimant,

v.

LAMBERT'S POINT DOCKS, INC. /
NORFOLK SOUTHERN RAILWAY COMPANY
c/o NORFOLK SOUTHERN CORP.,
Employer / Carrier,

And

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS,
Party In Interest.

DECISION AND ORDER

This proceeding involves a claim for benefits filed under the Longshore and Harbor Workers' Compensation Act ("the Act"), as amended, 33 U.S.C. § 901, *et seq.*

A formal hearing was held in Newport News, Virginia on March 15, 2012 at which time all parties were afforded full opportunity to present evidence and argument as provided in the Act and the applicable regulations.

The findings and conclusions which follow are based upon a complete review of the entire record in light of the arguments of the parties, applicable statutory provisions, regulations and pertinent precedent.

STIPULATIONS¹

The Claimant and Employer have stipulated to the following:

1. An employer/employee relationship existed at all relevant times;
2. The parties are subject to the jurisdiction of the Longshore & Harbor Workers' Compensation Act;
3. The Claimant alleges multiple injuries occurring on September 24, 2008;
4. A timely notice of injury was given by the employee to the employer;
5. A timely claim for compensation was filed by the employee;
6. The Notice of Controversion was timely filed.
7. The worker's average weekly wage at time of injury(ies) was \$356.18;
8. Temporary total disability (TTD) was paid from September 25, 2008 to February 20, 2010. (JS).

Issues

1. Is Claimant entitled to ongoing compensation beginning 02/21/2010?
2. Is Claimant's mental health treatment and diagnosis causally related to her work-related injury of 09/24/2008?
3. Should Claimant's average weekly wage be adjusted to reflect unemployment benefits earned from the Employer?

Contentions

Ms. Tillett-Bond contends that she is entitled to temporary total disability benefits from February 21, 2010 to the present and continuing based upon her psychiatric condition which arose out of her undisputed September 24, 2008 work related injury. Ms. Tillet-Bond argues that her work injury played a substantial role in her psychiatric condition and mental diagnosis; therefore, she is entitled to compensation benefits.

¹ The following abbreviations will be issued as citations to the record:

- JS - Joint Stipulations;
- TR - Transcript of the hearing;
- CX - Claimant's Exhibits; and
- EX . Employer's Exhibits.

The evidence demonstrates that prior to September 24, 2008 Ms. Tillett-Bond was working full time as a shortshoreman without any work restrictions. (See CX 30 and CX 32). She performed her work without any difficulty or problems with authority or coworkers. The evidence further demonstrates that prior to this accident Ms. Tillet-Bond was in top physical shape and won numerous awards as a body builder. (See CX 42).

On September 24, 2008, Ms. Tillett-Bond and other co-workers were tasked to place tarps over rail cars because a Nor'easter blew into the terminal. While Ms. Tillet-Bond was performing this task, the wind blew the tarp up, wrapped around her causing it to pick her up several feet off the ground, throwing her into a dark black tarp and dragged several feet. All the while her co-workers stared and thought she was dead.

The Employer does not dispute this work related injury and immediately accepted the accident as compensable under the Act. The Employer began to pay temporary total disability benefits and medical treatment until her benefits was terminated on February 20, 2010.

From September 24, 2008, Ms. Tillett-Bond's symptoms and injuries were solely being viewed as physical. The record supports that she suffered physical injuries in the form of a tear in her gluteus maximus, back pain and multiple contusions. The Employer provided medical treatment for those physical injuries.

Subsequently, Ms. Tillett-Bond began to complain of right shoulder, neck and right hand pain. (See CX 22). Ms. Tillett-Bond began to hold her right hand in a claw position, slumping over, complaining of swelling and pain.

Ms. Tillett-Bond was referred and continued to treat with specialist after specialist believing her hands were in a claw position that was affecting her shoulder and entire body. Ms. Tillett-Bond sought the assistance of the Department of Labor, the Employer and local physicians desperately seeking the cause of her symptoms. A common mantra among the evaluating physicians was that her condition was "bizarre."

In August of 2009, the Employer approved an initial evaluation with Dr. Scott W. Sautter, a psychologist who specializes in neuropsychology. Upon initial evaluation, Dr. Sautter admitted that in her mind, Ms. Tillett Bond's complaints were valid. He indicated that none of the tests he performed reached the criteria to prove exaggeration or maligning. Dr. Sautter further opined that her complaints were "somatic" in nature. (See CXI6-6).

She was finally able to seek treatment with Dr. Patrick Thrasher who also provided a diagnosis of PTSD and somatoform disorder.

From February 2010 until the present, Ms. Tillett-Bond has remained out of work due to her condition.

The Employer defends their denial on the premise that Ms. Tillett-Bond had previously psychiatric issues due to a discrimination suit she filed against her Employer and her Union. Ms.

Tillett-Bond does not deny that she underwent treatment for depression as a result of enduring sexual discrimination.

Specifically, her treating psychiatrist, Dr. Thrasher opined that Ms. Tillett-Bond is incapable of working. Dr. Lassiter assessed Ms. Tillett-Bond a Global Assessment of Functioning (“GAF”) score of 50 and opined that she could not work and referred her to a psychiatrist. Also, throughout the entire disputed period Ms. Tillett-Bond’s primary care physician, Dr. Lovell, opined that she is unable to work. (*See* CX 13-22 and CX 13-23).

Shockingly, even the Employer’s own psychiatrist, Dr. Jerome Blackman, who evaluated Ms. Tillett-Bond for an Independent Medical Examination (“IME”) at the request of the Employer, opined that she is incapable of working, is severely mentally ill and assessed a GAF of 37. Dr. Blackman opined that Ms. Tillett-Bond is disabled from any type of work based upon her condition. (*See* CX 5-7 and 5-17).

The evidence in the record overwhelmingly proves that Ms. Tillett-Bond’s psychiatric condition is directly related to her September 24, 2008 injury and that she is completely disabled and unable to perform any form of substantial gainful employment as a result of her injury.

As a side issue, Ms. Tillett-Bond also alleges that the average weekly wage (“AWW”) paid to her previously did not include all of her earnings. The record shows that the fifty-two (52) weeks prior to her work injury Ms. Tillett-Bond worked significantly as a shortshoreman and not in the longshore industry. She worked a great amount of time for Lambert’s Point Docks which entitled her to garner unemployment benefits from the railroad when work was not available.

On the days she was unable to find work from the longshore industry, she was paid a benefit from the railroad. Ms. Tillett-Bond contends that this benefit was an earned benefit similar to vacation and container royalty pay. Ms. Tillett-Bond was paid \$6,549.00 in total for those benefits. Therefore, she requests that her AWW be adjusted from \$356.18 to \$482.13 to include those benefits.

Claimant’s counsel argues that the Section 20(a) presumption has been raised regarding the incurrence or aggravation of a psychiatric impairment as a result of the work injury. This presumption has not been rebutted as Dr. Thrasher disagrees with the assumptions of Dr. Blackman.

The Employer attempts to paint a picture that Ms. Tillett-Bond was mentally ill prior to her injury because she lost her sexual discrimination lawsuit against the union. However, the evidence prior to and subsequent from her evidence shows something completely different. Ms. Tillett-Bond never attempted to conceal the fact that she sought psychiatric help prior to her injury due to a discrimination lawsuit she had filed against the Employer for sexual harassment.

However, prior to this accident, Ms. Tillett-Bond was working without limitation or difficulty and was earning her regular hours and performing her regular job duties efficiently.

She did not exhibit any significant psychiatric problems that would prevent her from performing her job duties during the fifty-two (52) weeks prior to her accident.

The employer notes that the claimant began seeing Dr. Robert Mitchell, a psychiatrist, in 2006. In August 2008, a month prior to the injury, she was noted to have anxiety and depression. Treatment by Dr. Mitchell continued into early 2009 which is contrary to the medical history given to Dr. Thrasher. In August 2011, Dr. Blackman diagnosed schizophrenia and a personality disorder and ruled out PTSD.

In his deposition, Dr. Thrasher opined that she had a conversion disorder and agreed that a conversion disorder can be caused by any number of emotional issues. Dr. Thrasher admitted that he has not gotten to the basis of what is causing the conversion disorder described. Indeed, he noted "I have speculation, but I don't have answers." (CX 2-31).

CX 6 is a report from Dr. Paul Mitchell, a neurosurgeon, in which he states he has no explanation for her claw deformity. He also states that he has never seen a neurological deficit develop four months post-accident, although it is not impossible.

Dr. Blackman was clear that either Claimant is faking her claw hand, or she is suffering from a delusion flowing from her paranoid schizophrenia. He reviewed the videos of her driving a car in 2009 and not demonstrating a claw hand in her left hand, such that the picture is confusing. (EX 28-36).

Importantly, Dr. Blackman does not disagree that she may suffer from a somatoform disorder, but this is merely a potential constellation of symptoms that fit the syndrome. He noted, "it doesn't tell you whether she has somatic delusions or conversion symptoms."

Dr. Sautter, a psychologist, evaluated the claimant and reviewed the surveillance film. Dr. Sautter reported impressions of a conversion disorder or a somatoform disorder, and indicated that the film did not suggest a neurological disorder. The claimant did not have PTSD and could return to work.

In this case no question can exist that claimant sustained a harm, the injuries diagnosed in the emergency room on September 24, 2008 by Dr. Graffeo - a lumbar strain, hip contusion and multiple abrasions. The employer has offered the reports of Dr. Neff, Dr. Bragg, Dr. Kline, Dr. Hogan, and Dr. Ross that establish that the claimant has no physical limitations as a result of these injuries nor any restrictions. Specifically, no physician has ever been able to ascertain any anatomical explanation for Claimant's upper extremity, neck and shoulder complaints. Further, Claimant has failed to provide any evidence of any anatomical explanation for these complaints. Indeed, all of these physicians released Claimant without any restrictions on her ability to work. Claimant was also extensively evaluated by a neuromuscular specialist at the University of Virginia - a physician she chose - who could offer zero explanation for her upper extremity complaints and neck complaints. Further, Claimant and her attorney conceded this in the opening statement to the Court, "no one could explain the physical component of her condition." (Tr.12).

Dr. Sautter was unequivocal that claimant does not have PTSD.

Dr. Sautter did not attribute any psychological or psychiatric limitation to Claimant.

Dr. Mitchell's records demonstrate - contrary to Dr. Thrasher's opinion and consistent with Dr. Blackman's opinion - that Claimant has suffered for many years with mental illness. This accident did not bring about some substantial deterioration of her mental condition. Her GAF of 45 before the accident [which had been no more than 55 in the year before hand] demonstrates that she was suffering from significant mental illness long before this accident. Indeed, her GAF has remained essentially unchanged to the present, demonstrating the validity of Dr. Blackman's assessment.

Dr. Thrasher, who Claimant was referred to by her attorney, is the only mental health provider who has ascribed any disability causally related to this accident. Yet Dr. Thrasher's opinion relating these mental illnesses to this accident is flawed, because it is premised on incorrect assumptions, false information supplied by the Claimant, and efforts to denigrate other physician's opinions.

The Benefits Review Board has made clear that unemployment compensation is not to be considered in calculating AWW. *Blakney v. Delaware Operating Co.*, 25 BRBS 273 (1992). In *Blakney* the BRB held, consistent with the Seventh Circuit Court of Appeals holding in, *Strand v. Hansen Seaway Service, Ltd.*, 614 F.2d 572, 11 BRBS 732 (7th Cir. 1980), that unemployment compensation benefits are properly excluded from wages, as they do not constitute earnings.

In this instance, there is no question that the unemployment benefits Claimant received were from the Railroad Retirement Board. They were not furnished by the Employer. Claimant was eligible to receive these benefits because she was working for a railroad employer, but Lambert's Point Docks, Inc. has nothing to do with payment of unemployment benefits.

Pertinent Laws and Regulations

Section 2(2) of the Act defines injury as:

The term 'injury' means accidental injury or death arising out of and in the course of employment, and such occupational disease or infection as arises naturally out of employment or as naturally or unavoidably results from such accidental injury, and including an injury caused by the willful act of a third person directed against an employee because of his employment.

33 U.S.C. §902(2). The statute clearly states that the injury to the employee must arise out of employment and in the course of employment. A work-related aggravation of a pre-existing condition is an "injury" under Section 2(2) of the Act. *Gardner v. Bath Iron Works Corp.*, BRBS 556 (1979), *affd sub nom. Gardner v. Director, OWCP*, 640 F.2d 1385 (1st Cir. 1981); *Preziosi v. Controlled Industries*, 22 BRBS 160 (1989). In addition, the Benefits Review Board had also held that term "injury" includes the aggravation of a pre-existing non-work-related condition or the combination of work and non-work-related conditions.

Section 20(a) of the Act creates a presumption that Claimant's disabling condition is causally related to his employment. 33 U.S.C. §920(a). In order to invoke the 20(a) presumption, Claimant must prove that he suffered a harm and that conditions existed at work or that an accident occurred at work which would have caused, aggravated, or accelerated his condition.

Once the presumption is invoked, Section 20(a) places the burden on the employer to come forward with substantial countervailing evidence to rebut the presumption that the injury was caused by the claimant's employment. *Swinton v. I Frank Kelly, Inc.*, 554 F.2d 1075,1081, 4 BRBS 466, 476 (D.C. Cir. 1976), *cert. denied*, 429 U.S. 820 (1976). Where aggravation or contribution to a pre-existing condition is alleged, the employer must establish that a claimant's condition was not caused or aggravated by his employment. *Cairns v. Matson Terminals, Inc.*, 21 BRBS 252 (1988).

Evaluation of the Evidence

At the hearing, Dr. Thrasher, a psychiatrist, testified that he began treating the claimant in June 2011. The claimant described the accident and reported treatment by Dr. Mitchell. She held her hands in a claw position. The initial impression was an undifferentiated somatoform disorder. The symptoms are not intentionally produced. (TR 30).

The physician stated that the claimant had PTSD which could come on decades after the trauma. She also met the criteria for major depression. Dr. Thrasher continued to treat the claimant and she had been seen more than 25 times. (TR 46).

Q Do you have an opinion as to whether or not you felt on that day that she could return to any form of work?

A She was not capable and remains incapable of working at this point from a psychiatric perspective.

Q Can you give us an explanation as to why you formed that opinion?

A Ms. Bond is extremely anxious, easily overwhelmed, unable to tolerate stress, has a labile mood, is prone to emotional breakdown under stress and would not be able to tolerate the stress of a working environment, particularly an environment on relatively rough, you know, macho kind of environment on the waterfront where she's likely to be victimized. (TR 47).

Dr. Thrasher stated that medication had been prescribed but she still was susceptible to panic attacks. While Dr. Mitchell noted paranoia, Dr. Blackman was incorrect in diagnosing schizophrenia. Dr. Thrasher did not feel that Dr. Mitchell had performed an in depth analysis. (TR. 52).

Dr. Thrasher had seen the surveillance tapes.

It was difficult to see her hands during those tapings, but I didn't see anything on those tapes that were - would suggest that she was doing something with her hands that she wouldn't be able to do with the claw hands. I mean, she was carrying a bag. I can't tell whether - her problem is not that she can't grip her hands it's that she can't open her hands. She was carrying a bag, a small plastic bag, if I recall correctly. I can't quite tell where it was held, but she can carry a bag hanging over her fingers.

(TR 62).

Dr. Thrasher acknowledged that the claimant's first visit was almost three years after the accident. The physician was aware that the claimant lost a sexual discrimination lawsuit in early 2009 and this had caused stress. The claimant had continued to struggle during the treatment.

A Anything the psychiatrist does is pretty much going to be based on what your patient tells you. It's a verbal specialty.

Q So, what you are looking for is a significantly upsetting event that would account for these symptoms and the change that you described from before and after the accident, correct?

A Correct.

(TR 86).

Harold Brown testified that he began working with the claimant in 2003. He was not present when the accident occurred. He saw her shortly thereafter and she was distraught as her injuries might affect her body building presentations.

The claimant testified that on one occasion in 2006 she and a male worker were placed in an area without restrooms. They each went separately and relieved themselves in a field. The claimant was written up for this but no action was taken against the male. She filed suit for discrimination but lost the case. In late 2006 Dr. Lavell, her family physician, referred her to Dr. Robert Mitchell for treatment of stress (TR 126). The physicians held her out of work and Dr. Mitchell continued to prescribe medication.

The injury in September 2008 occurred when high winds threw a tarp over her and she became entangled and was dragged. She saw Dr. Lavell who referred her to Dr. Bragg. Initially she had problems with her back and legs but by April 2009 she was having difficulty with the upper extremities. Her discrimination case went to trial in March 2009.

In 2009 she saw Drs. Neff and Hogan and was referred to Dr. Sautter, a

psychologist. Dr. Kline, an orthopedist, referred her to physical therapy. She was evaluated by Dr. Paul Mitchell, a neurosurgeon.

Dr. Lassiter referred her to Dr. Thrasher and she had seen Dr. Thrasher on a weekly basis since that time (TR 171). That treatment and medication had been beneficial. She saw Dr. Blackman at the request of the employer and she met with Barbara Byers, a vocational counselor.

The claimant stated that she surveillance tapes were made prior to her hands going into a total claw position (TR 177). She was now receiving Social Security Disability benefits.

Samuel Davis testified that he was a business agent for the union. Break bulk had been diminishing since 2006. Hiring at the union hall was by seniority and the claimant's seniority was at a very low level. Davis was not present at the time of the accident, but he did visit her in the emergency room. The claimant did not have problems returning to work after losing the discrimination case (TR 233).

Barbara Byers testified that she was a vocational rehabilitation counselor. A labor market survey was conducted in April 2010. Ms. Byers reviewed medical records which did not list physical or psychological restrictions. The labor market survey was based on sedentary and light duty work. In November 2010, Ms. Byers met with the claimant. In early 2010 Ms. Byers felt that the claimant could earn \$10 per hour for a 40 hour week.

In early 2011, Ms. Byers sent a list of potential jobs to several of the testifying physicians. Dr. Neff approved all of the jobs and Dr. Kline approved all but one. Another survey was conducted in January 2012 for positions such as customer service, travel clerk, and receptionist. Ms. Byers had not reviewed Dr. Thrasher's records until recently.

Jeffrey Browning testified that he was a special agent for the railroad police. Browning conducted video surveillance in September and October of 2009.

Denise Hawkins testified that she was a senior claims agent for the employer.

Q There's been some testimony today about the unemployment benefits that Ms. Bond received, do those come from Norfolk/southern or from the Railroad Retirement Board?

A The Railroad Retirement Board.

Q The Railroad Retirement Board is that for lay people the equivalent of the Social Security Administration for railroad employees?

A Yes.

Q Does Norfolk/Southern have anything or - I'm sorry, does Lambert's Point

Docks or Norfolk/Southern have anything to do with payment of unemployment benefits as have been described today?

A No.

(TR 264).

In December 2006 Dr. Robert Mitchell, a psychiatrist, informed Dr. Lovell that he had seen the claimant.

Actually, Ms. Bond was initially seen by Ronald Jacobson, P.h.D. on an emergency basis, since I was not available. Clearly she is a patient who can benefit from psychopharmacology. Consequently, Dr. Jacobson referred her on to me.

Today she presents with a history of anxiety and depression related to a specific job situation that includes a discrimination case that is ongoing. Mrs. Bond states that this had its onset during October and has continued with increasing symptoms during November and since that time. She describes depressed mood, increasing anxiety, lack of interest, lack of energy, crying spells, lack of motivation, periods of apathy and withdrawal, decrease in appetite, inability to find any pleasurable activity in her life, significant sleep disturbance, and increasing difficulty functioning. She denies any prior history of depression and there is no family history of depressive illness. Consequently this would appear to be a situational problem related to the stress and difficulty she is currently experiencing in the workplace. She did state that as an interim measure she did consult you and that she was prescribed Ativan 0.5mg, one three times a day, until she was able to schedule an appointment with me today. She is able to relate in logical and coherent fashion. Associations are intact. There is no evidence of any thought disorder or psychotic process. Affect is variable with underlying anxiety and depressed mood. There is some somatic preoccupation. There are ideas of reference reflecting a sense, I think, of being treated unfairly, not of paranoid proportion. There are no hallucinations currently or in the past. Fund of knowledge and information is adequate. She is oriented as to time, place, and person. Insight and judgment are intact. She is able to subtract serial 7's and interprets proverbs flexibly. She is of above-average intelligence.

Diagnostic Impressions:

Axis I: Situational depression with anxiety

Axis II: No Diagnosis

Axis III: No Diagnosis

Axis IV: Severe - difficulty with work-related problems, difficulty with interpersonal relationships

Axis V: Current 45, past year 55

Mrs. Bond has agreed to continue outpatient supportive therapy and medication management. I am prescribing Lexapro 10mg daily. I have suggested that she can continue the Ativan 0.5mg q. 4 to 6 hours p.r.n. as you prescribed for her and I am adding Ambien 10mg at bedtime on a p.r.n. basis. I will continue to see her on a regular basis.

The claimant was seen on numerous occasions in 2007 and 2008 and as late as May 2009 (EX 14).

The September 24, 2008 reports from Norfolk Fire-Rescue indicated that the claimant was sitting in a golf cart when she was first seen. She was oriented and denied loss of consciousness. Examination revealed small abrasions on the left forearm and right thigh. She was transported to the Emergency Room (CX 27).

At Sentara Norfolk General Hospital on September 24, 2008 an abrasion was noted on the right thigh. There were no neurological deficits (CX 22). X-rays of the lumbar spine and right hip and femur were considered to be normal (EX 23).

When deposed in November 2011 Dr. Graffeo testified that he was the Emergency Room physician who treated the claimant on September 24, 2008. The Claimant reported pain in the back and in the right hip. There was tenderness in the right thigh, and x-rays were negative. There were no complaints regarding the head or the upper extremities. Anxiety was not noted. The impression was lumbar strain (EX 30).

In November 2008 MRIs of the lumbar spine and the hips as well as a CT scan of the cervical spine were not remarkable (CX 23).

In early October 2008 Dr. Lovell referred the claimant to Dr. Bragg, a pain management specialist. The claimant reported that

her pain is constant in the right hip and low back and that she has pain in the right thigh along the right knee and in the left upper extremity. The patient denies bowel or bladder symptoms. She indicates her pain is made worse with standing, walking, bending forward, sitting, bending backwards, reaching, and lifting.

IMPRESSIONS:

1. Status post work-related injury September 24, 2008 due to fall.
2. Multiple contusions involving the right thigh, knee, right shin, and left arm.
3. Lumbar sprain.

PLAN: At this point, I have recommended that the patient be seen by a physical therapist where she can be taught appropriate gait training with crutches and receive modalities for pain control. I have asked that she continue on the Motrin and Flexeril. I have given her Ultracet. The patient is currently out of work and

will remain out of work. I will see her for follow up in a couple of weeks, earlier if there is any change in her status.

Dr. Bragg continued treatment and ordered MRIs and nerve conduction studies. In May 2009 it was reported that extensive workups did not explain her complaints of back and radicular pain.

In late August 2009, Dr. Bragg stated that the claimant had reached MMI regarding her back and lower extremities (CX 20).

In April 2009, Dr. Lovell referred the claimant to Dr. Neff, an orthopedist.

PHYSICAL EXAM: On physical examination she has diminished sensation in the right hand, not only over all fingers and in the palm as well as on the dorsum, and has diminished sensation to the wrist. She has no positivity to any of the testing today for carpal tunnel syndrome. She has a negative Tinel's. She has negative Phalen test. She tells me that she gets swelling of the knuckles at the MP Joint over the 2nd and 3rd. She must hold her hand in certain positions to prevent pain in the right hand, the forearm, the arm, the shoulder, as well as the right trapezius. She has satisfactory range of motion of her shoulder. She has complaints of pain, as well as spasm, not only in the shoulder, in the trapezius and the forearm. She has a plethora of symptomatic findings which are not substantiated by objective findings and are indeed somewhat bizarre and I cannot explain them on the basis of her MRI, which shows low grade partial thickness tearing of the supraspinatus tendon and mild subacromial/subdeltoid bursal inflammation. These changes may well be from her chronic body building.

EMG FINDINGS: The EMG and nerve conduction is an abnormal study showing mild carpal tunnel syndrome. There is no evidence of pinched nerve coming from the neck.

In May 2009, Dr. Neff stated

DISCUSSION: It would appear once again that Sonyo has a marked amount of symptom complaints, which are once again, quite bizarre and not typical in my opinion of significant pathology or injury but are typical of a "pain reaction" or a "paucity of clinical objective findings, but a plethora of multiple of [sic] unusual, bizarre complaints". There is no evidence of reflex sympathetic dystrophy. She states she is going to have a full neurologic work up.

In June 2009, the physician stated

DISCUSSION: I have told Ms. Bond that I can find no evidence of anything serious orthopaedically in the musculoskeletal area, that I can help her with. I find full motion of the shoulder and no tenderness. After having reviewed the MRI findings today I am of the opinion that she does not demonstrate any clinical

evidence of partial rotator cuff tear or of bursitis in the right shoulder. Her reactions to her alleged symptoms are not characteristic in my opinion, of any significant musculoskeletal problems.

In July 2009 Dr. Neff reported

DISCUSSION: I have once again discussed with the patient that I cannot explain her unusual pain problems and I have nothing further to offer her orthopaedically. I have explained that her symptoms are very unusual in my opinion for any known injury and do not fit with any specific injury complex.

PLAN: I will be glad to see her back on an as needed basis if referred from any of her other physicians, but at this point I am not giving her follow up visits since I have nothing further to offer.

(CX 17).

The claimant was referred to Dr. Hogan, a neurologist in May 2009. It was reported that

In April of 2009, she suddenly developed weakness/limpness in her right arm. She was found to have a tear in her shoulder. She has been using a sling ever since then. She was sent to our office for nerve conductions in April, which discovered evidence of carpal tunnel syndrome.

She now complains that the right hand moves involuntarily unless it is braced. She is wearing a brace on her right hand today.

Findings:

Generalized hyperreflexia
Question of upper motor neuron weakness

Otherwise normal neurological examination.

The right arm was kept in a sling and was not assessed. In the left arm, the brachioradialis reflex was hyperactive and the biceps reflex was hyperactive. Muscle tone seemed normal. Strength in the left arm was normal. In the legs, strength was normal. It was difficult to obtain full effort from the patient. Reflexes were increased with one-beat of clonus at left knee. Plantar responses were flexor her [sic]. She was able to walk on toes and heels but did so hesitantly. Her balance appeared adequate. Sensory examination was deferred. She did not exhibit typical color and trophic changes as would be expected in a patient with sensory neuropathy.

In July 2009, Dr. Hogan reported

EMG testing showed evidence of mild chronic C6-C7 radiculopathy and carpal tunnel syndrome, MRI scanning showed a mild degree of foraminal narrowing at the C4-5 and C5-C6 levels. No problems were discovered on the left.

The patient is now out of her slaying[sic]. She reports that she is unable to extend or abduct the fingers of her right hand. She says that sometimes the fingers move spontaneously. She also disclosed for the 1st time to me that she has recently developed similar problems in the left hand. About one month ago she began noticing weakness in extension of the left fingers. She now is unable to extend or abduct the fingers of her left hand.

ASSESSMENT

Physical findings in this patient are not consistent. It is clear from observing the patient that she can do more with the weak muscles than would be expected, given the degree of weakness she demonstrates on direct examination. Although she has mild chronic abnormalities on EMG and mild findings on cervical spine MRI to implicate C6 nerve root underway, her degree of weakness is far [sic] as a proportion to the abnormalities detected. Furthermore, there are no MRI findings on the left side to account for her new complaint of weakness in the left hand musculature. Therefore, although there are mild abnormalities present, I think the overall picture is one of functional illness.

(CX 14)

In April 2009, the claimant was seen at Norfolk Sentara Hospital and complained of

left hand and arm tingling and swelling since this am. Pt had fall in September with tingling in legs and arms frequently, pt states this is the first time arm has had swelling. Xrays negative for acute fracture or other pathology that could explain her sensation of swelling. Pt's clinically [sic] exam is not suggestive of acute pathology (i.e. A tenosynovitis) as she has no erythema, clinically appreciable swelling, fluctuance/induration, etc. Paresthesias are most likely chronic as Pt reports no significant change since her injury in 09/08.

(EX 6)

In August 2009 the claimant was referred by Dr. Neff to Dr. Sautter, a psychologist. Reportedly

Since the incident she has complained of back pain, lower-extremity problems, and numbness and tingling in her right upper extremity, which apparently began some time after the 9/24/08 accident. She demonstrated "claw" like activity in her right arm and wrist, as well. She has presented with multiple problems, related to arm and shoulder pain, and is presently seeing three physicians for this issue.

Ms. Tillett-Bond met again with Dr. Neff on 6/10/09 and, according to his office note; she had been placed on Neurontin by Dr. Hogan and now presented with complaints that her left arm and left hand had become problematic beginning earlier that week. Her description of the pain had also changed at this visit with Dr. Neff noting that ‘everything goes from her feet up to her left shoulder, whereas before she had tingling and numbness, she now has tingling and burning in her fingers and toes.’ Upon examination, Dr. Neff explained that he continued to find no evidence of significant orthopedic abnormality, that Ms. Bond’s reflexes were “excellent, that she had normal sensation to sharp and dull object testing and that no atrophy of the arm or forearm was observed in either arm.

MENTAL STATUS EXAMINATIONS -

Thought content was focused on her various somatic complaints and report of impaired physical functioning. Immediate, recent and remote recall ability was intact. Her ability to solve calculations and abstract reasoning skills were within normal limits. Intellectual functioning was estimated to be within average range. Ms. Tillett-Bond indicated that she can independently perform instrumental activities of daily living including use of the telephone, shopping, food preparation, housekeeping, laundry, taking medication and managing finances. She reported that she no longer drives, relying on others for transportation.

Testing showed that IQ was in the normal range.

DIAGNOSTIC IMPRESSIONS:

1. Undifferentiated Somatoform Disorder with Histrionic Features, where symptoms are unintentionally produced.
2. A rule out of a Conversion Disorder is made as her symptom complaints primarily include sensory and motor impairment, but there is not enough prior history to know whether or not a significant psychological distress was previously present and more currently sublimated into physical symptoms.
3. There are identified physical impairments, but her treating physicians do not identify them as related to the work accident.
4. Stressors include vocational and subjective health concerns.

RECOMMENDATIONS:

1. Ms. Tillett-Bond appears to have the capacity to return to the cognitive demands of her pre-morbid job status, or another job within her work limitations.

(CX 16)

In September 2009, the claimant was seen by Dr. Kline, an orthopedist. Following examination, the physician stated

My Impression is that the patient's bizarre symptoms are a combination of a pain management issue and are psychiatric in nature. I would like to place the patient in work hardening for a month and complete this with a functional capacity evaluation and performance evaluation to demonstrate the degree of symptom magnification. She's on a multitude of medications by Dr. Bragg and I will not make any changes to her medication. This trial of work hardening and performance evaluation will more or less be for evaluation rather than definitive treatment. I will see her back after this has been completed for a final opinion in the direction of the patient's care.

In October 2009, Dr. Kline reported that an FCE was conducted and that she was extremely inconsistent in the performance evaluation testing. (EX 8; See EX 10)

Reports from Dr. Lovell are on file. In April 2009, testing suggested carpal tunnel syndrome on the right. In May 2009, hyperventilation syndrome was an impression and psychiatric follow-up was recommended (CX 13).

In December 2009, Dr. Kline answered questions

1. What, if any, injury or condition have you diagnosed for Ms. Tillett-Bond related to her industrial accident of September 24,2008? None.
2. From an orthopaedic perspective and as a board certified orthopaedic surgeon specializing in upper extremities, is there any anatomical explanation for the bilateral "uncontrolled clawing of both hands"? None.
3. Was the clawing that Ms. Tillett-Bond demonstrated in your office on September 23, 2009 consistent or inconsistent with what you observed in the surveillance videos of her use of her hands on September 22, 2009? Inconsistent.
4. From an orthopaedic perspective, what, if any, functional limitations does Ms. Tillett- Bond have to her upper extremities which are causally related to her September 24, 2008 industrial accident? None.
5. Based upon your review of the surveillance videos, what, if any, opinion do you have as to whether or not Ms. Tillett-Bond is manufacturing these clawing symptoms? This one is behavioral and probably fictitious.

(EX 8)

In February 2010, Dr. Sautter stated

New records were reviewed and a video was observed that was significant enough to provide this addendum to the neuropsychological assessment and prior addendum to clarify the diagnosis. Records from Dr. Robert Mitchell, Psychiatrist, and Dr. Ronald Jacobson, Clinical Psychologist, were reviewed and indicated a psychiatric history prior to the reported injury at work. A post-injury report was reviewed from Dr. Sam Kline, Orthopedic Specialist, that indicated physical complaints were without medical evidence. The claimant was observed in a video, that was post-injury, that showed her using her hands without difficulty and without use of splints.

(EX 9)

In November 2010, the claimant was referred to the neurology clinic at the University of Virginia Health System. She reported

right arm pain, weakness, and spasm. She was previously healthy until a fall about 2 years ago, that happened at work. She does not recall any specific injuries to her arms. But two months later, she started to notice an achy and heavy sensation of her right shoulder. She was still able to use her arm and hand at that time. But, her symptoms continued to get worse. Now she reports constant pain in her right shoulder and arm, as well as pins and needles sensation. She reports muscle spasms running down from the shoulder to her arm and hand, that her hand is constantly in a ‘claw position’.

Carpal tunnel syndrome has been diagnosed. Current motor exam showed Normal bulk and tone, no fasciculations. Strength 5/5 throughout in the left upper and bilateral lower extremities. Patient holds her right shoulder and arm tight to the side, and complaining of having spasms in her shoulder and arm, although her muscle tone feels normal during the “spasm”, it is difficult to assess her strength in the right upper extremity reliably, but the triceps and biceps have 5/5 strength. Her fingers can be easily stretched out straight. There is no evidence of contracture.

EMG performed, which only showed a mild-to-moderate right median neuropathy. There is no evidence of brachial plexus injury or evidence of active cervical radiculopathy.

We discussed the EMG results with the patient. We explained to her that so far we have not find [sic] an underlying neuromuscular cause of her symptoms. We recommend her to discuss with her family physician for a referral to the pain clinic to see if her symptoms would improve if her pain is adequately controlled. We do not recommend further neurological diagnostic testing.

(CX 33)

The claimant was seen at Planet Chiropractic in November 2010 (CX 34).

In December 2010, Dr. Hogan stated that while Carpel Tunnel Syndrome was shown in April 2009, the physician would not express an opinion as to the origin of the disorder (EX 18). Dr. Kline expressed a similar opinion (EX 19).

Dr. Paul Mitchell, a neurosurgeon, evaluated the claimant in March 2011. The claimant reported

a long history of neck pain, back pain, and bilateral upper and lower extremity pain and weakness. The patient states that all of her symptoms started after a work related fall in 2008.

Several months after this incident she started to develop right upper extremity weakness to the point of developing a clawhand. She has always noticed that the left side was tending towards a claw deformity, but only recently over the last few months has become complete. She has been evaluated by multiple physicians. She has been diagnosed with carpal tunnel syndrome, mild cervical spondylosis, mild chronic radiculopathy, and some of the conditions [sic] even think that she has a somatoform disorder.

Physical examination today, the patient is in moderate distress. Her neck is exquisitely tender to palpation. She has negative range of motion secondary to pain. She has a significant breakaway weakness throughout in fact making it very difficult to document her motor strength. Her hands are stuck in a claw-like deformity involving all of her fingers. She can grip, however, but it is weak.

Tests were performed and she was seen in the following week.

ASSESSMENT:

1. Cervical spondylosis C4-5, C5-6, and C6-7 with very mild progression at C6-7.
2. Claw deformity of bilateral upper extremities, questionable etiology.

PLAN: Even with a slight progression of her spondylosis at C6-7, I cannot explain her claw deformity. I would like to send her to physical medicine or rehab doctor (Dr. Robert Walker) to have this evaluated. I do not feel like there are any indications for surgery in her case.

(CX 35)

The claimant began treatment with Dr. Thrasher in June 2011. She described her injuries and her courses of treatment. By December 2008 she began having weakness in the left hand.

Her physical condition deteriorated further, with weakness in her arms, pain and tingling in the fingers of her right hand. Neurological consultation lead to a

diagnosis of carpal tunnel of the right wrist. She then developed ‘claw hand,’ first in the right hand and then later in the left hand.

Dr. Sautter had diagnosed:

1. Undifferentiated Somatoform Disorder with histrionic features, where symptoms are unintentionally produced.
2. Rule out Conversion Disorder is made, as her symptom complaints primarily include sensory and motor impairment, but there is not enough prior history to know whether or not significant psychological distress was previously present or more currently sublimated into physical symptoms.
3. There are identified physical impairments but her treating physicians do not identify them as related to work accident.
4. Stressors include vocational and subjective health concerns.

Dr. Thrasher performed a mental status examination.

Her appearance was remarkable for bilateral “claw hands” with her thumb curled into her palm and her fingers flexed at the DIP and PIP joints. Her speech was clear, coherent, well articulated, and flowed at a normal rate and rhythm, with occasional pressure. Her thoughts were logical and coherent, but tended to be concrete. After describing the on the job incident she focused at great length on the injuries she received, the evolution of her many physical symptoms and the problems and the treatment interventions that she has had. Her affect initially was smiling and pleasant, and she worked hard to maintain her composure throughout the session. At times, her affect was inappropriate to her thought content in that she smiled while discussing difficult issues about her perceived limited physical functioning. When approaching difficult issues, however, she appeared close to tears

Diagnostic Impression:

- Axis I: Undifferentiated somatoform disorder, secondary to work related injury
 Rule out conversion disorder, secondary to work related injury
 Post traumatic stress disorder, chronic, secondary to work related injury.
 Major depression, recurrent: moderate to severe, without psychosis, exacerbated by her work related injury and its consequences.
- Axis II: No diagnosis.
- Axis III: Status post multiple soft tissue injuries following on the job accident.
 Right carpal tunnel syndrome.
 Bilateral “claw hand.”
 Hypertension.

Axis IV: Severe: Physical health, financial and legal problems
Axis V: GAF: 40

Discussion: Ms. Tillet-Bond is a woman who has been extremely proud of the perfect appearance of her body and her ability to achieve this perfection through will power, self discipline, perseverance and hard work. It is suspected that in the past she has dealt with emotional stresses by her obsessive physical workouts. She is a person who needs to present a positive picture emotionally and prefers to hide her emotional distress from others and from herself. The emotional consequences of her injury appear to have been converted into somatic symptoms in the early phases of her illness. As the somatoform defense has lost its ability to contain her emotions, post traumatic stress and depressive symptoms had become more prominent. The on the job accident caused physical injuries, both internal and external, which have disrupted a basic component of her self-concept; i.e., physical perfection and control over her body. This has led to an unconscious unintentional exaggerated focus on physical symptoms constituting somatoform disorder and possible conversion disorder. She is experiencing of [sic] posttraumatic stress disorder. Both the somatoform disorder and post traumatic stress disorder are a direct result of her on the September 24, 2008 job injury. The injury and its subsequent consequences have also caused a recurrence major depression.

Dr. Thrasher saw the claimant several times a month through early March 2012 (CX 1).

Dr. Lassiter, a psychologist, saw the claimant in March 2011. The diagnosis was dysthymic disorder (CX 4).

Dr. Paul Mitchell answered questions in June 2011.

1. Whether or not you have any explanation for physiologic perspective as to the basis of the claw deformity.

The simple answer to this question is no. She does not have a classic finding of claw deformity and I cannot explain it on a physiologic basis.

2. Given the fact that the claw deformity did not come about until at least four months after the occurrence of the accident. I asked your opinion as to whether or not you were able to relate it to the occurrence of the accident in September 2008.

This delayed presentation makes it very difficult to link to the accident in question. I can only say that I have never seen a neurologic deficit develop four months after an accident. It, however, does not mean that is not possible.

(CX 6)

On August 11, 2011, Dr. Blackman, a psychiatrist, examined the claimant. Recorded history included treatment by Dr. Robert Mitchell, a psychiatrist, in 2006 for a situational disturbance regarding a lawsuit. Mental status examination revealed that

the patient has now developed generalized paranoid delusions about the doctors who have evaluated her. She is convinced that they have all turned on her and lied to her, after first trying to be her friend. This belief seems to be an extension of an illness that began at least around 2006, when Dr. Mitchell suspected she was paranoid.

This pattern became crystal clear toward the end of my interview of her. She admitted to me that she had been “losing” her thoughts, and did not remember what she had just said. I had noticed this during the interview, and considered it mild looseness. She was also now describing blocking, a phenomenon characteristic of schizophrenia, where the patient loses track of what she was thinking, and cannot retrieve it.

A diagnostic complication is that although Ms. Tillett-Bond has a DSM-IV-TR Axis I diagnosis of schizophrenia, the Axis II diagnosis is narcissistic personality disorder. In other words, the patient has stabilized herself by focusing on her body, taking pride in her body, and taking pride in her intellect.

Still another diagnostic complication arises in relation to the surveillance videos of Ms. Tillett-Bond (undated). The first video shows Ms. Tillett-Bond going to her mailbox. It looks like she lifts mail from her mailbox without having to struggle, which is highly suggestive that her fingers were actually operational. She carried a couple of bags of something to her place.

Although I do not believe that any of her illness is work related (she is simply blaming the incident for her mental illness), it may be that she is disabled by the illness and unable to work. Certainly, if she functions in any way similar to what I saw in my office, she would be considered disabled from the standpoint of not being able to think clearly for more than a few minutes at a time. Perhaps with medication she will function somewhat better, but the prognosis is poor.

DSM-IV-TR DIAGNOSES

- | | |
|-----------|--|
| Axis I | Late onset paranoid schizophrenia |
| AxisII | Personality disorder comprising narcissistic, obsessional, and some antisocial (manipulative) traits |
| Axis IIIa | History of an incident on September 24, 2008 |
| Axis V | GAF score 37 |

(CX 5; EX 27)

When deposed in August 2011, Dr. Thrasher testified that he had reviewed many of the claimant's medical records. She was first tested in June 2011 and diagnoses were somatoform disorder, posttraumatic stress disorder, and major depression. "The clawhands, if the clawhands are psychologically based, then they probably meet criteria for conversion disorder. I think I had to rule out conversion disorder on my diagnosis." (CX 2; p 25)

She's very preoccupied with how she looks, and she sort of feels ruined from what, I think to most people would seem superficial and not important. For her, her life was body building. She had her own gym in her home. And she spent -- when she wasn't working, she spent hours working out.

She also feels like she can't go back to -- and she used to coach, people, both in terms of their weight routines and their nutrition, and she sort of feels like, well, she has no more credibility in being able to do that.

Q. And all of these views are because she's been involved in the accident?

A. She's been involved in the accident, has these physical consequences.

Q. Now, from a psychological standpoint, is she capable of working, as we sit here today?

A. Today, she's not. She's just completely overwhelmed and unable to contain herself emotionally.

(CX2; p 47)

Dr. Sautter was deposed in September 2011 and testified that he was a neuropsychologist who evaluated the claimant at the request of Dr. Neff in September 2009. Dr. Sautter stated "the diagnosis is undifferentiated somatoform disorder with histrionic features. Histrionic means that there's this additional complaints about physical problems." (CX 8; p 15) "Q. And you also mentioned that her right in a claw position throughout the evaluation and that on three occasions you noticed that her right finger had popped straight but then slowly back into position with the others. Is that accurate? A. Yes." (CX 8; p 26)

The claimant was seen at Chesapeake Care in November 2011. Her grip was weak and she was unable to open the hand completely. There were similar findings in January 2012 and a history of depression was noted (CX 11).

When deposed in November 2011, Dr. Blackman testified that he was a psychiatrist and evaluated the claimant in August 2011. There were records from Drs. Mitchell and Thrasher and from many others. Dr. Blackman stated "I think that she has late onset schizophrenia. . . . And I also thought she had personality problems compromising narcissistic, obsessional, and potentially some manipulative anti-social

traits. So from a psychiatric standpoint that's what I thought. I did not feel that she had post-traumatic stress disorder." (EX 28; p 18)

At times, she could pull it together and answer a question logically, but after a few seconds, she would start wandering off and her thoughts could not remain, what some general psychiatrists call, goal directed. She could not stay on the issue.

So the whole question about startle ability [sic] is she certainly has it. Whether that is due to an accident, I don't think it is. In my opinion, it is not. I think that she has had that for a long time.

(CX 18; p 24)

Q. All right. You also diagnosed her with a personality disorder compromising a narcissistic, obsessional, and some anti-social, manipulative traits?

A. Yes.

. . . What I testified to is that she is startled - - she startles easily, and she's easily overwhelmed by emotion, which could be associated with PTSD. Except that I saw all these other signs of schizophrenia, so in my opinion, those things are not due to the typical posttraumatic stress disorder. They are due to her schizophrenia.

(EX 28; p 30, 39)

DISCUSSION

The claimant was injured on September 24, 2008 and the employer paid temporary total disability benefits through February 20, 2010. By the later date there were no confirmable organic physical impairments.

The claimant has a psychiatric impairment which has been variously diagnosed as a personality disorder, somatoform disorder, anxiety, depression, conversion reaction, and as schizophrenia.

Dr. Robert Mitchell began treating the claimant in December 2006 for depression and anxiety. This treatment continued into early 2009. Therefore, the claimant had a preexisting psychiatric impairment.

Section 20(a) Presumption

In this case, the issue is whether or not a preexisting psychiatric disorder was aggravated by the work injury.

The majority of mental health professionals in this case have diagnosed disorders in the category of a neurosis rather than a psychosis. The claimant was able to function on a fairly normal level, with the assistance of Dr. Robert Mitchell, prior to the injury in September 2008.

The claimant was extremely proud of her awards in body building competitions prior to the injuries. After the injury, she perceived, whether correctly or incorrectly, that her appearance was damaged and that she could no longer participate in events. Her psyche was damaged and led to the “claw hands” and her withdrawal from society.

The Section 20(a) presumption applies in this case as there is a documented traumatic event that could have produced a psychiatric disorder or aggravated a preexisting disability as indicated by Dr. Thrasher.

Employer’s Rebuttal

Since the Section 20(a) presumption has been raised, the burden shifts to the employer to rebut the presumption. In order to rebut the presumption, the employer must produce substantial countervailing evidence that the claimant’s condition was not caused, aggravated, or contributed to by the work accident. *Brown v. Jacksonville Shipyards, Inc.*, 893 F.2d 294, 297, 23 BRBS 22, 24 (CRT) (11th Cir. 1990); *Swinton v. J. Frank Kelly, Inc.*, 554 F.2d 1075, 1082, 4 BRBS 466, 477 (D.C. Cir. 1976), *cert. denied*, 429 U.S. 820 (1976).

The United States Supreme Court has defined “substantial evidence” as “more than a mere scintilla,” or “such relevant evidence as a reasonable mind might accept as adequate to support a conclusion.” *Richardson v. Perales*, 402 U.S. 389, 401 (1971); *Universal Camera Corp. v. NLRB*, 340 U.S. 474, 477 (1951); *Conoco, Inc. v. Director, OWCP [Prewitt]*, 194 F.3d 684, 33 BRBS 187 (CRT) (5th Cir. 1999); *Lockheed Shipbuilding v. Director, OWCP*, 951 F.2d 1143, 1145, 25 BRBS 85, 87 (CRT) (9th Cir. 1991); *Abosso v. D.C. Transit Sys.*, 7 BRBS 47, 50 (1977); *Avignone Freres Inc. v. Cardillo*, 117 F.2d 385, 386 (D.C. Cir. 1940). It is not a preponderance standard. *Norfolk Shipbuilding & Drydock Corp. v. Faulk*, 228 F.3d 378, 386 (4th Cir.2000).

When aggravation of or contribution to a pre-existing condition is alleged, the presumption also applies, and in order to rebut it, the employer must establish that the claimant’s condition was not caused or aggravated by his employment. *Rajotte v. General Dynamics Corp.*, 18 BRBS 85 (1986); *LaPlante v. General Dynamics Corp./Elec. Boat Div.*, 15 BRBS 83 (1982); *Seaman v. Jacksonville Shipyards*, 14 BRBS 148.9 (1981); *See Hensley v. Washington Metro. Area Transit Auth.*, 655 F.2d 264, 13 BRBS 182 (D.C. Cir. 1981), *cert. denied*, 456 U.S. 904 (1982), *rev’g* 11 BRBS 468 (1979) (employer must establish that aggravation did not arise even in part from employment).

In the instant case, the Employer contends that Claimant suffers from a psychiatric disorder that is unrelated to the injury at work. Dr. Blackman reported a diagnosis of schizophrenia which he felt was complicated by a personality disorder and that the major diagnosis was late onset and could not be attributed to the work injury. Dr. Sautter diagnosed a somatoform disorder but focused on ability to work rather than the origin of the disorder.

Given the medical opinions in evidence in this case, I find the Employer has rebutted the 20(a) presumption by showing substantial countervailing evidence that Claimant's condition was not caused, aggravated, or contributed to by Claimant's injuries in September 2008.

Weighing the Evidence

Once the presumption is rebutted, it falls out of the case and the claimant must establish a causal relationship based on the record as a whole by a preponderance of the evidence. *Universal Mar. Corp.*, 126 F.3d at 262 (citing *Del Vecchio v. Bowers*, 296 U.S. 280, 286 (1935)). Therefore, I will assess the evidence as a whole regarding this issue.

There are numerous psychological and psychiatric opinions in the record. The majority of these opinions report a neurosis such as a somatoform disorder or a conversion reaction. All have indicated that a personality disorder is present. Only Dr. Blackman has diagnosed schizophrenia and this opinion is not consistent with the others.

Dr. Robert Mitchell treated Claimant prior to the injury in September 2008 and she did not lose time from work during that interval.

The undersigned is aware that Dr. Thrasher first saw the claimant several years after the injuries. However, Dr. Thrasher has spent many hours with the claimant and I find his assessment to be the most credible. It is concluded that a preexisting psychiatric impairment was aggravated by the work injury.

Benefits were paid through February 20, 2010 and all of the providers have indicated that she has been totally disabled on a psychiatric basis since that time.

The undersigned did review the surveillance tape (EX 17).

AVERAGE WEEKLY WAGE

The parties have stipulated that the claimant earned an average weekly wage of \$356.18 in the year prior to the September 2008 injuries.

Claimant's counsel states that when Ms. Tillett-Bond began as a full-time shortshoreman she primarily worked at Lambert's Point Docks. Lambert's Point paid the least amount of money in the industry; therefore, she would attempt to get work as a longshoreman. (Tr. 115). Ms. Tillett-Bond had to earn enough hours to qualify for benefits working for Lambert's Point. (Tr. 116).

Lambert's Point provides an opportunity to earn unemployment benefits from the railroad. (Tr. 119). In order to earn that benefit, Ms. Tillett-Bond had to show that she was "an able body" and was able to work for the entire 24 hour day. To qualify, she would go to her Union hall looking for work. If her local did not have work available, she would then go to another local in an attempt to secure work. If by the end of the night she was unable to secure

work, she would receive \$59.00 in unemployment benefits for that day. (Tr. 120). This benefit is taxable income and she had to file a W-2 stating that she received this benefit. (Tr. 121).

The ALJ has broad discretion in determining annual earning capacity under subsection 10(c). The objective of subsection 10(c) is to reach a fair and reasonable approximation of a claimant's wage-earning capacity at the time of her injury. Section 10(c) is used where a claimant's employment is seasonal, part-time, intermittent, or discontinuous.

Ms. Tillett-Bond alleges that her AWW paid to her previously did not include all of her earnings. The record shows that the fifty-two (52) weeks prior to her work injury Ms. Tillett-Bond worked significantly as a shortshoreman and not in the longshore industry. She worked a great amount of time for Lambert's Point Docks which entitled her to garner unemployment benefits from the railroad when work was not available. These are not the typical unemployment benefit that one would receive from the Department of Labor but rather constitutes as a benefit of hire for working for the railroad. These unemployment benefits are similar to that of container royalty payments and should be included in the AWW.

On the days she was unable to find work from the longshore industry, she was paid a benefit from the railroad. Ms. Tillett-Bond contends that this benefit was an earned benefit similar to vacation and container royalty pay and therefore should be included in her AWW.

Ms. Tillett-Bond was paid \$6,549.00 in total for those benefits. Therefore, she requests that her AWW be adjusted from \$356.18 to \$482.13 to include those benefits.

The employer states that the claimant has also produced records from the Railroad Retirement Board, Railroad Unemployment Insurance Act payments. (CX 28-1) These benefits are payable pursuant to a Federal Act for individuals qualifying as railroad workers, and are not paid by the Employer.

CX 32 is a letter from the Railroad Retirement Board indicating the specific dates Claimant was paid unemployment by the Railroad Retirement Board. The Railroad Retirement Board is the counterpart of the Social Security Administration, dealing with railroad workers, and has no connection or relation to the Employer. (CX 32-1 to 32-2)

The employer argues that the Benefits Review Board has made clear that unemployment compensation is not to be considered in calculating AWW. *Blakney v. Delaware Operating Co.*, 25 BRBS 273 (1992). In *Blakney* the BRB held, consistent with the Seventh Circuit Court of Appeals holding in, *Strand v. Hansen Seaway Service, Ltd.*, 614 F.2d 572, 11 BRBS 732 (7th Cir. 1980), that unemployment compensation benefits are properly excluded from wages, as they do not constitute earnings.

Claimant's low seniority with the ILA kept her from working as many days as she may have liked, but that does not give her the right to come back retroactively and attempt to artificially increase her AWW.

The claimant's arguments have been considered but I do not find support in the case law. The employer has cited *Blakney* and I do find this case to be on point. The Board stated "[t]herefore, we hold that the administrative law judge properly declined to include claimant's taxed unemployment benefits in his calculation of claimant's average weekly wage."

ORDER

1. Compensation is to be based on an average weekly wage of \$356.18.
2. The employer is to pay temporary total disability from September 25, 2008 and continuing.
3. The employer is entitled to a credit for previous compensation payments.
4. The employer is to provide treatment under Section 7 of the Act for residuals of the 2008 injury.
5. All computations are subject to verification by the District Director.
6. Interest as the rate specified in 28 U.S.C. § 1961 in effect when the Decision and Order is filed with the Office of the District Director shall be paid on all accrued benefits computed from the date each payment was originally due to be paid See Grant v. Portland Stevedoring Co., 16 BRBS 267 (1984).
7. Claimant's attorney, within 20 days of receipt of this order, shall submit a fully supported fee application, a copy of which shall be sent to opposing counsel, who then shall have ten (10) days to respond with objections thereto.

RICHARD K. MALAMPHY
Administrative Law Judge

RKM/ccb/jrs
Newport News, Virginia