CASE NO. 6066 CRB-4-15-12 : COMPENSATION REVIEW BOARD
CLAIM NO. 400081416

ANTONIO VITTI
CLAIMANT-APPELLEE : WORKERS' COMPENSATION COMMISSION

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: APRIL 21, 2017

CITY OF MILFORD
EMPLOYER
SELF-INSURED

and

PMA CUSTOMER SERVICE CENTER
ADMINISTRATOR
RESPONDENTS-APPELLANTS

APPEARANCES: The claimant was represented by David J. Morrissey, Esq., Morrissey, Morrissey and Mooney, LLC, 203 Church Street, PO Box 31, Naugatuck, CT 06770.

The respondents were represented by Scott Wilson Williams, Esq., Williams Moran LLC, PO Box 550, Fairfield, CT 06824.

This Petition for Review[1] from the December 3, 2015 Finding and Award of Jack R. Goldberg, the Commissioner acting for the Third District, was heard December 16, 2016 before a Compensation Review Board panel consisting of the Commission Chairman John A. Mastropietro and Commissioners Ernie R. Walker and Nancy E. Salerno.

[1] We note that a postponement and extensions of time were granted during the pendency of this appeal.

OPINION

JOHN A. MASTROPIETRO, CHAIRMAN. The respondent employer, the City of Milford, has appealed from a December 3, 2015 Finding and Award ("2015 Finding") reached by Commissioner Jack R. Goldberg which determined that the injury sustained by its employee, the claimant Antonio Vitti, was compensable pursuant to § 7-433c C.G.S.[2] The Finding and Award in this matter occurred subsequent to a formal hearing held pursuant to a remand this tribunal ordered in Vitti v. Milford, 5877 CRB-4-13-8 (September 16, 2014) ("Vitti I"). In Vitti I, we directed Commissioner Goldberg to clarify inconsistent findings in his August 14, 2013 Finding and Award ("2013 Finding"), and to consider the evidence in accord with what we determined was the applicable law in this matter; i.e., the heart and hypertension statute in effect as of the claimant's 2010 date of injury. On appeal, the respondents challenge the applicability of the statute to this

[2] The statute in effect as of the claimant's date of injury read as follows: **"Sec. 7-433c. Benefits for policemen or firemen disabled or dead as a result of hypertension or heart disease.** (a) Notwithstanding any provision of chapter 568 or any other general statute, charter, special act or ordinance to the contrary, in the event a uniformed member of a paid municipal fire department or a regular member of a paid municipal police department who successfully passed a physical examination on entry into such service, which examination failed to reveal any evidence of hypertension or heart disease, suffers either off duty or on duty any condition or impairment of health caused by hypertension or heart disease resulting in his death or his temporary or permanent, total or partial disability, he or his dependents, as the case may be, shall receive from his municipal employer compensation and medical care in the same amount and the same manner as that provided under chapter 568 if such death or disability was caused by a personal injury which arose out of and in the course of his employment and was suffered in the line of duty and within the scope of his employment, and from the municipal or state retirement system under which he is covered, he or his dependents, as the case may be, shall receive the same retirement or survivor benefits which would be paid under said system if such death or disability was caused by a personal injury which arose out of and in the course of his employment, and was suffered in the line of duty and within the scope of his employment. If successful passage of such a physical examination was, at the time of his employment, required as a condition for such employment, no proof or record of such examination shall be required as evidence in the maintenance of a claim under this section or under such municipal or state retirement systems. The benefits provided by this section shall be in lieu of any other benefits which such policeman or fireman or his dependents may be entitled to receive from his municipal employer under the provisions of chapter 568 or the municipal or state retirement system under which he is covered, except as provided by this section, as a result of any condition or impairment of health caused by hypertension or heart disease resulting in his death or his temporary or permanent, total or partial disability. As used in this section, 'municipal employer' shall have the same meaning and shall be defined as said term is defined in section 7-467."

injury, claiming that the version of the statute in force in 1992 should be applied to the facts of this case. The respondents further argue the 2015 Finding erroneously determined that the claimant's Giant Cell Myocarditis ("GCM") was a heart disease within the scope of § 7-433c C.G.S. We are not persuaded by either argument. We find that Commissioner Goldberg properly determined this matter consistent with our decision in Vitti I and the 2015 Finding is supported by probative evidence. Therefore, we affirm the 2015 Finding.

Many of the facts of this case were discussed at length in Vitti I and need not be extensively restated. To summarize, the claimant, a Milford police officer since 1993, suffered cardiac distress while on a 2010 vacation trip. It was determined upon examination that he was suffering from acute myocarditis and eventually, after consultation with Dr. Detlef Wencker, the claimant underwent a heart transplant on September 29, 2010. Dr. Wencker determined, after an examination of tissue from the claimant's diseased heart, that the claimant was suffering from GCM, an extremely rare and highly lethal condition.

At the formal hearing for the 2015 Finding, Dr. Wencker testified that while GCM could be an autoimmune disease, it is localized to the heart and does not impact other organs. He testified that he had dealt with approximately ten (10) patients in GCM during his twenty-five (25) years of practice. Dr. Wencker further testified that while GCM may be mediated by an autoimmune process, there is no proof that this causes the ailment. He cited a work by Dr. Leslie Cooper of the Mayo Clinic published in 1997 entitled Idiopathic Giant Cell Myocarditis which noted the medical community's inability to identify the cause of GCM. Respondents' Exhibit 6. Dr. Wencker said that in the

claimant's case, there was no evidence of autoimmune disease and therefore he diagnosed GCM as a primary cardiac condition. He further said that while the claimant had been treated with prednisone for inflammation, it had not been effective, and had he relied on the evidence that prednisone was effective in treating GCM, the claimant would have died. Dr. Wencker said it was not possible for GCM to spread to the heart from some other part of the body. He differentiated GCM from sarcoidosis as sarcoidosis was a different type of disease which could form in the lungs or other organs. Had the claimant suffered from sarcoidosis, he would not have been a candidate for a heart transplant. Dr. Wencker indicated that due to the rare nature of GCM, there was sparse evidence as to causation, but there was no basis in the scientific literature or the claimant's case that implicated the claimant's employment. He also noted that patients with GCM die of heart failure, and of no other cause.

The respondents presented testimony from Dr. Martin Krauthamer.
Dr. Krauthamer testified that he knew of GCM but had no personal experience with the disease in his practice. He had conducted a records review and researched the disease prior to his testimony. He said there was no reference in medical literature associating employment with the development of GCM and said that with a reasonable medical probability he did not believe the claimant's employment caused the disease. He said that he considered GCM an autoimmune disease and because there was a twenty to twenty-five percent (20% to 25%) risk of a transplanted heart, subsequent to GCM, being subject to GCM again, this was not heart disease. He said immunosuppressive therapy is effective is some cases of GCM and its effectiveness suggested it was an immune

disease. Dr. Wencker, however, disagreed with these opinions and testified the absence of a recurrence bolstered his position that GCM was a primary disease of the heart.

Counsel for the claimant introduced responses received from the aforementioned Dr. Cooper of the Mayo Clinic to questions counsel had posed. Dr. Cooper stated that in ninety-five percent (95%) of cases, GCM inflammation was limited to the heart. In those cases, it is a solely cardiac disease mediated by immune cells, many of which were in the heart. Commissioner Goldberg also noted that respondents' counsel argued that Brooks v. West Hartford, 4907 CRB-6-05-1 (January 24, 2006), in which the Workers' Compensation Commission determined sarcoidosis was not a heart disease, was the closest case on point to the issues in this case.

Based on this record, Commissioner Goldberg concluded that the Compensation Review Board decision in Vitti I established that the terms of § 7-433c C.G.S. in effect in 2010 should be applied to this case. He concluded that the claimant was eligible for § 7-433c C.G.S. benefits and the claimant filed a timely claim for such benefits. The trial commissioner determined that the opinions of Dr. Wencker should be accorded great weight in light of his knowledge of GCM and that he was credible and persuasive in this matter. The commissioner distinguished Brooks, supra, on the basis that sarcoidoisis is a disease that affects several organs while GCM is solely a disease of the heart. As the trial commissioner found GCM was a heart disease within the terms of the statute, he ordered the respondents to pay all requisite benefits.

The respondents filed a Motion to Correct seeking to remove references to the version of § 7-433c C.G.S. in effect in 2010 and replace it with the 1992 version of the law, which included a "rebuttable presumption" provision where the respondents could

challenge a finding of workplace causation. The trial commissioner denied this motion and the respondents have commenced this appeal. They argue that the "rebuttable presumption" version of the statute should be applied and they successfully rebutted the presumption that the claimant's heart disease was work-related. They also argue that the evidence presented did not support the result the trial commissioner reached in this case. We are not persuaded.

On appeal, we generally extend deference to the decisions made by the trial commissioner. "As with any discretionary action of the trial court, appellate review requires every reasonable presumption in favor of the action, and the ultimate issue for us is whether the trial court could have reasonably concluded as it did." Daniels v. Alander, 268 Conn. 320, 330 (2004). The Compensation Review Board cannot retry the facts of the case and may only overturn the findings of the trial commissioner if they are without evidentiary support, contrary to the law, or based on unreasonable or impermissible factual inferences. Kish v. Nursing & Home Care, Inc., 248 Conn. 379, 384 (1999); Fair v. People's Savings Bank, 207 Conn. 535, 539 (1988). Nonetheless, while we must provide deference to the decision of a trial commissioner, we may reverse such a decision if the commissioner did not properly apply the law or reached a decision unsupported by the evidence on the record. Christensen v. H & L Plastics Co., Inc., 5171 CRB-3-06-12 (November 19, 2007).

As an initial matter, we must address a Motion to Dismiss filed by the claimant regarding this appeal. The claimant argues that since the remand from Vitti I to the trial commissioner involved essentially a ministerial act, there were no grounds for the respondents to appeal from the subsequent Finding and Award. We disagree, as we find

that this contention is inconsistent with the substance of the 2015 Finding and precedent on the issue. The trial commissioner clearly evaluated the relative merits of the evidence presented in reaching his conclusions in the 2015 Finding. This was not a ministerial act because it required deliberation on his part to reach this decision. See Hummel v. Marten Transport, Ltd., 90 Conn. App. 9, 13-15 (2005), *aff'd,* 282 Conn. 477 (2007), *citing* Szudora v. Fairfield, 214 Conn. 552 (1990). Therefore, we deny the Motion to Dismiss.

We now address the substance of the respondents' appeal. They argue that the commissioner erred by applying the version of § 7-433c C.G.S. which was in effect on the date of the claimant's injury in 2010. However, the trial commissioner did precisely what this tribunal directed him to do in our decision in Vitti I. Our decision on that issue has the effect of *res judicata* and will not be revisited on appeal. See Bailey v. State/Greater Hartford Community College, 5603 CRB-1-10-11 (October 5, 2011), *aff'd*, 139 Conn. App. 910 (2012)(Per Curiam), *cert. denied*, 308 Conn. 904 (2013); Gilbert v. Ansonia, 5342 CRB-4-08-5 (May 14, 2009); Hicking v. State/Department of Correction, 4935 CRB-2-05-4 (April 10, 2006). The determination of which version of the heart and hypertension statute is applicable to the claimant's injury is now "the law of the case." The claimant needed only to establish his illness was due to a "heart disease" to obtain compensation, and the issue of workplace causation was not relevant to a determination of his right to receive benefits.

The respondents argue that the evidence on the record does not support a conclusion that GCM was a "heart disease" and therefore an award of benefits to the claimant was beyond the scope of § 7-433c C.G.S. We note counsel for the respondent advanced similar arguments in O'Brien v. Stamford Fire Department, 5945 CRB-7-14-7

(September 11, 2015), which cited Brooks, supra, "for the proposition that a trial commissioner may reasonably determine an injury to a claimant's heart need not constitute 'heart disease' within the meaning of § 7-433c C.G.S." Our evaluation of the Brooks precedent in O'Brien is instructive as to how we believe we should evaluate this case.

> We commence our discussion by reviewing the precedent relied upon by the respondents. We do not find Brooks, supra, of much precedential value in this dispute. In Brooks the cardiac issues which led to the death of the decedent were clearly the sequalae [sic] of his sarcoidosis, an inflammatory ailment similar to cancer which was not specific or isolated to the heart. The trial commissioner did not consider these circumstances as due to "heart disease" and this tribunal affirmed that factual finding. The decedent in Brooks was not diagnosed with any other sign of coronary disease. The reasoning in Brooks that a non-coronary disease merely manifested itself in the heart is not supported by the record present in this case. The respondents point to no diagnosis of any non-cardiac ailment which the claimant was suffering from which would explain the presence of his arrhythmia. We do not extend the reasoning in Brooks that a non-coronary disease can be the cause of cardiac distress to cases where no other agent for the claimant's condition can be identified.

O'Brien, supra.

On the other hand, we do find Brooks has precedential value relative to the manner in which we must review a trial commissioner's evaluation of contested medical evidence, especially in cases regarding § 7-433c C.G.S.

> The dispositive issue is the first one: whether this board can overrule the trier's determination that the decedent's sarcoidosis did not constitute heart disease. One of the primary tenets of our standard of appellate review is that the trial commissioner has the right and the duty to decide how much of the medical evidence presented to him is persuasive and reliable. Duddy v. Filene's (May Department Stores Co.), 4484 CRB-7-02-1 (October 23, 2002); Pallotto v. Blakeslee Prestress, Inc., 3651 CRB-3-97-7 (July 17, 1998). A commissioner may choose to credit all, part or none of an expert's testimony. O'Reilly v. General Dynamics

> Corp., 52 Conn. App. 813, 819 (1999). On review, this board may not second-guess a commissioner's inferences of evidentiary credibility, and we may reverse factual findings only if they are unsupported by the evidence or if they fail to include undisputed material facts. Id.; Warren v. Federal Express Corp., 4163 CRB-2-99-12 (February 27, 2001).

Brooks, supra.

The trial commissioner in the present case concluded that GCM was a "heart disease." See Conclusion, ¶ h. We have reviewed the evidence to see if this was a reasonable conclusion. In so doing, we take reference that on remand the trial commissioner clearly stated that he found the opinion of Dr. Wencker credible and persuasive on this issue. See Conclusion, ¶ c. This determination is one for the trial commissioner to reach when the parties present expert witnesses offering contradictory opinions. Dellacamera v. Waterbury, 4966 CRB-5-05-6 (June 29, 2006), n.1. As we held in Strong v. UTC/Pratt & Whitney, 4563 CRB-1-02-8 (August 25, 2003), "[i]f on review this board is able to ascertain a reasonable diagnostic method behind the challenged medical opinion, we must honor the trier's discretion to credit that opinion above a conflicting diagnosis." Therefore, our inquiry must focus on whether Dr. Wencker's testimony supported the finding and conclusions reached by the trial commissioner.

Dr. Wencker offered live testimony before the trial commissioner at the formal hearing held on July 24, 2012. He testified that GCM was localized to the organ of the heart. July 24, 2012 Transcript, p. 40. He further testified that at the time the claimant required a heart transplant, he was suffering from no other diseases or medical conditions, id., 50, and had the claimant been suffering from sarcoidosis, he would not have been a transplant candidate due to the multi-organ involvement of the illness. Id.

Dr. Wencker said that he was not even sure the claimant had autoimmune disease due to his failure to respond to prednisone. Id., 50-51. Later, when asked to compare this situation with the facts in the Brooks case, Dr. Wencker offered this testimony as to the claimant's GCM.

> It is, to my understanding, not a systemic disease. To my understanding, it's a disease primarily of the heart. And it might be associated with autoimmune disease, but the systematic disease has not been confirmed. You need to individualize every single case of advanced heart failure. Particularly in this case, Mr. Vitti, this is a specific cardiac giant cell myocarditis.

Id., 62.

Dr. Wencker further testified that due to the rare nature of the disease and the small number of patients included in published studies, it was "far-fetched" to conclude that GCM was a systemic disease. Id., 71. Dr. Wencker refuted the opinion of Dr. Krauthamer that GCM was part of an autoimmune process that could cause heart disease because in eighty percent (80%) of the cases, no other organ system is involved. Id., 74-75. Dr. Wencker further offered testimony that sarcoidosis involved the development of granulomas which could present themselves diffusely across the body in organs such as the lungs, while GCM manifested itself only in the heart. Id., 94. He further noted that while patients with sarcoidosis could die of pulmonary failure, patients with GCM died exclusively of heart failure. Id., 101.

Dr. Wencker testified again before the trial commissioner at a January 16, 2013 formal hearing. He reiterated his disagreements with Dr. Krauthamer's opinion, pointing out that in his opinion, the case cited by the respondents for finding GCM was associated with multiple organ failure involved a misunderstanding in the 1960's between the nature

of sarcoidosis and GCM. January 16, 2013 Transcript, pp. 26-29. In all other respects, we find the witness essentially reiterated his prior testimony.

Given this testimony from a witness whom the trial commissioner found persuasive and credible, we believe the trier reasonably determined that GCM was a heart disease. We must credit a trial commissioner's determination on this issue if there is evidence to support it. Brooks, supra. We believe, similar to the circumstances in O'Brien, supra, that the trial commissioner could reasonably determine that the claimant, at the time of his cardiac distress, was suffering not from a more generalized ailment that resulted in a cardiac injury but, rather, from a localized heart disease. Such a disease is properly compensable within the terms of § 7-433c C.G.S.

Commissioner Goldberg appropriately followed the direction of this tribunal's remand in Vitti I. The 2015 Finding is supported by probative evidence from a witness the commissioner found credible and persuasive.

Therefore, we affirm the 2015 Finding.

Commissioners Ernie R. Walker and Nancy E. Salerno concur in this opinion.

CERTIFICATION

THIS IS TO CERTIFY THAT a copy of the foregoing was mailed this 21st day of April 2017 to the following parties:

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