CASE NO. 6460 CRB-8-21-12 : COMPENSATION REVIEW BOARD
CLAIM NO. 800203840

ROBERT BERRY : WORKERS' COMPENSATION
CLAIMANT-APPELLANT COMMISSION

v. : NOVEMBER 9, 2022

UP REALTY, L.L.C, UPLIFT CONTRACTING
INC., and HANDSON CONTRACTING, INC.
EMPLOYER

and

EVEREST NATIONAL INSURANCE c/o
SEDGWICK CLAIMS MANAGEMENT SERVICES, INC.
INSURER
RESPONDENTS-APPELLEES

APPEARANCES:

The claimant was represented by Michael P. Foley, Jr., Esq., Michael P. Foley, Jr., P.C., 1120 South Main Street, Cheshire, CT 06410.

The respondents were represented by Gerald V. Davino II, Esq., Testan Law, 515 Centerpoint Drive, Suite 115, Middletown, CT 06457.

This Petition for Review from the November 29, 2021 Finding and Denial of David W. Schoolcraft, Administrative Law Judge acting for the Eighth District, was heard on June 24, 2022 before a Compensation Review Board panel consisting of Chief Administrative Law Judge Stephen M. Morelli and Administrative Law Judges Daniel E. Dilzer and William J. Watson III.

OPINION

STEPHEN M. MORELLI, CHIEF ADMINISTRATIVE LAW JUDGE. The claimant has petitioned for review from the November 29, 2021 Finding and Denial of David W. Schoolcraft (finding), Administrative Law Judge acting for the Eighth District. We find no error and accordingly affirm the decision.[1]

The administrative law judge identified as the sole issue for determination whether the medical condition which led to the claimant's hospitalization and the amputation of his left leg was causally related to an ankle contusion which arose out of and in the course of his employment. The administrative law judge made the following factual findings which are pertinent to our review. On Friday, May 11, 2018, the claimant was employed by Uplift Contracting, Inc., a/k/a Handson Contracting, Inc., both of which were affiliated with Up Realty, L.L.C., and subject to the provisions of the Connecticut Workers' Compensation Act. On this date, the claimant was engaged in the demolition of a bathroom in a Middletown apartment building owned by the employer. While he was wielding a thirty-pound sledgehammer to break up an old cast-iron tub, a piece of iron flew off and struck him on the inner (medial) side of his left ankle. He was wearing work boots at the time which covered his lower leg up to the point of impact.

Approximately an hour and a half later, the claimant stopped working due to pain and was driven home by a coworker, Scott Fontaine. The claimant had to lean on Fontaine in order to get up the steps to his apartment. Once they arrived at the apartment, the claimant removed his work boot; the ankle was very painful and appeared to be swollen, but there was no blood or any other obvious sign of a serious injury. The

[1] We note that two motions for extension of time were granted during the pendency of this appeal.

claimant did not believe the ankle had been fractured; he neither sought medical attention nor applied ice to the ankle, although he may have taken an over-the-counter analgesic such as Tylenol. For the rest of that day, the claimant stayed off his foot, mostly watching television from his bed. Although walking was painful, the claimant was still able to use the bathroom, fix something to eat, and take his medication. The ankle was sore when he went to bed.

When the claimant awoke on Saturday, May 12, 2018, the ankle was still swollen, bruised, discolored, and painful. The claimant remained at home all day and, at some point, began experiencing abdominal pain. He also became nauseated and vomited. Fontaine stopped by the claimant's apartment, likely around lunchtime, and found the claimant still nauseated and vomiting. The claimant complained that he was concerned about the pain in his foot; Fontaine offered to take the claimant to the hospital but the claimant refused. Fontaine stayed for about fifteen minutes and then left, intending to come back and check on the claimant the following day. The claimant remained inactive for the rest of the day, although he was able to get up to use the bathroom and get something to drink.

By Sunday, May 13, 2018, the claimant felt even more unwell. In addition to experiencing nausea and abdominal pain, he was feverish and had chills. Fontaine did not stop by. The claimant remained in bed for most of that day; if he got out of bed at all, it was to use the bathroom or get a drink of water. He testified that his recollection of that day is unclear and he felt too unwell generally to pay much attention to his ankle.

On Monday, May 14, 2018, Fontaine arrived at the claimant's apartment some time prior to 8:00 a.m. He knocked on the door but there was no answer, so he let

himself in. He found the claimant naked on the bed, lying in a fetal position and looking emaciated. Although he was able to rouse the claimant enough to get him to speak, some of what the claimant said was "delusional and nonsensical." Findings, ¶ 14. Fontaine called 911, and an EMT and a paramedic from Hunters Ambulance Service arrived shortly thereafter.

When the ambulance crew arrived, the claimant was still lying on the bed, partially alert. The paramedic reported his Glasgow Coma Scale (GCS) score as thirteen out of fifteen, with a low verbal score because the claimant's "words were understandable but inappropriate to the situation."[2] Findings, ¶ 15. The paramedic also noted that the claimant appeared very emaciated and estimated his weight to be 110 pounds. The paramedic reported that the claimant's pupils were dilated, his pulse was "fast and thready," and his blood pressure was low. Findings, ¶ 16, *citing* Claimant's Exhibit B, p. 4. Fontaine provided the ambulance crew with information about what he had observed when he visited the claimant on Saturday; in addition, he apprised the crew that the claimant was a smoker and had a history of substance abuse but had been clean for some time. The crew was also informed about the claimant's current medications and known allergies.

The ambulance crew carried the claimant down the steps with a stair-chair; he was unable to hold his head up and became unresponsive while being carried. When they reached the stretcher on the ground level, the paramedic could not feel a carotid pulse and began cardiopulmonary resuscitation (CPR); an oral airway was inserted and an IV

[2] "The Glasgow coma scale assesses brain function on the basis of how a patient responds to certain stimuli by opening the eyes and giving verbal and motor responses." State v. Coccomo, 115 Conn. App. 384, 389, n.1 (2009), *rev'd*, 302 Conn. 664 (2011).

started. After about eight minutes, the crew detected a pulse and stopped cardiac compressions, although they continued to ventilate the claimant. By the time they arrived at the emergency department at Middlesex Hospital, the claimant was hypoxic and in respiratory failure. A breathing tube was inserted which would remain in place for ten days. The claimant underwent an EKG, chest x-rays and a CT scan of the brain. When he returned to the emergency department, hospital personnel were again unable to locate a pulse; CPR was restarted, he was administered epinephrine, and circulation resumed. While in the emergency department, the claimant experienced episodes of atrial fibrillation and tachycardia.

The claimant also underwent a CT scan of his neck as well as an abdominal CT scan which showed pockets of fluid in his abdomen and ileus of the colon. The claimant's blood pressure continued to drop; although it had initially been recommended that the claimant be transferred to Hartford Hospital, there was no EKG evidence of an ST-segment elevation myocardial infarction, so he was admitted to the critical care unit (CCU) at Middlesex Hospital. Prior to being transferred to the CCU, the claimant had a consultation with Manju M. John, a cardiologist, who reported that the claimant's laboratory results demonstrated "evidence of acute renal failure, likely ATN [acute tubular necrosis], hypernatremia [excess salt in the blood], leukocytosis [high white blood cell count indicative of infection] and lactic acidosis suggestive of septic shock." Findings, ¶ 23, *quoting* Claimant's Exhibit C, p. 22. John also reported that a chest x-ray had not shown any evidence of pneumonia.

The claimant's EKG showed sinus rhythm with no sign of cardiac ischemia. John noted that the claimant's "troponin is significantly elevated about 6.5 – this is likely

multifactorial from severe hypotension, sepsis, acute renal failure and likely from demand ischemia secondary to severe hypotension possibly in the setting of underlying fixed coronary artery disease." Findings, ¶ 24, *quoting* id. John diagnosed the claimant as having sustained, inter alia, a non-ST elevation myocardial infarction and recommended treatment with heparin for forty-eight to seventy-two hours provided there were "no absolute contraindications." Id.

While in the CCU, the claimant was treated by Nicole Weinreb, a critical care specialist. In her initial evaluation dated May 14, 2018, Weinreb reported the claimant as suffering from:

> acute respiratory failure; altered mental status likely due to "metabolic encephalopathy"; hypovolemic shock; septic shock "of unclear etiology"; profound renal failure "likely due to hypovolemic shock as well as probably ATN from septic shock"; malnutrition (at this point he was documented to weigh 132 pounds); and a lung mass (which had shown up on a CT scan of the neck). Regarding the cardiovascular system, she noted hypotension due to septic shock and, probably, also due to hypovolemic shock. Like Dr. John, she felt the claimant had a NSTEMI, as opposed to a STEMI. Based on her concerns over the GI issues, however, Dr. Weinreb held off on authorizing heparin, which is a blood thinner that increases risk of internal bleeding.

Findings, ¶ 25, *quoting* id., 13-14.

By the time Weinreb wrote her initial assessment on May 14, 2018, she had spoken with the claimant's family and been advised that he had sustained an ankle injury the week before. With regard to this injury, Weinreb wrote:

> [the claimant] supposedly had an ankle injury last week there is no bruising on his ankles or evidence for deformity. He does have a spot on the top of the left foot which could potentially look like the head of a hammer. It is not tender to palpation. We can do some imaging of his foot when he is more stable.

Claimant's Exhibit C, p. 14.

On May 15, 2018, Weinreb again evaluated the claimant, and her medical diagnoses were essentially the same as they had been the day before. Weinreb reported that the claimant was suffering from an altered mental status "likely due to metabolic encephalopathy from his multiple metabolic derangements and dehydration as well as septic shock"; acute respiratory failure; and acute kidney injury. Id., 77. Weinreb also reported that the claimant's cardiac diagnoses included cardiac arrest, non-sustained ventricular tachycardia, paroxysmal atrial fibrillation, and NSTEMI. In addition, the claimant was suffering from hypotension "due to septic shock as well as probably hypovolemic shock." Id.

On May 15, 2018, Stacy Sanzone, a palliative care APRN, met with Weinreb and the claimant's family. Based on her discussion with family members, Sanzone reported that a coworker had found the claimant, who "had gone home from work on Friday because he had actually hit his ankle with a hammer or other tool." Id., 39. She further noted that the claimant had been "unable to walk because of the injury," id., and when the coworker went to check on the claimant the day after the injury, the claimant "was acting all crazy, repeating things around his house, acting delirious." Id. Sanzone reported that the claimant's ex-wife indicated that the claimant had been taking anxiety medication prescribed by a psychiatrist whom he saw every two or three weeks, and the ex-wife wondered if the claimant had run out of his anxiety medication because had been unable to secure transportation to pick it up.[3]

[3] At his deposition, the claimant testified that he did not run out of any of his medications over the weekend and that he was "adamant" about regularly taking his blood pressure and cholesterol medicine. Claimant's Exhibit G, p. 49.

On May 16, 2018, the claimant was examined by David Miner, a nephrologist, who opined that the claimant had sustained an "[a]cute kidney injury secondary to ischemic acute tubular necrosis (ATN)." Id., 53. Miner recommended changing the composition of the claimant's intravenous fluids but did not believe the claimant required hemodialysis at that time. See id. Also on May 16, 2018, laboratory cultures of the claimant's sputum demonstrated the presence of Methicillin-Resistant Staphylococcus Aureus (MRSA); by this point, the claimant had been put on antibiotics. See id., 171. On May 17, 2018, Thejas Swamy, another nephrologist, put in an urgent order for the placement of a jugular port for dialysis. See id., 93.

By May 18, 2018, the claimant was more alert, and his urinary output and the circulation to his hands had improved. However, his left leg "remained cold and purple and showed mottling. There was concern he might have rhabdomyolysis, a condition where dying muscle tissue causes proteins and electrolytes to be released into the bloodstream, putting the kidneys and heart at risk." Findings, ¶ 32. The claimant subsequently had a consultation with Megan Shue, a vascular surgeon, who noted the claimant's rising creatinine levels and expressed concern that the claimant was experiencing "renal failure from rhabdomyolysis due to muscle death of the leg." Claimant's Exhibit C, p. 62. Shue recommended that the claimant "undergo above-knee amputation for control of ischemia as well as systemic toxicity." Id.

Later that same day, the claimant underwent a surgical amputation of his left leg above the knee. The pathological evaluation of the amputated limb indicated:

> There are multiple skin lesions present, the largest on the lateral mid foot measuring 5 cm. There are several (approximately nine) areas of eschar on the lateral aspect of the leg extending from the calcaneus up to just below the knee.... There is skin slippage

> present, and the muscle is notably discolored. Sectioning of the vessels at the margin appear to show some thrombosis. The popliteal artery shows approximately 50% stenosis. The skin lesions are superficial and none are deep enough to consider osteomyelitis.

Id., 65-66.

On May 19, 2018, the claimant was examined by Peter Pace, another critical care physician, who noted that the claimant's blood pressure had dropped during dialysis and recommended changes to the claimant's dialysis regimen. Because the claimant had a fever, he was examined by Irida Moll, an infectious disease specialist, on May 20, 2018. Moll reported that lab studies were "significant for leukocytosis which has been worsening in the last 2 days," id., 46, and the claimant's May 16, 2018 sputum culture demonstrated "[h]eavy growth" MRSA. Id., 49. Moll was uncertain whether the claimant's fever was due to an infection or a drug reaction and recommended that the claimant be kept on the antibiotic Vancomycin.

On May 21, 2018, Todd Barry, a critical care physician, ordered another CT scan of the claimant's chest because of x-ray findings possibly suggestive of cancer. In reviewing this scan, John's May 21, 2018 progress note indicated that the CT findings included "[m]ultifocal pulmonary opacities in the lower lobes, likely pneumonia, new since prior exam." Id., 140.

Following his surgery, the claimant was put back on a heparin drip, at which point he developed a gastrointestinal bleed; on May 21, 2018, he underwent a blood transfusion because of a drop in hemoglobin. An endoscopy was performed on May 22, 2018, and the claimant was found to have a duodenal ulcer that was not actively bleeding. The heparin was discontinued and the claimant was put on an intravenous proton pump

inhibitor. Also on the same date, because of his persistent fever, the claimant had a consultation with Lavanya Jitendranath, another infectious disease specialist. Jitendranath was not convinced that the claimant's fever was due to an infection but ordered an ultrasound of the gall bladder. On May 23, 2018, Jitendranath reported that she did not believe the fever was due to pneumonia.

By May 23, 2018, the claimant's kidney function had improved and he was able to stop dialysis. However, on May 26, 2018, the claimant experienced an acute onset of lower abdominal pain with blood in his stool, and underwent an examination with James Michael Parker, a surgeon. Parker reviewed the abdominal CT scan and indicated that his "best diagnosis is ischemic colitis at the watershed area of the splenic flexure. This is not likely spontaneous bacterial peritonitis given the lack of tenderness on exam." Id., 38. Parker recommended the claimant be administered antibiotics intravenously with no oral intake.

By June 1, 2018, the claimant's renal failure had resolved and his condition had sufficiently stabilized such that he was able to be discharged to Gaylord Hospital for post-acute care and rehabilitation. The hospital discharge summary indicates that the left-leg amputation was "secondary to leg ischemia from cardiac arrest," id., 2, and lists the following diagnoses:

> Left AKA [above-knee amputation]
> Cardiac Arrest – NSVT [non-sustained tachycardia], Paroxysmal Afib, NSTEMI
> Hypomagnesemia
> Upper GI bleed due to ulcer (resolved on PPI)
> Ischemic Colitis
> Protein Malnutrition
> Sepsis and septic shock due to MRSA pneumonia – resolved
> Acute respiratory failure due to above
> Upper extremity DVTs, non-occlusive, unable to anticoagulate due to bleed
> HTN [hypertension]

Depression
Chronic Pain
Phantom Pain

Id., 1.

The claimant remained at Gaylord until June 26, 2018, at which point he was discharged and subsequently seen on an out-patient basis for instructions on the use of a prothesis. On August 3, 2018, the claimant underwent an examination with Kimberly Hudson, a cardiac care APRN, who ordered a nuclear stress test. The test, which was conducted on August 23, 2018, did not cause chest pain or result in any other significant cardiac findings. At some point in November 2018, the claimant was diagnosed with colon cancer, for which he underwent surgery.

On January 28, 2019, the claimant, through counsel, filed a "form 30C" notice of claim for compensation alleging that he had sustained an injury to his left leg and a heart attack as a result of being struck in the left leg by a piece of flying metal on May 11, 2018.[4] This notice listed the employer as "Level Construction, Inc." Administrative Notice Exhibit 1. On February 19, 2019, again through counsel, the claimant filed a second notice of claim reporting the same allegations as the first notice but identifying the employer as "Up Realty, L.L.C." Administrative Notice Exhibit 3. On March 11, 2019, counsel for Everest National Insurance filed a "form 43" disclaimer identifying the employer as "Hands On & UpRealityNY."[5] Administrative Notice Exhibit 6.

[4] "A form 30C is the document prescribed by the workers' compensation commission to be used when filing a notice of claim pursuant to the Workers' Compensation Act, General Statutes § 31-275 et seq." Mehan v. Stamford, 127 Conn. App. 619, 622 n.4, *cert. denied*, 301 Conn. 911 (2011).

[5] "A form 43 is a disclaimer that notifies a claimant who seeks workers' compensation benefits that the employer intends to contest liability to pay compensation." Mehan v. Stamford, 127 Conn. App. 619, 623 n.6, *cert. denied*, 301 Conn. 911 (2011).

On June 12, 2019, the claimant testified at a deposition, stating that he had been sober for two years prior to the date of injury on Friday, May 11, 2018. He explained that he left work early on Friday, May 11, 2018, because he was in pain following the accident; he also described what happened when he removed his boot after Fontaine had brought him home. He indicated that for the rest of the day on Friday, he primarily stayed off his foot but was able to move around well enough to get himself something to eat. He testified that when Fontaine visited him on Saturday, he was still trying to stay off his foot but was able to get around the apartment as necessary and take his usual daily medications. However, he indicated that by Sunday, he had become physically ill and that things were a "blur" after that, including the early days of his hospitalization.[6] Claimant's Exhibit G, p. 51. The claimant also testified that prior to the May 11, 2018 work-related accident, he had never been diagnosed with malnutrition and he had no history of cardiac or vascular disease.[7] The claimant indicated that his only known health conditions as of the date of injury were hypertension, high cholesterol, and anxiety.

On July 13, 2019, more than a year after the date of injury, Fontaine met with an investigator who had been retained by the claimant's attorney and signed an affidavit regarding the circumstances of the claimant's injury and the events of the following weekend. On February 6, 2020, Fontaine testified at a deposition, explaining that the claimant reported the workplace injury to him on the morning of Friday, May 11, 2018, and that at some point thereafter, he had to drive the claimant home and assist him up the

[6] The administrative law judge noted that although the claimant testified that he did not become physically unwell until Sunday, May 13, 2018, the fact that Fontaine was able to inform the ambulance crew of the claimant's gastrointestinal symptoms on Monday, May 14, 2018, even though he had not visited the claimant on Sunday, suggests that the claimant must have begun exhibiting the symptoms prior to Fontaine's visit on Saturday, May 12, 2018.

[7] The claimant did testify that he had been advised by medical professionals to drink Ensure, and he admitted that he didn't "eat as much as he should." Claimant's Exhibit G, p. 64.

stairs because the claimant was having difficulty walking. He indicated that he had examined the claimant's ankle at work and helped the claimant get into bed when they arrived at the apartment.

Fontaine testified that when he returned on the following day, the claimant was still in bed and his foot was swollen and discolored. He offered to drive the claimant to the hospital but the claimant declined. He then testified regarding the condition in which he had found the claimant on the morning of Monday, May 14, 2018, and his decision to call 911. He described what happened when the ambulance crew arrived and how he partially videotaped the encounter. He indicated that he did not speak with the claimant's ex-wife and was unable to get any information regarding the claimant's condition from the hospital. He was eventually able to visit the claimant in the hospital after the amputation.

On the basis of the foregoing, the administrative law judge concluded that on Friday, May 11, 2018, the claimant sustained a work-related injury to his inner left ankle. The injury resulted in immediate pain which gradually increased, requiring the claimant to leave work early; however, it did not break the skin or cause a fracture. Although the claimant was in pain when he put any weight on his foot during the day on Friday, he was still able to fix something to eat and drink, take his medications, and tend to his other personal needs. On Saturday, May 12, 2018, the claimant's foot was still painful but he was able to move around his apartment when necessary. However, at some point during the day, he became physically ill and began to experience abdominal pain, nausea and vomiting. He remained at home and declined Fontaine's offer of a ride to the hospital. It is not clear if the claimant ate or drank anything after he became ill.

The claimant developed a MRSA infection which eventually manifested as pneumonia. No expert opinion connected the MRSA or pneumonia to the ankle injury. At some point, the MRSA developed into sepsis; however, there was likewise no evidence linking the sepsis to the ankle injury. On Sunday, May 13, 2018, the claimant began suffering from a fever in addition to his other symptoms. He stayed in bed, and his condition deteriorated into septic shock. There was no evidence in the record regarding the condition or appearance of his ankle that day.

By the following Monday morning, the claimant was badly dehydrated and demonstrating a "severely altered mental state" which was referred to in the records as "delirium." Conclusion, ¶ G; see Claimant's Exhibit C, p. 39; Claimant's Exhibit H, p. 18; Claimant's Exhibit H [Claimant's Deposition Exhibit 5, ¶ 21]. However, there was no evidence in the record suggesting that the claimant's injury prevented him from taking his usual daily medications over the course of the weekend, although he may well have stopped taking any pills once he began experiencing nausea and vomiting. As such, "[t]he claimant's altered mental state on May 14, 2018 was the direct result of his septic shock, possibly compounded by the dehydration." Conclusion, ¶ H.

In addition, the claimant's blood pressure was critically low due to septic and hypovolemic shock. By the time the ambulance crew removed the claimant from his apartment, his blood pressure had dropped so low that his heart was not able to pump enough blood to produce a pulse and he required CPR. Nevertheless, although:

> the claimant suffered a life-threatening cardiovascular crisis on May 14, 2018, the cardiac symptoms – variously referred to as a heart attack or incidents of "cardiac arrest" – were the result of the claimant's dramatic loss of blood pressure and were not caused by any coronary artery obstruction or other defect within the heart.

> Indeed, there is no evidence the claimant sustained any lasting injury to the heart as a result of the events of May 14, 2018.

Conclusion, ¶ J.

Rather, the cardiovascular symptoms experienced by the claimant were due to "severe shock, and the critically low blood pressure (i.e., shock) caused a reduction in blood flow to the claimant's extremities, including his left leg." Conclusion, ¶ K.

The administrative law judge did not find persuasive the August 13, 2019 opinion of Michael A. Luchini, an orthopedic surgeon, postulating that the claimant's collapse on Monday, May 14, 2018, was caused by dehydration due to the claimant's inability to walk during the preceding weekend. The trier noted that this opinion was not only based on the "incorrect factual premise" that the claimant was bedridden but was "also medically inconsistent with the overwhelming consensus of medical opinion that the medical crisis on May 14, 2018 was the result of septic shock." Conclusion, ¶ L.

Similarly, the administrative law judge did not find persuasive the opinion of Raghuraman R. Vidhun, a cardiologist, who opined that the reason the circulation in the claimant's left leg did not recover was due to the contusion on the claimant's left ankle. Rather, the trier concluded that even though the claimant may not have previously been diagnosed with or undergone treatment for vascular disease, "there is ample evidence in the medical records to conclude that prior to May 11, 2018, the claimant had some degree of arterial stenosis, specifically in the vessels serving the left leg." Conclusion, ¶ N. The trier therefore found more persuasive the report provided by Samuel S. Hahn, an interventional cardiologist, opining that the claimant's left ankle injury and episode of left leg ischemia were coincidental.

The administrative law judge concluded that although the claimant did sustain a contusion to his left ankle on Friday, May 11, 2018, "the cardiovascular crisis over the weekend – which led to both his hospitalization and the eventual amputation of his left leg – was an intervening and supervening event that severed the chain of causation between that work accident and any subsequent medical treatment or incapacity to work." Conclusion, ¶ O. As such, the trier determined that although the left ankle injury was compensable, any incapacity to work associated with that injury did not extend beyond three days. In addition, given that the site of the contusion was subsequently amputated, and no medical treatment was undertaken for the contusion prior to the amputation, the claimant was entitled to no additional benefits apart from a full day's wages for Friday, May 11, 2018.

The claimant filed a motion to correct which was granted in part, and this appeal followed. On appeal, the claimant contends that the administrative law judge erroneously relied upon medical opinions "which were based on speculation and conjecture" in reaching his conclusion that the claimant's work-related contusion to his left ankle was not a substantial contributing factor to his subsequent hospitalization or the amputation of his left leg. Appellant's Brief, p. 20, *citing* Struckman v. Burns, 205 Conn. 542, 554 (1987). The claimant also asserts that the administrative law judge's denial of the balance of the proposed corrections in his motion to correct constituted error.

We begin our analysis of this matter with a recitation of the well-settled standard of review we are obliged to apply to a trier's findings and legal conclusions.

> [T]he role of this board on appeal is not to substitute its own findings for those of the trier of fact. Dengler v. Special Attention Health Services, Inc., 62 Conn. App. 440, 451 (2001). The trial commissioner's role as factfinder encompasses the authority to

> determine the credibility of the evidence, including the testimony of witnesses and the documents introduced into the record as exhibits. Burse v. American International Airways, Inc., 262 Conn. 31, 37 (2002); Tartaglino v. Dept. of Correction, 55 Conn. App. 190, 195 (1999), *cert. denied*, 251 Conn. 929 (1999). If there is evidence in the record to support the factual findings of the trial commissioner, the findings will be upheld on appeal. Duddy v. Filene's (May Department Stores Co.), 4484 CRB-7-02-1 (October 23, 2002); Phaiah v. Danielson Curtain (C.C. Industries), 4409 CRB-2-01-6 (June 7, 2002). This board may disturb only those findings that are found without evidence, and may also intervene where material facts that are admitted and undisputed have been omitted from the findings. Burse, supra; Duddy, supra. We will also overturn a trier's legal conclusions when they result from an incorrect application of the law to the subordinate facts, or where they are the product of an inference illegally or unreasonably drawn from the facts. Burse, supra; Pallotto v. Blakeslee Prestress, Inc., 3651 CRB-3-97-7 (July 17, 1998).

McMahon v. Emsar, Inc., 5049 CRB-4-06-1 (January 16, 2007).

We note at the outset that it is well-established in our case law that the "traditional concepts of proximate cause furnish the appropriate analysis for determining causation in workers' compensation cases," Dixon v. United Illuminating Co., 57 Conn. App. 51, 60 (2000), and "the test for determining whether particular conduct is a proximate cause of an injury [is] whether it was a substantial factor in producing the result." (Internal quotation marks omitted.) Paternostro v. Arborio Corp., 56 Conn. App. 215, 222 (1999), *cert. denied*, 252 Conn. 928 (2000), *quoting* Hines v. Davis, 53 Conn. App. 836, 839 (1999). In Birnie v. Electric Boat Corp., 288 Conn. 392 (2008), our Supreme Court stated that "the substantial factor standard is met if the employment "'*materially or essentially contributes* to bring about an injury….'" (Emphasis in the original.) Id., 412, *quoting* Norton v. Barton's Bias Narrow Fabric Co., 106 Conn. 360, 365 (1927).

In order to establish the requisite causal connection between the employment and the injury, a claimant "must demonstrate that the claimed injury (1) arose out of the

employment, and (2) in the course of the employment…." Sapko v. State, 305 Conn. 360, 371 (2012), *quoting* Daubert v. Naugatuck, 267 Conn. 583, 589 (2004). The claimant therefore "bears the burden of proof, not only with respect to whether an injury was causally connected to the workplace, but that such proof must be established by *competent evidence*." (Emphasis in the original.) Dengler v. Special Attention Health Services, Inc., 62 Conn. App 440, 447 (2001), *quoting* Keenan v. Union Camp Corp., 49 Conn. App. 280, 282 (1998). As such,

> [e]xpert opinions must be based upon reasonable probabilities rather than mere speculation or conjecture if they are to be admissible in establishing causation.... To be reasonably probable, a conclusion must be more likely than not.... Whether an expert's testimony is expressed in terms of a reasonable probability that an event has occurred does not depend upon the semantics of the expert or his use of any particular term or phrase, but rather, is determined by looking at the entire substance of the expert's testimony.... When reports are the substitute for testimony, the entire report should be examined, not only certain phrases or words. (Internal citations omitted.)

Struckman, supra, 554–55.

In the present matter, the claimant points out that the parties stipulated to the existence of an employer-employee relationship, and the evidence presented demonstrated that the claimant "was healthy and was able to perform his job as a laborer for Up Realty, which he worked up to 55 hours a week prior to the date of the accident." Appellant's Brief, p. 5. In fact, "[t]he Claimant testified that he did not have any prior history of vascular disease or vascular disorders and he described himself as being relatively healthy for the majority of his life." Id., 8. The claimant further points out that the cardiac care APRN, in her August 3, 2018 report, noted that an echocardiogram

performed during the claimant's hospital stay "revealed normal systolic function, mild LVH and no significant valvular disease." Claimant's Exhibit E.

The claimant challenges the opinion provided by Robert S. Napoletano, a vascular surgeon, following a review of the claimant's hospital records, who concluded that the claimant's "past history was significant for vascular disease ...." Respondents' Exhibit 3. Napoletano further opined that the decreased blood flow to the claimant's extremities during the heart attack and subsequent resuscitation efforts "[predisposed] him to developing ischemic changes as well as gangrene of the lower extremities." Id. However, the claimant avers that "[t]here was simply no evidence introduced at trial that the Claimant had any pre-existing heart, vascular or respiratory issues prior to the date of the accident," Appellants' Brief, p. 5, and Napoletano's opinion was therefore based on "speculation and conjecture." Id., 18, *citing* Struckman, supra, 554.

In addition, the claimant challenges the validity of the opinion proffered by Hahn, also following a records review, indicating that the claimant's pneumonia and sepsis would have occurred even if he had not sustained the ankle injury. In his report dated January 29, 2021, Hahn stated:

> There is, however, a clearly plausible and widely medically accepted rationale for the development of Mr. Berry's vascular injury which is completely unrelated to the ankle injury: acute limb ischemia due to the in situ thrombosis of arteries to the left leg which was in turn due to underlying peripheral arterial disease in conjunction with low blood flow and hypercoagulability.

Respondents' Exhibit 2, p. 1.

It is the claimant's position that Hahn's opinion was also based on "speculation and conjecture" in light of the lack of evidence demonstrating that the claimant suffered from pre-existing peripheral artery disease and the fact that Hahn failed to reference any

prior medical records suggesting otherwise. Appellant's Brief, pp. 19-20, *citing* Struckman, supra.

The claimant therefore contends that the administrative law judge erred in relying upon the opinions of both Napoletano and Hahn in concluding that the work-related injury to the claimant's left ankle was not a substantial contributing factor to the amputation of the left leg.

We disagree. In his November 29, 2021 Memorandum, the administrative law judge directly addressed the extent to which the evidentiary record provided a basis for the inference that the claimant did, in fact, suffer from pre-existing peripheral artery disease. He stated that when the claimant was admitted to the hospital:

> one of the items listed in the prior medical history was hypertension, and one of his own experts, Dr. Vidhun, begins his December 4, 2020 report by noting the history of hypertension, high cholesterol (hyperlipidemia), and smoking. That history, combined with the necropsy findings of sclerosis in the arteries of the amputated leg and the vague history of prior complaints in the left leg, is enough to support the suspicions of Dr. Weinreb and Dr. Hahn that before the work accident the claimant had some vascular compromise in the left leg. I believe there is ample evidence in the record to conclude that the claimant had some degree of circulatory compromise in the left leg prior to his circulatory collapse, and that the sudden and sustained loss of blood pressure that began on or about May 14, 2018 was a significant factor in causing the necrosis that led to the amputation.

November 29, 2021 Memorandum, p. 11.

Our review of the evidentiary submissions indicates that this observation by the administrative law judge is supported by the following entries in the claimant's medical reports from Middlesex Hospital:

1. The medical history portion of the May 14, 2018 emergency report and the June 1, 2018 discharge summary both list hypertension among the various diagnoses. See Claimant's Exhibit C, pp. 1, 15.

2. The May 16, 2018 progress note authored by Weinreb states that the claimant's ischemia of the left lower extremity was "secondary to high pressor requirements and likely preexisting disease." Id., 88.

3. Weinreb's progress notes of May 16, 2018, and May 17, 2018, both indicate that the claimant had been complaining to a family member about pain in his left leg, leading Weinreb to suspect that the claimant suffered from "underlying vascular disease and the low perfusion when in shock [caused] ischemia...." Id., 84, 98.

4. Shue's May 18, 2018 operative note states that the claimant's "superficial femoral and profundal femoral arteries were noted to be completely thrombosed." Id., 62.

5. The May 24, 2018 anatomic pathology note indicates that "[s]ectioning of the vessels at the margin appear to show some thrombosis. The popliteal artery shows approximately 50% stenosis." Id, 66.

In addition, the cardiac care APRN, in her August 3, 2018 report, listed, inter alia, hypertension and hyperlipidemia as diagnoses, see Claimant's Exhibit E, p. 2, while Hahn, in his report dated April 20, 2020, stated that the claimant's "medical history of hypertension and hyperlipidemia along with ongoing cigarette smoking and possibly substance abuse are significant risk factors for the development of vascular disease." Respondents' Exhibit 1, p. 6. Hahn also referenced Weinreb's report noting the

comments of the claimant's family member relative to the episodes of left leg pain the claimant had ostensibly experienced prior to the accident.

In his January 29, 2021 report, Hahn observed that:

> Dr. Weinreb clearly recognized the possibility and importance of pre-existing vascular disease as a risk factor for acute limb ischemia ... [on May 16, 2018] and commented on it in her progress note. The vascular surgeon, Dr. Shue, also expressed her opinion that Mr. Berry likely had underlying vascular disease of the left leg.

Respondents' Exhibit 2, p. 2.

In light of the foregoing evidentiary submissions, we do not find erroneous the inferences drawn by the administrative law judge relative to his conclusion that the claimant was likely suffering from pre-existing underlying vascular disease when he sustained his ankle injury. "It is … immaterial that the facts permit the drawing of diverse inferences. The [administrative law judge] alone is charged with the duty of initially selecting the inference which seems most reasonable and his choice, if otherwise sustainable, may not be disturbed by a reviewing court." Fair v. People's Savings Bank, 207 Conn. 535, 540 (1988), *quoting* Del Vecchio v. Bowers, 296 U.S. 280, 287 (1935).

Similarly, we find the evidentiary record also provides an adequate basis for the administrative law judge's ultimate conclusion that the ankle injury was not a substantial contributing factor to either the medical condition which led to the claimant's hospitalization or the amputation of his left leg. We note at the outset that Hahn, in his report dated April 20, 2020, opined "that the claimant's bloodwork showed that he was chronically malnourished before the incident, and that alone made him susceptible to infection." November 29, 2021 Memorandum, p. 9, *citing* Respondents' Exhibit 1, p. 5. In addition, Hahn stated:

> Mr. Berry was a man with significant chronic illness. He is a recovering substance abuser including alcohol and opiates. By all accounts, he was a very thin, cachectic man. He was clearly chronically malnourished as evidenced by his serum albumin and prealbumin levels.... Chronically low serum albumin levels are a powerful risk factor for overall poor health, infections and morbidity/mortality ... and certainly contributed to his susceptibility to severe systemic infection/sepsis. (Internal citation omitted.)

Respondents' Exhibit 1, p. 5.

We further note that the claimant's medical reports consistently mention his history of alcoholism, asthma and hypertension, and a general surgery consultation note authored by Monika Hoang-Skawinska, PA-C, reference the claimant's "complex medical history" in describing him as "a smoker, alcoholic, malnourished ...."[8] Claimant's Exhibit C, pp. 34, 37.

In addition, the Middlesex Hospital emergency medical report states that upon arrival, the claimant "appeared to be cachectic," id., 1, and Fontaine testified that when he visited the claimant at his apartment on Monday, May 14, 2018, the claimant "looked like a skeleton." Claimant's Exhibit H, p. 17. Both Fontaine's July 13, 2019 affidavit and the Hunters Ambulance Service report describe the claimant as "emaciated." Id. [Claimant's Exhibit 5, p. 2, ¶ 20]; Respondents' Exhibit 4, p. 4. At his deposition, the claimant testified that he had previously undergone treatment for drug addiction, anxiety and depression. Vidhun referenced the claimant's "history of hyperlipidemia, hypertension, tobacco abuse and polysubstance abuse along with a history of alcohol use...." Claimant's Exhibit J [December 4, 2020 report, p. 1.]

[8] The claimant testified that he had outgrown his asthma. See Claimant's Exhibit G, p. 26.

Moreover, as noted by the administrative law judge, "the hospital records document gastrointestinal problems ranging from a bleeding duodenal ulcer to problems with the colon that included ischemic colitis and, as would be revealed a few months later, colon cancer." November 29, 2021 Memorandum, p. 13. As the trier pointed out:

> the claimant did not become a thin man over one weekend. He testified that he is not a big eater, and his friend testified that he, the claimant, never really drank water. [See Claimant's Exhibit H, p. 30.] It is likely he did not start that ill-fated weekend in a strong position, but he clearly was *able* to feed himself and drink fluids up to the point he got sick, developed abdominal pain and started vomiting. Whether that sickness was the direct result of sepsis from pneumonia or the indirect result of his colon cancer does not ultimately matter for our purposes. (Emphasis in the original.)

Id., 14.

More generally speaking, we believe the evidentiary record also provides a sufficient basis for the inferences drawn by the trier relative to the series of unfortunate medical events which unfolded in this claim. For instance, we note that Hahn, following his review of the claimant's voluminous hospital chart, opined that the claimant:

> developed an acute bacterial pneumonia with antibiotic resistant Staphylococcus aureus. The pneumonia resulted in sepsis causing delirium. The delirium precluded him from maintaining adequate hydration and seeking medical assistance. The combination of sepsis and hypovolemia resulted in catastrophic septic and hypovolemic shock resulting in circulatory collapse which mimicked a 'cardiac arrest.'

Respondents' Exhibit 1, p. 2.

Hahn further explained that subsequently:

> The low blood pressure due to sepsis, low cardiac output due to extreme dehydration and vasoconstriction due to vasopressors resulted in spontaneous thrombosis of arteries in [the claimant's] left groin/thigh which supplied blood to the left leg. The left leg

> became necrotic and was not salvageable; he required an above the knee amputation within 3 days of his admission.

Id.

Ultimately, Hahn concluded that:

> The cause of [the claimant's] left leg amputation was irreversible ischemia due to acute thrombosis of the arteries to the leg (profunda femoris and superficial femoral arteries). This was caused by the low blood pressure and low cardiac input due to his septic and hypovolemic shock and aggravated by the addition of vasopressor medications which resulted in vasoconstriction of his arteries.

Id., 6.

Hahn also observed that "[t]he sequence of events described above is more or less shared by myself, [the claimant's] treating ICU physician, Dr. Weinreb, his treating vascular surgeon, Dr. Shue, and the additional physician reviewer, Dr. Napoletano."[9] Id.

We further note that the progress notes authored by Weinreb on May 15, 2018, May 16, 2018, and May 17, 2018, all indicate that the claimant was experiencing a wide array of systemic complications, including acute respiratory failure, which Weinreb attributed to septic and hypovolemic shock. See Claimant's Exhibit C, pp. 77, 83-84, 97-98. In addition, Weinreb's notes for May 16, 2018, and May 17, 2018, reflect that the claimant had tested positive for MRSA. See id., 84, 98. Moreover, Shue, the claimant's vascular surgeon, stated in her May 18, 2018 consultation note that the claimant "likely [had] extremity ischemia secondary to vasospasm and shock." Id., 27. Finally, Napoletano opined as follows: "My conclusion after reviewing his hospital course is that it is likely during his heart attack and resuscitation efforts, there was decreased peripheral

[9] Hahn noted that his opinion differed from the opinion offered by Napoletano in that Hahn did not believe the claimant had suffered a heart attack; rather, "all of his hemodynamic instability can be attributed to his septic and hypovolemic shock." Respondents' Exhibit 1, p. 6.

flow to the extremities which would predispose him to developing ischemic changes as well as gangrene of the lower extremities." Respondents' Exhibit 3, p. 1.

With specific regard to the severity of the ankle injury sustained by the claimant, we note that in the history and physical section of the claimant's discharge summary, Weinreb reported the injury under "miscellaneous," stating that the claimant had "supposedly" sustained an ankle injury but the ankle was neither bruised nor deformed, and a spot on the top of the left foot which resembled "the head of a hammer" was not tender to palpation. Claimant's Exhibit C, p. 14. The ankle injury is also referenced in the May 15, 2018 hospice and palliative care consult note authored by Stacy Sanzone, APRN, in which she stated that "[a]pparently the patient had gone home from work on Friday because he had actually hit his ankle with a hammer or other tool." Id., 39, 54. Napoletano, after noting that the claimant had testified that he "essentially carried out activities of daily living throughout the weekend after his injury on Friday," Respondent's Exhibit 3, p. 1, stated:

> Review of the medical record did not show any evidence of a significant injury to the foot; however, there is also no good documentation for a detailed examination of his foot, given the fact that he was brought to the hospital in cardiac arrest. Review of the record during his hospitalization also did not define any significant injury to the foot. There was no x-ray. There is also no evidence of any break in the skin due to his injury.

Id.

Napoletano therefore concluded that:

> I cannot conclusively say that his injury was in any way related to his subsequent heart attack and amputation. As noted above, there is just no documentation of significant injury to his foot and thus does not support the trauma to his foot as being a cause of his

> mental status changes, poor fluid intake, and subsequent heart attack and admission to the hospital.

Id.

Similarly, Hahn opined that the claimant:

> suffered a co-incidental left lower extremity contusion on 5/11/2018 but it [is] my expert medical opinion to a reasonable degree of medical certainty that the injury was not a substantial contributing factor to the development of his sepsis or the ultimate amputation of his leg. The pneumonia and subsequent sepsis would likely have occurred even if the ankle injury on 5/11/2018 had not occurred.

Respondents' Exhibit 1, p. 2.

In addition, Hahn noted that although the injury appeared to cause a "significant contusion (bruise) without fracture of bones or significant laceration," id., 5, "[t]here was no evidence of cellulitis or other significant soft tissue infection involving the left ankle ... which was etiologically related to the sepsis." Id. Moreover, "[n]o significant ankle or lower leg injuries were noted by the EMT, ER physician, ICU physician or vascular surgeon on multiple physical examinations." Id., 6. As such, Hahn opined that it was "speculative to state that a soft tissue injury of the ankle resulted in an above the knee amputation many days later." Id., 12-13, *quoting* Respondents' Exhibit 2, p. 1.

Ultimately, the administrative law judge was not persuaded that the claimant's ankle injury was a substantial contributing factor to either the medical condition which led to his hospitalization or the subsequent amputation of his left lower extremity. Rather, he determined that "[t]here is simply no basis in the record to conclude there is any connection between the foot injury and either the sepsis or the GI issues." November 29, 2021 Memorandum, p. 14. The claimant has challenged this conclusion, asserting that the administrative law judge's reliance upon the opinions offered by

Napoletano and Hahn constituted error. However, it is well-settled that "[u]nless causation under the facts is a matter of common knowledge, the plaintiff has the burden of introducing expert testimony to establish a causal link between the compensable workplace injury and the subsequent injury." Sapko v. State, 305 Conn. 360, 386 (2012). Given that the element of causation in the present matter is clearly not "a matter of common knowledge," the claimant appears to be implying that the trier should have relied instead upon the opinions offered by Luchini and/or Vidhun.

We are not persuaded. Although Luchini, in his August 13, 2019 medical examination report, attributed the amputation to vascular ischemia caused by shock, cardiac arrest, and the use of vasopressors, he also opined that these factors were "secondary to his dehydration and pain which are causally related to his being bedridden for 3 days." Claimant's Exhibit I, p. 2. His opinion is therefore inconsistent with the evidentiary record, which reflects that until the claimant became ill at some point on Saturday, and possibly for some time thereafter, he was still sufficiently mobile to be able to use the bathroom and fix himself something to eat and drink.

Vidhun also attributed the necrosis in the claimant's left lower extremity to the use of vasopressors, opining that although the claimant had contracted:

> MRSA pneumonia that caused sepsis which likely contributed to low [blood pressure] and need for pressors. It is my experience that the use of pressors, no matter how severe the peripheral arterial disease, does not by itself lead to poor perfusion of one limb without affecting other extremities. I have seen pressors cause gangrenous necrosis that affects both the upper and lower extremities. Hence, in my opinion I think the loss of Mr. Berry's limb is linked to the injury sustained at work.

Claimant's Exhibit J [December 4, 2020 report, p. 2].

However, Hahn directly addressed Vidhun's theory in his follow-up report dated January 29, 2021, stating:

> The reason only one limb was affected was because of the unfortunate development of thrombus in one leg and not the other. The cause of the thrombus was a confluence of factors including pre-existing conditions, the severity of his overall illness, and the powerful yet dangerous medications he needed to sustain his life during the critical initial several days.

Respondents' Exhibit 2, p. 2.

In his follow-up report of April 22, 2021, Vidhun disagreed, opining that Hahn had "[discounted] the fact that [the claimant] suffered an injury that triggered a change in the blood flow to his lower extremity that led to the occurrence of low flow state." Claimant's Exhibit J [April 22, 2021 report, p. 1]. In assessing this causation opinion, the administrative law judge noted that Vidhun:

> did not – at least in his initial report – claim that the catastrophic loss of blood pressure that brought [the claimant] to the hospital was in any way caused by the work accident. Rather, he merely asserts that the prior ankle injury made him more susceptible to severe consequences from that intervening medical emergency. In addition to turning the logic of the traditional 'take your victim as you find him' adage on its head, this argument presents a serious practical problem. If his theory were to be accepted, then the amputation of the leg would be compensable but *not* the medical condition that led to that amputation, nor the extensive hospitalization and disability that preceded that amputation.

November 29, 2021 Memorandum, pp. 11-12.

The trier further stated that in order to establish causation, Vidhun would need to have meant that either the ankle contusion caused the cardiovascular crisis, which theory the trier rejected as "too conclusory to be credited," or the "ankle injury changed the blood flow within the entirety of the limb ...." Id., 12. The trier remarked that although

the latter theory would have been "worth exploring," id., it was not. The trier therefore rejected Vidhun's opinion, stating that:

> For me to conclude that a swollen ankle would cause a blood clot at the other extreme of the leg would require either a credible expert opinion, or resort to mere speculation. There is nothing in Dr. Vidhun's report that provides the former and I am not entitled to rely on the latter.

Id., 13.

It is axiomatic that a finder of fact "may accept or reject, in whole or in part, the testimony of an expert." (Internal citations omitted.) Tartaglino v. Dept. of Correction, 55 Conn. App. 190, 195 (1999), *cert. denied*, 251 Conn. 929 (1999). Given that it was well within the trier's discretion to rely on the opinions offered by Hahn and Napoletano rather than those offered by Luchini or Vidhun, we decline to find error in this regard.

We concede that neither the hospital records nor the expert opinion relied upon by the administrative law judge definitively establish the reason why the claimant became so ill on this particular weekend. We further recognize that the claimant, prior to sustaining the ankle injury and the subsequent cascade of unfortunate medical events, was successfully engaged in fulltime employment involving at least some degree of manual labor. Nevertheless, in denying the claim for compensation for the claimant's hospitalization and amputation, the administrative law judge accurately observed that:

> The work injury need not be the principal cause of the later injuries, but there must be a causal connection that can be deemed to satisfy the significant factor test. In this case, when comparing the actual chain of events with the underlying assumptions of the claimant's experts, I cannot find any causal connection.

November 29, 2021 Memorandum, p. 14.

Given that our review of the evidentiary record in this matter has revealed nothing which would cause us to question the inferences and conclusions drawn by the administrative law judge, we decline to reverse the decision.[10]

The November 29, 2021 Finding and Denial of David W. Schoolcraft, Administrative Law Judge acting for the Eighth District, is accordingly affirmed.

Administrative Law Judges Daniel E. Dilzer and William J. Watson III concur in this Opinion.

[10] The claimant has claimed as error the administrative law judge's denial of the balance of the proposed corrections in his motion to correct. Our review of these corrections indicates that the claimant was merely reiterating the arguments made at trial which ultimately proved unavailing. As this board has previously observed, when "a motion to correct involves requested factual findings which were disputed by the parties, which involved the credibility of the evidence, or which would not affect the outcome of the case, we would not find any error in the denial of such a motion to correct." Robare v. Robert Baker Companies, 4328 CRB-1-00-12 (January 2, 2002).