Commonwealth of Kentucky
Workers' Compensation Board

OPINION ENTERED: July 27, 2022

CLAIM NO. 201964871

BLUELINX PETITIONER

VS. **APPEAL FROM HON. W. GREG HARVEY,**
ADMINISTRATIVE LAW JUDGE

ESTATE OF DAVID WILLIAMS
TRACEY BURNS, EXECUTRIX
ELIJAH WILLIAMS, MINOR CHILD
and HON. W. GREG HARVEY,
ADMINISTRATIVE LAW JUDGE RESPONDENTS

OPINION
AFFIRMING AND REMANDING

* * * * * *

BEFORE: ALVEY, Chairman, STIVERS and MILLER, Members.

STIVERS, Member. Bluelinx seeks review of the January 18, 2022, Opinion, Award, and Order of Hon. W. Greg Harvey, Administrative Law Judge ("ALJ"). The ALJ found David Williams ("Williams"), who died on October 27, 2019, sustained a September 12, 2018, work-related left ankle injury while in the employ of Bluelinx. The ALJ also found the October 25, 2019, left ankle surgery performed by

Dr. Ryan Finnan with OrthoCincy Orthopaedics & Sports Medicine ("OrthoCincy") reasonable and necessary treatment of the work injury. Because Williams died two days later on October 27, 2019, the ALJ was required to determine whether his death resulted from the October 25, 2019, surgery. Relying primarily upon the opinions of Dr. Steven Wunder, the ALJ concluded Williams' death resulted from a sudden cardiac event "proximately caused by the work-related surgical procedure." Pursuant to KRS 342.750, the ALJ awarded a lump sum death benefit to the Estate and weekly income benefits to Elijah J. Williams ("Elijah"), Williams' minor child.[1] The ALJ also awarded temporary total disability ("TTD") benefits to the Estate of David Williams ("Estate") from September 20, 2018, through October 15, 2019, with Bluelinx receiving a credit for past TTD benefits paid and the wages Williams earned during the period TTD benefits were awarded. Bluelinx also appeals from the February 18, 2022, Order overruling its Petition for Reconsideration.

BACKGROUND

The Form 101 alleges, while in the employ of Bluelinx, Williams sustained a September 12, 2018, left ankle injury. The Form 101 also alleges the work injury resulted in Williams' death. We will refer to the Respondents collectively as the Estate.

Tracey Burns, Executrix of the Estate ("Burns") testified at a May 6, 2021, deposition and at the November 19, 2021, hearing. Burns' deposition reveals that her brother, Williams, was born on October 27, 1969, and died on October 27,

[1] KRS 342.750(6) mandates the Estate receive a lump sum death benefit computed by the Commissioner and KRS 342.750(1)(d) directs Elijah receives weekly income benefits.

2019. She was appointed Executrix of the Estate. Williams had two children from a previous marriage. Williams' oldest child died at approximately 24 or 25 years of age. The youngest child of the two is approximately 28 years old.[2] Williams' second marriage produced no children. Elijah, born March 11, 2009, is Williams' 12-year-old child.[3] Williams was never married to Elijah's mother. Burns is Elijah's court appointed conservator.

Burns testified Williams began working for Bluelinx as a truck driver in June 2017. Although she was unsure of the shift and hours worked, she believed Williams drove a regular route. Burns was also unsure of Williams' job duties and rate of pay. UC Health Primary Care was Williams' primary medical provider. Burns testified she was unaware of Williams' medical history including previously experiencing chest pain. Although Williams was a diabetic, Burns was unfamiliar with the medication he took. Williams did not tell Burns how or when he sustained the left ankle work injury. She was unaware of any medical treatment Williams underwent for this injury. Burns was not sure whether she and her brother were on conversant terms at the time of the September 2018 injury. Similarly, she was unaware Williams had been hospitalized in early 2019 for shortness of breath or that he was previously diagnosed with renal failure. Williams had also not informed Burns he had previously experienced deep vein thrombosis or sepsis.

Williams told Burns he was to undergo surgery on October 25, 2019. Her nephew, Williams' adult son, took him to the facility where surgery was

---

[2] The first names of Williams' adult children were not provided. Neither were dependents of Williams at the time of his death.

[3] At the time of his death, Williams had full custody of Elijah.

performed and brought him home that same day. When Burns talked to Williams after the surgery, he told her he was okay.[4] Williams' adult son took care of him after the surgery. Burns did not see Williams after the surgery and received no updates regarding his post-surgical condition. Burns talked with her brother by phone on his birthday, the day he died. During their conversation, he voiced no physical complaints. Williams' sons were at his home on the date he died. Burns provided the following about what occurred on October 27, 2019:

> Q: Do you mind just telling me and the Judge about what happened, or what you understand happened?
>
> A: My nephew was in the room with him. Both of my nephews were in the room with him and –
>
> Ms. Stamm: I'm going to – note my objection. She was not there. She would be speaking not from personal knowledge.
>
> Ms. Spuzzillo: Okay. Are you advising her not to answer?
>
> Ms. Stamm: She can continue her response.
>
> A: They were both in the room with him. It was – he was just renting a room from somebody. So they – said that he looked over, and he wasn't breathing, and my nephew did CPR on him. Called 911 and started CPR on him, and that's all I know.
>
> Ms. Spuzzillo: Okay. Okay. And you mentioned that he was renting a room from somebody. Was he living in a house or an apartment?
>
> A: A house.

At the November 19, 2021, hearing, Burns testified she had concerns about her ability to recall because she "had a ministroke four or five years ago, so my

---

[4] Burns testified she was out of town when she spoke with Williams after his surgery.

memory and sometimes when I'm even talking I forget my words." Much of Burns' testimony is a reiteration of her deposition testimony. She added that when she saw Williams after the injury he walked with a limp and appeared to be in pain. Burns explained how she became aware her brother had died.

> Q: How did you find out that David passed away?
>
> A: Justin called me on the way to the hospital following the ambulance.
>
> Q: Did you go to the hospital?
>
> A: Yes, ma'am.
>
> Q: What happened after you got to the hospital?
>
> A: They took me to a conference room and the doctor came in. He waited for me to get there to tell everybody he had passed.

Elijah currently lives with his mother in Burlington, Kentucky. Burns testified that prior to the surgery her brother was fine except for ankle pain. She spoke with her brother twice on the day he returned home from the surgery. When Williams called Burns on his birthday, his only complaint was ankle pain. Burns did not talk to her brother on a regular basis about his health condition. An autopsy was not performed.

The Estate introduced the records of St. Elizabeth Business, St. Elizabeth Healthcare, OrthoCincy, UC Physicians, and NovaCare Rehabilitation. The Estate also introduced the October 5, 2020, report of Dr. Wunder and his November 1, 2021, rebuttal report in response to the letters and deposition testimony of Dr. John David Corl, a cardiologist, who testified on behalf of Bluelinx. Bluelinx

introduced the June 15, 2021, and August 15, 2021, letters of Dr. Corl and his July 14, 2021, deposition and attached exhibits.

In Dr. Wunder's October 5, 2020, report he recounted the medical treatment Williams underwent following the injury:

> He started to see Dr. Finnan at OrthoCincy for care. He was transitioned to a short boot. He was diagnosed with a chronic insertional tendinosis with acute Achilles strain. He started physical therapy on September 26, 2018, at NovaCare. He had 12 therapy visits. He had some improvement in pain and range of motion, and on December 27, 2018, he wanted to be returned to work. He went through conditioning and work hardening. He was placed at MMI and released to work on February 4, 2019.
>
> On February 19, 2019, he underwent another DOT physical. Again, his vital signs were stable. The blood pressure was 140/90 and heart rate was 85. His heart exam was normal. He was certified to meet the DOT physical requirements for a two-year certification. He was advised to have periodic monitoring for his blood pressure.
>
> He returned to work for a few months, and had recurrent pain over the left Achilles. There was direct pain over the Achilles insertion. He was noted to have chronic venous statis changes of his mid leg, but not distally. Range of motion was limited. He went back to Dr. Finnan. Dr. Finnan advised surgery for an insertional Achilles debridement and repair with excision of a Haglund's deformity. It was approved through BWC.
>
> Surgery was planned for early October, 2019, but delayed due to elevated blood sugar. He was placed on Glyxambi and had significant improvement in his blood sugars. He was cleared for surgery. His hypertension was controlled. He had a history of congestive heart failure. His EKG was stable. He had regular rhythm, no angina, no shortness of breath, and a 2017 echocardiogram showed an ejection fracture of 50 to 55 percent.

> He underwent the surgery on October 25, 2019. There were no complications with the procedure. He was discharged home with gabapentin, naproxen, oxycodone, acetaminophen, and promethazine.
>
> Postoperatively, his adult son was staying with him, and noted that he was having difficulty breathing. They called 911. They found him unresponsive. CPR was started. He was pronounced dead at the hospital. His death certificate indicated the cause of death to be complications of congestive heart failure.

Dr. Wunder noted the records from St. Elizabeth Hospital, St. Elizabeth Physicians, and UC Primary Care noted several chronic conditions in Williams' past medical history, but nothing suggesting an immediate threat to his life. He set forth the contents of a letter and medical questionnaire report authored by Rebecca Leach, an APRN at UC Primary Care. Williams' death certificate listed congestive heart failure as the cause of death. St. Elizabeth Hospital's records from 2014 reveal Williams had been admitted with a diagnosis of congestive heart failure. Dr. Wunder proffered the following opinions:

> 1. Diagnoses prior to the September 12, 2018, work injury would have consisted of congestive heart failure, DVT, diabetes, liver abscesses, obesity, bacteremia, hypertension, gout, and cellulitis.
>
> 2. Based on a review of the medical records, his cardiac condition prior to the October 25, 2019, surgery was not immediately life threatening. In fact, he had a preoperative history and physical which showed his cardiac exam to be normal. There was no shortness of breath. He had normal vital signs.
>
> 3. Prior to the October 25, 2019, surgery, the medical records established that his congestive heart failure was stable with treatment.
>
> 4. My diagnoses, as they pertain to the work event on September 12, 2018, would be an Achilles tendon strain at the insertion with a Haglund's deformity.

> 5. Mr. Williams had not reached MMI for his work injury prior to his death, since he just had the surgery several days before.
>
> 6. I believe the medical treatment rendered, including the October 25, 2019, surgery performed by Dr. Finnan was reasonable and necessary for the care and relief of the work injury.
>
> 7. Congestive heart failure would be considered a risk factor for surgery. The rate of death doubles in the perioperative time frame in those with a history of congestive heart failure and subsequent noncardiac surgery. There is a higher-than-normal risk of death during and after surgery.
>
> 8. In my opinion, based upon the notes from the nurse practitioner, and Dr. Wyenandt, Mr. Williams' cardiac condition did not pose an immediate threat of death prior to the October 25, 2019, surgery.
>
> 9. Given the well-documented stable condition of Mr. Williams' congestive heart failure, it is unlikely he would have succumbed to congestive heart failure on October 27, 2019, or a reasonable time thereafter, if he had not undergone the work-related surgery on October 25, 2019. As noted above, there is perioperative risk factor of death with congestive heart failure and noncardiac surgery.

Bluelinx countered with Dr. Corl's June 15, 2021, letter. Dr. Corl, a practicing interventional cardiologist in Cincinnati, Ohio, specializes in coronary and peripheral interventional procedures. He has been board certified by the American Board of Internal Medicine in Cardiovascular Disease since 2003 and Interventional Cardiology since 2005. Dr. Corl has also been board certified by the National Board of Physicians and Surgeons in Internal Medicine, Cardiovascular Disease and Interventional Cardiology since March 2015. Dr. Corl set forth the medical records and documents he reviewed including the death certificate. Dr. Corl discussed the contents of Williams' medical records from January 2014 forward. He noted

Williams sustained a left ankle injury and underwent treatment including surgery on October 25, 2019. Regarding the cause of Williams' death, Dr. Corl opined:

> Unfortunately, Mr. Williams experienced cardiac arrest two days after surgery on October 27, 2019. He was found unresponsive at home at approximately 11:04 pm. CPR was initiated by bystanders. Patient was found to have pulseless electrical activity (PEA) when medics arrived. Despite resuscitation efforts at Mr. Williams' home, in the ambulance and at the St. Elizabeth emergency department, he did not survive and he was pronounced dead on October 27, 2019 at 11:59 p.m.
>
> The Kentucky Certification of Death lists 'complications of congestive heart failure' as the immediate cause of death. No other diagnoses were listed on the death certificate. The cause of death is not definitively known as there was no autopsy performed. In light of his medical history and extensive cardiac risk factors outlined above, the most likely cause of death was sudden cardiac death (SCD).
>
> Based on my review of the available medical records, there was no direct causal relationship between successful/uncomplicated elective outpatient left ankle surgery on October 25, 2019 and his sudden cardiac death (SCD) on October 27, 2019.

Bluelinx introduced Dr. Corl's July 14, 2021, deposition. Regarding Williams' comorbidities prior to the October 25, 2019, surgery, Dr. Corl testified:

> A: Well, from a cardiac standpoint or cardiac risk factor standpoint, he had elevated blood pressure, hypertension, hyperlipidemia, diabetes, morbid obesity, and probably likely sleep apnea as well as some non-cardiac things over the years with the abscess and so forth. The diagnosis of heart failure, I think, is in question. I'm not sure he actually had the heart failure. If he did, that would be another comorbid condition.

Dr. Corl explained the importance of the pre-existing conditions in formulating his opinion about the cause of death.

Q: You noted that he had diabetes as well as a laundry list of other conditions. Why is that important to understand from a cardiology standpoint in making opinions regarding cause of death in a case such as Mr. Williams?

A: Well, I think when you add up those risk factors, it just statistically makes certain things more likely, like underlying coronary disease or sudden cardiac death, which the vast majority is from coronary disease, 70 percent or so is related to coronary disease in these sudden deaths like this. So it comes into play because he's got multiple risk factors including the diabetes, the obesity, the hypertension, hyperlipidemia, sleep apnea. These all make sudden cardiac death more likely as it relates to those risk factors.

Q: Generally speaking, in the absence of a surgery such as one that Mr. Williams underwent on October 25, 2019, would these risk factors that we've just discussed be – could they potentially lead to sudden cardiac arrest or death?

A: Yeah, absolutely. These are ongoing risks that the longer you have it, the less controlled they are, the higher the risk. It's a building risk, continuous risk, and they call it sudden cardiac death for a reason because it's sudden, you know, there's typically no warning or less than an hour of warning for that type of an event, so I think that's what happened. In my opinion, that's what happened, a sudden cardiac death, and statistically, that's the most likely cause.

Q: And would that, would sudden cardiac death that you've just opined, would that be related to the surgery of October 25, 2019, on the Achilles tendon?

A: No.

Q: Why?

A: I don't think it was in play, I mean, there's always, you know, whenever someone has cardiac death, there's always something they did a day before, two days before, three days before. It doesn't mean it's related, it's just a sudden event that happens. And the surgery was an elective surgery, it was a low risk surgery from a

> cardiac standpoint. As the report from Dr. Wunder notes, he didn't have any symptoms going into that surgery, there was no evidence of being decompensated or having any heart failure or anginal symptoms, asymptomatic leading into surgery. When he left that day after surgery, he was noted to be stable and euvolemic, which is an important word that they used, that his volume status was euvolemic, so no evidence of heart failure.
>
> So I don't see any evidence at all that there was any heart failure in play at the time of surgery or around the surgical procedure. So I don't think the surgery had any role in his death at all.
>
> Q: In the absence of surgery, could these comorbidities or his condition, as you understand it from review of the medical records, have caused sudden cardiac death?
>
> A: Yeah. Like I said, they're all risk factors for that coronary disease, and in and of themselves, some of them have, you know, increased risk for a sudden cardiac death. Certainly sleep apnea, which he most likely had, things like that definitely can contribute, so that's where the statistical cause of this would lie is with the sudden cardiac death event cardiac-related.

Dr. Corl testified a September 8, 2017, record generated by April Leach, a nurse practitioner, revealed Williams weighed 338 pounds. An October 2018, note revealed Williams weighed 370 pounds with a body mass index of 50.18. Dr. Corl offered the following regarding the significance of Williams' weight and BMI:

> Q: From a cardiac standpoint and a cardiology standpoint, what's the importance of that weight and BMI?
>
> A: Well, the big – I mean, it's a risk factor for a lot of these coronary risk factors, hypertension, hyperlipidemia, diabetes, but also the sleep apnea that we talked about. I mean, with a BMI of 50, your chances of having obstructive sleep apnea is in the mid to high 70 percent for a prevalence, so a high likelihood

> is he had sleep apnea. And there was discussion about getting a sleep study in outpatient. I think that, again, got derailed with that prolonged hospitalization. So people were considering it, and it's a likely diagnosis, but we know that it's underdiagnosed and undertreated in society, especially in the US. You know, that's just another risk factor that plays in, and the sudden cardiac death is increased as well.
>
> Q: With the sleep apnea and the BMI over 50?
>
> A: Yeah.
>
> Q: Do you have an opinion as to what the percentage of increase that would be for sudden cardiac death for someone with sleep apnea and a BMI over 50?
>
> A: Not sure about percentage, but it's up, and, again, those risk factors for sleep apnea also are risk factors for coronary disease with obesity, and, you know, which leads to diabetes, hypertension, hyperlipidemia. So they're all interlaced. But we know the more we learn about sleep apnea, the more the stress is on the heart, ongoing stress day-to-day, and it just increases your risk of cardiac events in general.
>
> Q: And that's something I want to ask your opinion on. You know, in light of his weight, his BMI with his other comorbid conditions that you've discussed today, how does that affect the function of the heart?
>
> A: Well, you know, the sleep apnea is a tremendous strain if it puts pressures [sic] in the lungs are elevated, and with that interrupted sleep, that's a stress on the heart as well. It increases your, like I said, cardiac events, arrhythmias, like AFib are increased with that. It's a huge cause for that. So it just increases all those risks like we talked about.

Dr. Corl did not believe there were any warning signs of congestive heart failure prior to the October 25, 2019, surgery. He explained as follows:

> A: No. He was stable. I didn't see any symptoms leading up to cardiac failure at that point or breathing, even Dr. Wunder noted that in his report that things were stable going in. There was no signs of decompensation, and

when you look at the risk of surgery, if you put it into the risk calculator, the American College of Surgery has a risk calculator, you get the point for heart failure if you've a new diagnosis of 30 days or symptoms within 30 days of the surgery. So he wouldn't even have gotten a point for heart failure in that calculator anyway. And if you put him into that calculator, he comes out as a low risk patient for that procedure, and that procedure is also on the low risk side as well for him. So I don't think the procedure played a role here.

Q: And, Doctor, we are – he had the surgery on October 25, and I want to go to your timeline here. Looking at, I'm on page 17 in your timeline. He had a left Achilles bursitis and calcaneus spur of the left foot which they did surgery on October 25th. In review of the surgical notes, did you find anything abnormal from a cardiac standpoint with regard to how he progressed throughout surgical intervention?

A: No. I mean, it all looked good, even on that note from Jones Anesthesia, cardiovascular stable and euvolemic, and that's an important word, I mean, that tells you the volume status is good. They don't just put that in there to put that in there.

Q: So – go ahead.

A: Something they evaluated and put in the record that his volume status as normal.

Q: So the word euvolemic, E-U-V-O-L-E-M-I-C, …, that, Dr. Corl, you say is an important word?

A: Yeah. Because –

Q: Go ahead. Why is it?

A: Your volume status is normal, you're not volume overloaded like you would be with heart failure, you're not dehydrated like you could be with dehydration, so the volume status after surgery was euvolemic, I mean, it was normal. So there's no sign at all of heart failure there with that. And to develop heart failure the following day is just unlikely. I just don't see where that would be a trigger.

Dr. Corl disagreed with the diagnosis of congestive heart failure as the cause of death contained in St. Elizabeth Hospital's October 27, 2019, emergency department note. He believed there were no red flags indicating the surgery in question may produce an abnormal outcome. He explained why he believed the surgery did not cause Williams' death.

> A: No. Again, that's why they call it sudden cardiac death. I mean, we are talking he's at risk for that whether he has surgery or not. It's just one of those risks that's ongoing. It's an inherent risk with his comorbid conditions.
>
> Q: Dr. Wunder on point nine on page four makes the conclusion, "given the well-documented stable condition of Mr. Williams' congestive heart failure, it is unlikely he would have succumbed to congestive heart failure on October 27, 2019, or a reasonable time thereafter"; do you agree or disagree with that?
>
> A: Well, I don't think he did succumb to heart failure, so I guess, just on the merits I don't think – again, I don't think the surgery had anything to do with it. I think he had inherent risks, and, you know, sudden cardiac death was the issue. I just don't think it's connected with what happened two days earlier.
>
> Q: Do you believe that the surgery increased his risk for sudden cardiac death?
>
> A: I don't think it did, no.
>
> Q: And that's because you don't believe that he had congestive heart failure, a true, true condition, diagnosis of congestive heart failure, correct?
>
> A: He doesn't. I think there's a high likelihood he had underlying coronary disease with these risk factors just because of the way things turned out, but, again, I don't think the surgery played a role in that either way.
>
> …

> A: Well, yeah. I think we've talked about these risk factors, these comorbid conditions a lot. I think it certainly plays a role in death. Again, that complications of congestive heart failure, I just don't agree with it as far as the true cause.

Dr. Corl acknowledged there was no way of knowing the actual cause of Williams' death:

> A: I don't think anyone knows the actual cause, I mean, we're playing in the probability world here. And I'll be honest, even if an autopsy, where the autopsy doesn't necessarily clear the air either, so it's not definitive that an autopsy is going to prove one way or the other 100 percent of the time.

Dr. Corl explained why he disagreed with Dr. Wunder's opinions regarding the cause of death.

> Q: Understood. Ms. Stamm asked you about the surgical calculator that you've referenced a few times in your testimony. That's something that's standard and set forth by an accredited association – surgical association, correct?
>
> A: Yeah. And, again, it just goes along with Wunder's letter. This patient was, you know, sufficiently low risk to proceed with that surgery. The surgery is a lower risk surgery, and he was clinically doing well from a symptomatic standpoint. So I agree with Wunder, I think the surgery was – he was cleared, so to speak, for surgery.
>
> Q: And --- but you disagree with Dr. Wunder in that the proximate cause of Mr. Williams' death was not the surgery, but instead sudden cardiac disease related to his significant comorbidities?
>
> A: Yeah, exactly. We talked about the disagreements. I'm just saying as far as being clinically stable or clinically asymptomatic leading up, no shortness of breath, not immediately life-threatening, all these things, I agree with him on those points. But I disagree about succumbing to heart failure. I just don't think heart failure was in play before, during, or after the surgery.

Q: And you disagree with him that the surgery for the alleged work-related injury of the left Achilles tendon repair was the proximate cause of his death or led to the complications of congestive heart failure?

A: Yeah. I disagree with that.

Dr. Corl acknowledged that no surgical procedure was risk free.

Q: You indicated that this surgery and ankle surgery was, I think your term was sufficiently low risk. Is any surgical procedure risk-free?

A: No. Yeah, everything's got a risk, I mean, I talk to patients about driving to a pre-op clearance has a risk, you know, so there's nothing zero risk, zero percent risk, but certainly would be considered low risk for sure.

Q: And even though it is low risk, could a fatality occur as a result of an ankle surgery?

A: It could, but, I mean, he made it through the surgery. I'm not sure why we're talking about the surgery. He lived through the surgery. Now, if this case involved someone dying in the middle of surgery, then I think all these questions are more pertinent. But, again, I don't think the surgery had anything to do with his death.

Q: And what about general anesthesia; is that risk-free?

A: Nope.

…

Q: Sorry. Does the fact that somebody makes it through surgery eliminates [sic] surgery as a cause of a death 24 or 48 hours later?

A: No. I'm not saying that. You know, you can have, you know, incisional problems, you may not come out of surgery, stable so to speak, you know. But an elective surgery where you're discharged home, I think it's much less of an issue compared to someone who has bypass surgery, and they're in the hospital for four or five or maybe more days trying to recover, and, you know, heal up from that. That's a different level of surgery.

> So I think a lot of times we think about that scenario as far as complications can be drawn out weeks, months later, you know, incisional issues and so forth. So depends on the surgery of how involved, how risky the procedure is, et cetera. But this didn't strike me as a real taxing procedure on someone's heart.

Dr. Corl's August 15, 2021, letter reads, in relevant part, as follows:

> Based on my review of the echocardiogram images Mr. Williams had normal systolic and diastolic function. Congestive heart failure (CHF) is a condition caused by abnormal systolic and/or diastolic function. There were no findings on the echocardiogram to support the diagnosis of congestive heart failure. Based on my review of the medical records and the echocardiogram images Mr. Williams did not have congestive heart failure.
>
> These echocardiogram findings further support my opinion that there was no direct causal relationship between successful/uncomplicated elective outpatient left ankle surgery on October 25, 2019 and his sudden cardiac death (SCD) on October 27, 2019.

In rebuttal, the Estate introduced Dr. Wunder's November 1, 2021, letter which reads, in relevant part:

> I am surprised by the statements by Dr. Corl, as it is irrefutable that cardiac complications occur in those undergoing major, noncardiac surgery. In fact, cardiac complications are common after noncardiac surgery, and include sudden cardiac death. The single largest cause of perioperative death, I would agree with Dr. Corl, would be major adverse cardiac events. The number of patients undergoing noncardiac surgery is wide and is growing, and annually, 500,000 to 900,000 of these patients experience perioperative cardiac death, nonfatal myocardial infarction, or nonfatal cardiac arrest. Noncardiac surgery is associated with significant cardiac morbidity, mortality, and cost. Patients undergoing noncardiac surgery are at risk for major perioperative cardiac events. Perioperative myocardial infarction occurs primarily during the first three days after surgery, as was noted here. Some theorize that patients are receiving narcotic therapy and may not

experience cardiac symptoms during a myocardial infarction. On studies which have examined perioperative cardiac death, authors attributed the cause to myocardial infarction in 66 percent of the cases and to arrhythmia or heart failure in 34 percent of the cases. It is felt that surgery with associated trauma, anesthesia, analgesia, intubation, extubation, pain, bleeding, and anemia all initiate inflammatory, hypercoagulable stress and hypoxic states, that are associated with perioperative elevations in troponin levels and mortality. It is irrefutable that general anesthesia can initiate inflammatory and hypercoagulable states, and a sudden cardiac death syndrome. The stress of the surgery also involves increased levels of catecholamines and increased stress hormone levels. Perioperative hypoxia can also lead to myocardial ischemia. It is felt that 75 percent of deaths after noncardiac surgery are due to cardiovascular complications, as outlined by Dr. Corl, and I am certain he must be aware of this. I have enclosed a review article from the *New England Journal of Medicine* supporting that noncardiac surgery can precipitate complications such as death from cardiac causes, myocardial infarction or injury, cardiac arrest, or congestive heart failure. The number of patients receiving noncardiac surgery is increasing worldwide. More than 10 million adults worldwide have a major cardiac complication in the first 30 days after noncardiac surgery. As the *New England Journal of Medicine* article points out, if perioperative death were considered as a separate category, it would rank as the third leading cause of death in the United States. I am surprised that Dr. Corl was not aware of that. Surgery initiates an inflammatory response, stress, hypercoagulability, activation of sympathetic nervous system, and hemodynamic compromise, all of which can trigger cardiac complications.

I am really confused as to what point Dr. Corl is trying to make. He seems to be arguing that the claimant did not have congestive heart failure. He points out that no autopsy was done, and the cause of death was speculation. In addition to cardiac complications, sudden death can also be associated with deep venous thrombosis and pulmonary emboli, and Mr. Williams had a history of DVT already. Whichever complication his cause of death is attributed to, (congestive heart

> failure or pulmonary embolism), they occur at an increased frequency in the perioperative state. There is no way that Dr. Corl can make the statement that there was no direct causal relationship between Mr. Williams' noncardiac, left ankle surgery on October 25, 2019, and his death on October 27, 2019. Sudden cardiac death is a known complication of noncardiac surgery.

In finding Williams sustained a September 12, 2019, left ankle injury and his death resulted from the medically reasonable and necessary October 25, 2019, surgery, the ALJ provided the following findings of fact and conclusions of law which are set forth *verbatim*:

> There is no question Williams sustained a work-related left ankle injury on September 12, 2018. The October 25, 2019, left ankle surgery was medically reasonable and necessary to treat the work injury. At issue is whether Williams' death resulted from the surgery. The death certificate identified the cause of death ad complications from congestive heart failure. Dr. Wunder opined Williams' heart condition was not immediately life threatening prior to the surgery. However, Dr. Wunder felt the work-related surgery caused the congestive heart failure to result in Williams' death.
>
> The Estate argues KRS 342.750 dictates benefits be paid because the surgery for the work-related left ankle injury caused Williams' death. It also argued KRS 342.680 establishes a rebuttable presumption of work-relatedness where the Plaintiff can set forth a prima facie case that the death was the result of the work injury. Dr. Wunder opined the rate of death doubles in the perioperative timeframe for surgical patients who have a history of congestive heart failure. The Estate also argues the Defendant failed to rebut the presumption of work-relatedness of Williams' death.
>
> The ALJ disagrees with that argument. Dr. Corl's opinion was clear that he did not feel the surgery caused Williams' death. In fact, Dr. Corl opined Williams did not have congestive heart failure. He explained why he was of that opinion and explained that although that diagnosis was postulated in 2014, the heart

catheterization needed to confirm that diagnoses was never done as it was determined Williams had liver abscesses. Dr. Corl noted that condition caused Williams' symptoms and that after the liver abscesses were treated, Williams never had any further cardiac workup or symptoms.

Dr. Corl did candidly testify that the cause of death is not definitively known as no autopsy was performed. He also noted that his testimony was offered in the realm of probability as no one can definitely know what caused the sudden cardiac event. Dr. Corl went back and reviewed the echocardiogram done on Williams' heart in 2014, and concluded he did not have congestive heart failure.

The ALJ is mindful of the Estate's citation of the blackletter law that the injurious consequences of a work-related injury are compensable. *See* Coleman v. Emily Enterprises, Inc., 58 S.W.3d 459 (Ky. 2001); *see also* Addington Res. Inc. v. Perkins, 947 S.W. 2d 421 (Ky. App. 1997).

Dr. Corl's deposition in this case is thorough and persuasive. The ALJ is very mindful of the temporal relationship between the surgery and Williams' untimely death. Within two days of the surgery Williams died. That death is tragic. By all accounts Williams was a good worker, an upstanding father, and a beloved brother. The ALJ does not doubt those facts and deeply regrets Williams' passing and his family's loss. More specifically, Williams' sons lost a loving father. That too is not lost on the ALJ.

The law, however, dictates the undersigned decide this case based on the evidence from the medical experts. Dr. Wunder has offered a sound opinion regarding Williams' death. However, Dr. Wunder is not a cardiologist and Dr. Corl is. Dr. Corl thoughtfully explained why he did not believe Williams had congestive heart failure. He explained the hospitalization in 2014, and the role of Williams' liver abscesses. Dr. Corl also explained all the comorbidities Williams had that he believed contributed to the sudden cardiac death. He was very specific that the surgery played no role in Williams' death. In the years after 2014, Williams had no cardiac treatment and had

normal cardiac functioning. Post-operatively Williams' heart was performing normally and he was discharged home with normal cardiac performance.

Dr. Wunder's rebuttal report is also persuasive. In that report, Dr. Wunder opined cardiac complications commonly occur in patients who undergo noncardiac surgery. One of the things that occurs is sudden cardiac death. He opined myocardial infarction following surgery primarily occurs within three days of the procedure. He also noted general anesthesia can cause inflammation and sudden cardiac death. The report includes an article from the New England Journal of Medicine that explores sudden cardiac death as a consequence of noncardiac surgery.

A reading of the totality of the evidence is important. The undersigned interprets Dr. Wunder's opinion to be that Williams' surgery resulted in a cardiac event that caused his death. Dr. Corl also opines a cardiac event occurred that caused Williams death. However, he is of the opinion that the surgery did not result in or cause the cardiac event. Dr. Corl reasoned that events occur to all persons who die from sudden cardiac death but that does not mean that those events are causative.

Here, the ALJ acknowledges Dr. Corl's superior qualifications on cardiac issues. However, Dr. Wunder has responded to Dr. Corl's opinion and cited evidence from the New England Journal of Medicine. The question is whether the surgery proximately caused the sudden cardiac death. Dr. Corl testified about statistical probability based on the comorbid factors. Williams had the same comorbid factors for years prior to the surgical procedure. Two days after being placed under general anesthesia he was found unresponsive and died. The ALJ agrees with Dr. Corl that Williams did not have congestive heart failure and that he suffered sudden cardiac death. However, the ALJ finds Dr. Wunder's opinion that the surgery caused the sudden cardiac event persuasive. This is true in light of the facts that Williams was not treating for congestive heart failure, did not have pre-operative cardiac concerns or red flags. It is possible Williams might have had a sudden cardiac event on October 27, 2019, if he had not had surgery. It is also possible he could have had sudden cardiac at any point for the years he carried the same comorbidities

> described by Dr. Corl. However, Williams did not have a sudden cardiac death until two days after the surgery. Dr. Wunder has offered sufficient evidence that noncardiac surgery is a known cause of sudden cardiac death. The facts coupled with Dr. Wunder's opinion are persuasive to the ALJ and cause the ALJ to conclude Williams' death by a sudden cardiac event was proximately caused by the work-related surgical procedure.

Pursuant to KRS 342.750(6), the ALJ awarded a lump sum death benefit to the Estate. The Estate was also awarded TTD benefits from September 20, 2018, through October 15, 2019, with interest. Bluelinx was granted a credit for any TTD benefits paid and for wages Williams earned during the period TTD benefits were awarded. Medical benefits were not awarded. As required by KRS 342.750(1)(d), Elijah was awarded weekly benefits equal to 50% of Williams' average weekly wage subject to the maximum rate of $424.24 for the 2018 injury. The benefits terminate pursuant to KRS 342.750(1)(e).

This generated a 23-page Petition for Reconsideration from Bluelinx contending the ALJ committed an error because his decision was based on "sympathy and a desired outcome" rather than reasonable medical probability. Much of its argument is reiterated in its appeal brief. Bluelinx also argued the ALJ committed patent error as his decision is not supported by "well-reasoned substantive evidence of an expert witness." Bluelinx observed the *New England Journal of Medicine* article was inapplicable as it discussed the cardiac complications arising from major non-cardiac surgery and not cardiac complications arising from minor non-cardiac surgery. Thus, the ALJ's reliance upon the article is misplaced.

It also complained the ALJ relied upon the contradictory and unfounded testimony of Dr. Wunder who "expressed a cardiac opinion with no education, experience, or training." Finally, Bluelinx asserted the ALJ committed patent error in determining the death was work-related without a factual basis thereby setting a precedent that any death within some undetermined proximity of a work-related procedure is work-related. In overruling the Petition for Reconsideration, the ALJ provided the following in his February 18, 2022, Order which is set forth *verbatim*:

> …
>
> Within its' Petition for Reconsideration, the Defendant first contends the ALJ committed error by basing his decision on sympathy and a desired outcome instead of the facts and reasonable medical probability and the evidence. Bluelinx takes issue with the ALJ's discussion of the decedent and his sister's testimony about him. It also argues "[t]he Administrative Law Judge packed a tremendous amount of sympathy conjuring facts and alluding inferences…" The Defendant then argues the ALJ set about to "make right" for the family in the Opinion.
>
> KRS 342.281 limits Petitions for Reconsideration to a tool that allows patent errors appearing on the face of an award to be corrected. The Defendant's first argument that the ALJ substituted emotion for sound legal reasoning in this case does not lend itself to relief via a Petition for Reconsideration. In addition, the ALJ feels compelled to respond to Bluelinx's argument that the ALJ had a desired outcome in the case motivated by sympathy. The ALJ chose to humanize Williams, the decedent, by discussing his personal disposition and characteristics. That was done largely out of respect for his passing and the fact that his minor child and family might read the undersigned's decision and understand that time was taken to understand the claim and who Mr. Williams was. Regardless of the outcome, the undersigned would have undertaken that analysis. The

death was tragic regardless of whether it was caused by, or related to, the work injury and resulting treatment. Acknowledging that fact is simply to acknowledge the death of any person is worthy of reverence. A reading of the ALJ's opinion makes clear that, in fact, the decision on work-relatedness and causation of Williams' passing was difficult and that the ALJ took great pains to identify why the undersigned ultimately found Dr. Wunder's causation opinion more persuasive given the facts of the case.

The Defendant argues Dr. Corl is the only reliable opinion on causation and that the ALJ's failure to adopt his opinion is error. It also argues the ALJ agreed with Dr. Corl that Williams did not have congestive heart failure and therefore could not also find the surgery caused the sudden cardiac event that resulted in death. It is important to understand what the ALJ found. The undersigned found Dr. Wunder's opinion that the surgery caused a sudden cardiac event that resulted in Williams' death most persuasive. In making that finding the ALJ relied on the literature cited by Dr. Wunder and his opinion that surgical procedures increase the risk of sudden cardiac death within the first three days after the procedure. Those opinions were considered along with the fact that Williams' risk factors for sudden cardiac death existed for years and that the only variable in the days prior to his death was the surgical procedure. Dr. Wunder offered a sound opinion that non-cardiac surgery increases the risk of a cardiac event in the three days that follow the procedure. Dr. Corl identified the risk for sudden cardiac death as "building risk, continuous risk…" He indicated Williams had comorbidities for sudden cardiac death for years. Nonetheless it was not until two days after the work-related foot surgery that Williams died of sudden cardiac death. The timing of Williams' death, coupled with Dr. Wunder's opinion regarding the role of non-cardiac surgery causing sudden cardiac death was persuasive to the ALJ.

The remainder of Bluelinx's Petition is a reargument of the case and is contrary to the limitations imposed by KRS 342.281 as to the scope of a Petition for Reconsideration. The ALJ has provided well more than sufficient explanation of his findings to permit

> meaningful appellate review. Shields v. Pittsburgh and Midway Coal Mining Co., 634 S.W.2d 440 (Ky. App. 1982).

Bluelinx first argues the ALJ's opinion is wrought with descriptions and characterizations demonstrating he relied upon "emotional persuasion" and he totally disregarded the facts and substantial medical evidence. It complains the ALJ's decision was in part based upon sympathy. Bluelinx insists there is no factual or sound medical basis for the ALJ's decision. Consequently, the decision is not based on medical evidence proffered within reasonable medical probability. Bluelinx relies upon the holding of the Kentucky Court of Appeals in Pierce v. Kentucky Galvanizing Co. Inc., 606 S.W.2d 165 (Ky. App. 1980). It points out whether Williams' death was due to the work-related surgery involves medical relationships not apparent to a lay person. Thus, the ALJ may not disregard the medical evidence. It emphasizes Dr. Corl's opinions and deposition testimony and asserts he based his opinion on reasonable medical probability and statistical causation and causation that is more likely than not versus Dr. Wunder's opinions which were rebutted and based at best on causes he "felt" to be true. Thus, the ALJ's opinion is erroneous since the only evidence in the record based on reasonable probability and causal probability was provided by Dr. Corl.

It also complains that since the ALJ accepted Dr. Corl's opinion that Williams did not suffer from congestive heart failure, he cannot find Williams' death "was caused by increased risk of perioperative death due to congestive heart failure." Bluelinx observes Dr. Corl couched his opinions on the basis of "more likely," "statistical cause," "risk calculator," and what is "statistically most likely." In its

view, these terms establish reasonable medical probability. However, Dr. Wunder's opinions were based on misplaced "theory" and causes that were "felt to be true." Bluelinx emphasizes Dr. Corl advised that the comorbidities increase the risk of sudden cardiac death absent the surgery. Thus, Dr. Corl believed the comorbidities were "statistically most likely" the cause of death because sudden cardiac death usually happens with less than an hour warning.

It emphasizes Dr. Corl unequivocally opined the sudden cardiac death could not be determined to be related to the work-related surgery. In Bluelinx's view, the entire foundation of Dr. Wunder's opinion is that Williams had congestive heart failure. However, Dr. Corl, the only cardiac expert to testify, opined there was no evidence of congestive heart failure which the ALJ accepted as fact. It complains the ALJ cannot rely upon Dr. Wunder's medical opinions since he accepted Dr. Corl's opinion that Williams did not suffer from congestive heart failure, thereby obviating the foundation of Dr. Wunder's causation opinion.

It also complains Dr. Wunder's reliance upon the *New England Journal of Medicine* is misplaced as the article is inapplicable to the facts because it addresses cardiac complications arising in patients undergoing major non-cardiac surgery. It argues Williams underwent minor non-cardiac surgery. However, even if one accepts the *New England Journal of Medicine* article as probative, the ALJ was left with nothing more than a remote possibility. Thus, the article does not constitute substantial medical evidence nor is it based on reasonable medical probability.

Bluelinx argues as follows:

> [Dr. Wunder] stands by his position that the claimant had congestive heart failure, which was summarily

> disproven by Dr. Corl (via echocardiogram) and dismissed by the Administrative Law Judge. If we medically cannot rely on Dr. Wunder's foundational opinion, we cannot rely on his opinion as a whole. There are insufficient facts or data in the record to support this finding. Just because a condition or circumstance is 'capable of causing' an event does not mean the event is the probable cause.

Next, Bluelinx argues the ALJ did not support his opinion with well-reasoned substantive evidence of an expert but relied on the contradictory opinions and unfounded testimony of a physician who offered a "cardiac opinion" with no education, experience, or training to render such an opinion. It observes that comparative evidence must have sufficient scientific validity to be admissible under Daubert v. Merrell Dow Pharm., Inc., 509 U.S. 579, 593-594 (1993). It provides a laundry list of problems with the ALJ's reliance upon Dr. Wunder's opinions. Bluelinx insists the close relationship in time between surgery and the death is not sufficient to support a finding of work-relatedness. It complains the ALJ cannot choose to adopt Dr. Wunder's refuted opinion "in light of substantial and clearly 'superior,' unrebutted evidence of an experienced and scientifically based expert." Bluelinx argues as follows:

> It is also inconsistent to admit that there was no evidence of cardiac treatment, that the claimant had normal heart functioning and was discharged home with normal cardiac performance, then to turn around and rely on Dr. Wunder's opinion regarding congestive heart failure and cause of death. His opinion is clearly based on a predisposition of cardiac conditions which did not exist.

Finally, in a related argument, Bluelinx asserts the Estate failed to prove the surgery was a proximate or direct cause of Williams' death. Bluelinx

asserts the mere possibility of a work connection is insufficient to establish a causal connection between the surgery and Williams' death. Rather, the standard is one of probability. It asserts the bottom line is that there is no evidence of a direct causal relationship between the surgery and Williams' death. According to Bluelinx, since the Estate did not offer substantial evidence, expert opinion, or applicable data to show a causal connection between the routine low risk surgery and Williams' death, a finding of work-relatedness is unconscionable. Bluelinx seeks reversal of the ALJ's decision that the work-related surgery caused Williams' death.

ANALYSIS

We must first necessarily resolve Bluelinx's second argument that Dr. Wunder does not constitute an expert as defined by Daubert v. Merrell Dow Pharm., Inc., supra. Bluelinx argues that in applying the standards set down by the United States Supreme Court in Daubert, Dr. Wunder's opinions cannot be relied upon as he is unqualified to offer such opinions. According to Bluelinx, Dr. Wunder's opinions are unreliable as he proffered unfounded "cardiac opinions with no education, experience, or training to render an opinion in this claim." Bluelinx emphasizes that since Dr. Wunder is not a cardiologist, it was illogical to rely upon his opinion concerning a cardiac issue. According to Bluelinx, since Dr. Corl is the only cardiologist to testify in this claim, pursuant to Daubert, his opinions are the only reliable medical evidence upon which the ALJ could rely. Therefore, since Dr. Wunder's opinions "cannot constitute reliable or relevant evidence," the decision must be reversed. We summarily reject that argument since Bluelinx did not put

forth an evidentiary challenge to Dr. Wunder's report and the opinions expressed therein pursuant to Daubert and request the ALJ to conduct a Daubert inquiry.

In the October 5, 2021, Benefit Review Conference Order and Memorandum ("BRC") the parties listed the contested issues. A review of the BRC Order reveals a Daubert challenge was not raised at the BRC nor at the hearing. Because Bluelinx failed to raise this issue prior to submission of post-hearing briefs, it waived any objection to the admission of Dr. Wunder's reports and the opinions expressed therein. 803 KAR 25:010 § 10(6)(a)-(e) reads as follows:

> (6) Notices of filing or motions to file medical reports shall list the impairment rating assigned in the medical report or record in the body of the notice or motion.
>
> (a) Upon notice, a party may file evidence from two (2) physicians in accordance with KRS 342.033, either by deposition or medical report, which shall be admitted into evidence without further order if an objection is not filed.
>
> (b) An objection to the filing of a medical report shall be filed within ten (10) days of the filing of the notice or the motion for admission.
>
> (c) Grounds for the objection shall be stated with particularity.
>
> (d) The party seeking introduction of the medical report may file a response within ten (10) days after the filing of the objection.
>
> (e) The administrative law judge shall rule on the objection within ten (10) days of the response or the date the response is due.

No objection was filed to the introduction of Dr. Wunder's reports or the *New England Journal of Medicine* article attached to the November 21, 2021, report. Moreover, Bluelinx failed to assert an objection to the form of Dr. Wunder's reports

at any time during the litigation. The medical report was signed by Dr. Wunder, and the Estate provided his medical index number. It is clear pursuant to 803 KAR 25:010 § 10 that Dr. Wunder's report was filed into evidence without further order.

The BRC Order identifies the following issues: "Work related injury/causation of the heart condition and death. Injury as defined by the Act as to the heart condition and death, Permanent income benefits per KRS 342.730, including multipliers and entitlement to lump sum death benefit, AWW (pre and post), and Underpayment /Overpayment of TTD benefits." Bluelinx did not raise the admissibility of Dr. Wunder's medical reports grounded on a Daubert challenge either at the BRC or the hearing. Further, it did not cite to Daubert in its post-hearing brief. Because Bluelinx failed to challenge the admissibility of Dr. Wunder's report prior to submission of the case for a decision, the Estate did not have a fair opportunity to respond or submit evidence into the record concerning this challenge. 803 KAR 25:010 Section 13 (12) provides only contested issues shall be the subject of further proceedings. Because Bluelinx did not file an objection to the admissibility of Dr. Wunder's medical reports or the *New England Journal of Medicine* article and did not list the admissibility of his medical reports as a contested issue at the BRC, Bluelinx is precluded from now raising a challenge/objection to Dr. Wunder's report and his opinions.

Our ruling is supported by the Court of Appeals' holding in Sargent & Green Leaf v. Quillen, 2010-CA-001612-WC, rendered February 11, 2011, Designated Not To Be Published. The Court of Appeals held a Daubert challenge was not available to Sargent and Green Leaf since it was precluded from first

challenging the doctor's report after the final hearing as it failed to raise an objection based on Daubert prior to submission of the case for decision. The Court of Appeals explained:

> In this case, the ALJ held that Sargent was precluded from challenging the admissibility of Dr. Rogers' report after the final hearing since it failed to raise a *Daubert* objection prior to submission of this case for decision; Sargent challenged the admissibility of Dr. Rogers' report for the first time in its post-hearing brief, and neither raised the issue at the benefit review conference conducted by the ALJ prior to the final hearing during which the ALJ identified all contested issues, nor during the final hearing itself. As a result, Quillen was not afforded an opportunity to present evidence on the reliability of Dr. Rogers' report under the *Daubert* standard. Accordingly, the ALJ concluded that Sargent waived its *Daubert* objection.
>
> We agree that because the *Daubert* challenge was not raised at the benefit review conference and Quillen did not have a chance to present evidence in support of his position, Sargent's post-hearing challenge was untimely. *See* 803 KAR [footnote omitted] 25:010, Section 13(14) ("Only contested issues shall be the subject of further proceedings.").

Slip Op. at 3.

Our holding in the case *sub judice* is also buttressed by the Kentucky Supreme Court's holding in Copar, Inc. v. Rogers, 127 S.W.3d 554, 560-561 (Ky. 2003). The Supreme Court explained:

> 803 KAR 25:010E, § 12 (now 803 KAR 25:010, § 14) provided as follows:
>
>> (1) The Rules of Evidence prescribed by the Kentucky Supreme Court shall apply in all proceedings before an administrative law judge except as varied by specific statute and this administrative regulation.

> (2) Any party may file as evidence before the administrative law judge pertinent material and relevant portions of hospital, educational, Office of Vital Statistics, Armed Forces, Social Security, and other public records. An opinion of a physician which is expressed in these records shall not be considered by an administrative law judge in violation of the limitation on the number of physician's opinions established in KRS 342.033.

KRE 103 provides that an allegation of error may not be based on a ruling that admits evidence unless a substantial right of the party is affected and unless the party makes a timely objection or motion to strike. It was not until after the claim was taken under submission, in its tardy brief to the ALJ, that the employer first objected to the use of opinions contained in the claimant's hospital records to prove the existence and cause of her psychiatric condition. The employer maintains, however, that the regulation concerning medical reports is more specific than the regulation concerning the Rules of Evidence and, therefore, that hospital records must meet the requirements of the medical report regulation in order for the opinions they contain to be considered as evidence. It requires that medical reports must be signed or authenticated and accompanied by a statement of the qualifications of the individual making the report. Seeking to excuse its failure to object earlier, the employer maintains that if the claimant intended to rely on opinions from the hospital records to prove a psychiatric injury, it was her burden to give notice of their intended use.

Contrary to the employer's assertion, we are persuaded that nothing in 803 KAR 25:010E, § 9 or 12 abrogates KRE 103. The time for taking proof with respect to this claim closed well before the hearing was held. At the hearing, the ALJ specifically noted that the hospital records were the only evidence concerning the psychiatric condition. It was apparent, therefore, that the claimant intended to rely upon them to prove the condition's existence and cause. Yet, when questioned by the ALJ, the employer failed to object to such use of any medical opinions they contained and indicated only

> that it intended to introduce no psychiatric evidence. Furthermore, the employer signed, without objection, the hearing order that listed the hospital records as evidence for the claimant.
>
> 803 KAR 25:010E, § 12(2) is a specific regulation that addresses the admission of hospital records into evidence. It clearly anticipates that medical opinions contained in such records will sometimes be considered by an ALJ. Although the regulation specifies that opinions contained in such records shall not be considered in violation of KRS 342.033, it does not require that they be signed by the author or that the qualifications of the author be attached. Therefore, it is open to debate whether 803 KAR 25:010E, § 9 applies to opinions that are found in hospital records. In any event, we are persuaded that the employer's failure to raise a timely objection to such use of the claimant's hospital records was fatal to its present assertion of error.

Since we have rejected Bluelinx's second argument, we will address Bluelinx's first argument the ALJ's decision is erroneously based on emotional persuasion and sympathy and Dr. Wunder's opinions were not based on reasonable medical probability.

While the ALJ understandably expressed sympathy for the Williams' family's plight, he addressed the medical evidence in depth and resolved the cause of Williams' death relying solely on the medical evidence. Further, as previously held, the ALJ enjoyed the discretion to consider the opinions expressed by Dr. Wunder since Bluelinx failed at any point during the litigation to object to the admissibility of Dr. Wunder's report and the opinions expressed therein. Unquestionably, whether Williams' death resulted from the October 25, 2019, surgery, which no one disputes was work-related treatment, must be resolved based upon medical evidence comprising substantial evidence.

As the claimant in a workers' compensation proceeding, the Estate had the burden of proving the reasonableness and necessity of the surgery treating a work-related condition resulted in Williams' death. *See* KRS 342.0011(1); Snawder v. Stice, 576 S.W.2d 276 (Ky. App. 1979). Since the Estate was successful in that burden, the question on appeal is whether there was substantial evidence of record to support the ALJ's decision. Wolf Creek Collieries v. Crum, 673 S.W.2d 735 (Ky. App. 1984). "Substantial evidence" is defined as evidence of relevant consequence having the fitness to induce conviction in the minds of reasonable persons. Smyzer v. B. F. Goodrich Chemical Co., 474 S.W.2d 367 (Ky. 1971).

In rendering a decision, KRS 342.285 grants an ALJ as fact-finder the sole discretion to determine the quality, character, and substance of evidence. Square D Co. v. Tipton, 862 S.W.2d 308 (Ky. 1993). An ALJ may draw reasonable inferences from the evidence, reject any testimony, and believe or disbelieve various parts of the evidence, regardless of whether it comes from the same witness or the same adversary party's total proof. Jackson v. General Refractories Co., 581 S.W.2d 10 (Ky. 1979); Caudill v. Maloney's Discount Stores, 560 S.W.2d 15 (Ky. 1977). Although a party may note evidence that would have supported a different outcome than that reached by an ALJ, such proof is not an adequate basis to reverse on appeal. McCloud v. Beth-Elkhorn Corp., 514 S.W.2d 46 (Ky. 1974). Rather, it must be shown there was no evidence of substantial probative value to support the decision. Special Fund v. Francis, 708 S.W.2d 641 (Ky. 1986).

The function of the Board in reviewing an ALJ's decision is limited to a determination of whether the findings made are so unreasonable under the

evidence that they must be reversed as a matter of law. Ira A. Watson Department Store v. Hamilton, 34 S.W.3d 48 (Ky. 2000). The Board, as an appellate tribunal, may not usurp the ALJ's role as fact-finder by superimposing its own appraisals as to weight and credibility or by noting other conclusions or reasonable inferences that otherwise could have been drawn from the evidence. Whittaker v. Rowland, 998 S.W.2d 479 (Ky. 1999).

If the work-related surgery resulted in the sudden cardiac event, Williams' death is work-related, and the Estate and the workers' dependents are entitled to the benefits delineated in KRS 342.750. This premise was firmly established in Elizabethtown Sportswear v. Stice, 720 S.W. 2d 732 (Ky. App. 1986). In Slater Fore Consulting, Inc. v. Rife, 2016-SC-000131-WC, rendered August 24, 2017, Designated Not To Be Published, the Kentucky Supreme Court reaffirmed the principle that injuries occurring during a claimant's treatment for a work-related injury are compensable. Citing Elizabethtown Sportswear v. Stice, supra, the Supreme Court expounded:

> Next, Slater challenges the ALJ's conclusion that Rife's lumbar injury, suffered when he fell in the intensive care unit of the hospital while recovering from the December 2012 cervical surgery, is causally related to his work injury. The ALJ relied on *Pond Creek Collieries Co. v. La Santos*, 212 S.W.2d 530 (Ky. 1948) and *Elizabethtown Sportswear v. Stice,* 720 S.W.2d 732 (Ky. App. 1986), in finding that this lower back injury was compensable. Both cases address injuries occurring in the course of a patient's treatment for a work-related injury.
>
> In *Pond Creek,* the claimant fell from a hoist car at a coal mine and suffered multiple injuries including fractured ribs and a punctured lung that led to his hospitalization. 212 S.W.2d at 531. On his third day in the hospital, he

fell and x-rays revealed a hip fracture, an injury not previously identified. *Id.* It was impossible to determine when the hip fracture occurred but this Court's predecessor concluded that regardless of whether it was part of the original workplace injury or solely a result of the hospital fall it was still compensable. *Id.* at 532. "[E]ven if his hip was fractured when he fell from or beside his hospital bed, this occurred during his medical treatment at a time when he could not be held accountable for his acts, and as direct and proximate result of the original injury suffered in an 'accident arising out of and in the course of his employment.'" *Id.* Almost forty years later, in *Elizabethtown Sportswear,* the Court of Appeals addressed a case brought by the estate of a worker who suffered a work-related back injury. 720 S.W.2d at 733. The worker was hospitalized over a year following the injury for recurring back pain and a lumbar myelogram was ordered. *Id.* Tragically, she suffered an allergic reaction to the dye used in the procedure and died within twenty-four hours. *Id.* Relying in part on *Pond Creek*, the *Elizabethtown Sportswear* panel held that the widower was entitled to death benefits for this work-related death. *Id.* at 734. The court reasoned that an employee or her estate can recover for additional disability (or death) suffered as a result of medical treatment for the work-related injury. *Id.*

Slater summarizes what it perceives as the distinction between this case and the foregoing cases as follows:

> Here, there is no evidence that Appellee's fall in the hospital was in any way caused by his work injury or the treatment he was receiving. The simple fact that he fell *while in the hospital* does not lead to the conclusion that the fall is a 'direct and natural result' of his treatment. There is a clear difference between an injury that occurs *during* treatment and an injury that is *caused* by the treatment. The hospital fall must therefore be considered a subsequent intervening cause and not 'a direct and natural result' of the work injury.

Appellant's Brief at pp. 15–16 (emphasis in original).

> Here, as in *Pond Creek*, Rife was confined to the hospital following cervical surgery necessitated by his work-related injury. While still in the intensive care unit following a week-long coma, he stood to get up from a chair and fell, injuring his lower back in a manner that required further surgery in June 2013. We see no principled basis for distinguishing Rife's situation from that of the claimant in *Pond Creek.* The ALJ properly found the lumbar injury to be compensable and, consequently, the Board and Court of Appeals appropriately affirmed.

Slip Op. at 2-3.

In resolving whether Williams' death is work-related, the ALJ was presented with competing opinions of Dr. Corl, a cardiologist, versus the opinions of Dr. Wunder, a physiatrist. Thus, at first blush it appears the opinions of Dr. Corl, the cardiac expert, trump the opinions of Dr. Wunder. However, the ALJ enjoys the sole discretion to determine the medical evidence upon which he will rely.

Bluelinx relies substantially upon Pierce v. Kentucky Galvanizing Co. Inc., supra. In Pierce, the evidence revealed Pierce had angina attacks at work and elsewhere but the only actual heart attack he sustained was at home. Further, he had not been at work since March 4, 1976, three days before he sustained a myocardial infarction on March 7, 1976, while watching television at his residence. The Court of Appeals noted since Pierce's heart attack occurred some three days after he was last on the job, the question of whether the physical exertion attached to his job precipitated his heart attack is uniquely one for the medical experts. The ALJ had dismissed the claim because Pierce failed to establish the heart condition was caused by work. The Court of Appeals affirmed holding:

> We characterize as minimal the evidence tending to support appellant's claim that his heart attack was work-

related. There is clear and substantial evidence which demonstrates that appellant was a likely candidate for a heart attack. None of the recognized risk factors discussed previously were in any way shown to be work-related. There is no contention that appellant's occupation was in the high mental stress category sometimes associated with higher risk of heart attack. There is no claim that his coronary artery disease was in any way caused by his work.

Appellant's heart attack did not occur at work. Even if it had, that fact alone would not establish causation. See *Armco Steel Corp. v. Lyons*, 561 S.W.2d 676 (1978). Appellant's and the Board's reliance on the "totality of the circumstances" standard contained in *Moore v. Square D Company*, Ky., 518 S.W.2d 781 (1975), is misplaced. Moore, supra, permits the Board to go beyond the medical testimony in determining causation, but nothing in the non-medical evidence suggests that appellant's heart disease or heart attack arose out of his employment. It is only Dr. Lewis' opinion which furnishes any shred of support for appellant's position. In light of appellant's established medical history and diagnoses and the opinions of both Dr. Handley and Dr. Olash which substantially hold that the physical exertion involved in appellant's job had, if anything, a miniscule and remote causal relationship to his ultimate heart attack we do not think that, in this context, Dr. Lewis' opinion can be considered substantial evidence. Substantial evidence is not simply some evidence or even a great deal of evidence; rather, substantiality of evidence must take into account whatever fairly detracts from its weight. *Beavers v. Secy. of Health, Education and Welfare*, 577 F.2d 383 (6th Cir. 1978).

If the positions were reversed and Dr. Olash and Dr. Handley had testified based on their medical expertise that appellant's job-related physical exertion was the likely and probable cause of his heart attack and only Dr. Lewis had disagreed, we doubt very seriously if the Board would, or could as reasonable persons, have rejected the former opinions in favor of the latter. But taking the objective medical evidence, i. e., the unquestioned medical diagnosis discussed earlier in conjunction with the internist's and cardiologist's opinions, the only reasonable conclusion to be reached

> is that appellant's heart attack was caused by his coronary artery disease and not the conditions under which he worked.
>
> This case, perhaps, presents an example of the Board being overzealous in liberally construing the Workmen's Compensation Act. The rule of liberal construction does not extend to evidentiary matters. KRS 342.004. The question of work-relatedness in this case was fundamentally an evidentiary one. At most, only a possibility that appellant's heart attack arose out of his employment was established. A mere possibility is not alone sufficient to support the Board's findings of fact. *Terry v. Associated Stone Co.*, Ky 334 S.W.2d 926 (1960); *Seaton v. Rosenberg*, Ky., 573 S.W.2d 333, 338 (1978).

Id. at 168.

However, in the case *sub judice*, Dr. Wunder's opinions are not couched in terms of possibilities. Rather, the opinions set forth in his reports were couched in terms of a reasonable degree of medical probability. The last sentence of his October 24, 2020, report states all his answers "have been given to a reasonable degree of medical probability." Thus, the ALJ could reasonably conclude Dr. Wunder's opinions expressed in that report and the subsequent report were couched in terms of reasonable medical probability. In his November 1, 2021, report, Dr. Wunder's opinions are not equivocal but emphatic. He noted 500,000 to 900,000 patients undergoing non-cardiac surgery experienced perioperative cardiac death, non-fatal myocardial infarction, or non-fatal cardiac arrest. He agreed with Dr. Corl that the single largest cause of perioperative death is major adverse cardiac events. Further, non-cardiac surgery is associated with a significant cardiac morbidity, mortality, and cost. Significantly, perioperative myocardial infarction occurs primarily in the first three days after surgery as occurred in the case *sub judice*. Dr.

Wunder added that, irrefutably, "general anesthesia can initiate inflammatory and hypercoagulative states, and sudden cardiac death syndrome." He represented the attached article from the *New England Journal of Medicine* supports the premise that "non-cardiac surgery can precipitate complications such as death from cardiac causes, myocardial infarction or injury, or cardiac arrest, or congestive heart failure." He opined "surgery initiates an inflammatory response, stress, hypercoagulability, activation of sympathetic nervous system, and hemodynamic compromise, all of which can trigger cardiac complications." He observed the *New England Journal of Medicine* article points out if perioperative deaths were considered in a separate category it would rank as the third leading cause of death in the United States. Contrary to Bluelinx's characterizations, Dr. Wunder's opinions were based on reasonable medical probability. Without question, medical opinion evidence must be founded on probability and not merely possibility or speculation. Young v. LA Davidson Inc., 463 S.W.2d 924, 926 (Ky. 1971). Although Dr. Wunder was not required to use the phrase "in terms of reasonable medical probability," he did so in this case; thereby, rendering the argument concerning this issue meritless.

As noted by the Court of Appeals in Lexington Cartage Co. v. Williams, 407 S.W.2d 395, 396 (Ky. App. 1966):

> In Grimes v. Goodlett and Adams, Ky., 345 S.W.2d 47, we recognized that expert medical witnesses often find it impossible to state a medical cause of a disability with absolute certainty. We concluded that '* * * The facts or hypothesis on which the professional witness testifies need not be conclusive. They are sufficient if in his opinion they indicate the cause within reasonable probability.' See also Lewis v. United States Steel Corp., Ky., 398 S.W.2d 490.

We reject the premise that since the ALJ agreed with Dr. Corl's opinion Williams did not have congestive heart failure, and his death resulted from a sudden cardiac event, the ALJ could not find Williams' death to be work-related. Notably, Drs. Corl and Wunder concluded Williams experienced a sudden cardiac event on October 27, 2019. Relying on Dr. Corl's opinions, the ALJ rejected Dr. Wunder's opinions that Williams suffered from congestive heart failure and his congestive heart failure was adversely affected by the October 25, 2019, surgery.

However, in his November 1, 2021, letter, after reviewing Dr. Corl's reports and deposition testimony, Dr. Wunder also addressed another potential cause of Williams' death noting "cardiac complications are common after non-cardiac surgery and include sudden cardiac death." In this letter, Dr. Wunder addressed the potential of non-cardiac surgery producing a major perioperative cardiac event. He opined patients undergoing non-cardiac surgery are at risk for major perioperative cardiac events which he believed is what occurred in this case. As support for his opinions, Dr. Wunder cited from the attached article from the *New England Journal of Medicine*. He noted Dr. Corl did not believe the cause of death was congestive heart failure and did not accept the diagnosis set forth on the death certificate listing the cause of death as congestive heart failure. Based on Dr. Corl's opinions and his belief regarding the inaccurate diagnosis of the cause of death as congestive heart failure, Dr. Wunder then addressed the potential for cardiac complications occurring after a patient undergoes non-cardiac surgery. Significantly, he agreed with Dr. Corl that the single largest cause of perioperative death is major adverse cardiac event. Dr. Wunder's November 1, 2021, letter directly addresses, in

terms of reasonable medical probability, the propensity for non-cardiac surgery to produce sudden cardiac death.

Significantly, during his deposition testimony, Dr. Corl acknowledged there was no definite manner to determine the actual cause of Williams' death. Consequently, his opinions would be phrased in terms of probability. Dr. Corl added that even if an autopsy were performed it would not definitively establish the cause of death. Dr. Corl noted Williams had multiple conditions which at various times were uncontrolled, contributing to the risk of a sudden cardiac event which is why he believed statistically sudden cardiac death was by far the most likely scenario.

Dr. Corl believed that since this surgery was sufficiently low risk the surgery could be undertaken. Dr. Corl stated "the surgery is a low-risk surgery and [Williams] was clinically doing well from a symptomatic standpoint." He agreed with Dr. Wunder that Williams had been cleared for surgery. Just as important, Dr. Corl opined no surgical procedure is risk free, as with every surgery there is risk. However, he observed some surgeries are considered low risk. Dr. Corl provided the following:

> Q: Even though it is a low risk could a fatality occur in ankle surgery?
>
> A: It could. But I mean he made it through the surgery.
>
> Dr. Corl elaborated further as follows:
>
> A: Any surgery in which an anesthesia is administered is not risk free.

Dr. Corl also testified that even though the patient makes it through surgery, this does not eliminate surgery as the cause of the death occurring 24 to 48

hours later. Importantly, Dr. Wunder's opinions that non-cardiac surgery may result in sudden cardiac death is confirmed by the testimony of Dr. Corl. Dr. Wunder's opinions were phrased in terms of reasonable medical probability and are partially supported by Dr. Corl's deposition testimony. Therefore, we find no merit in Bluelinx's argument Dr. Wunder's opinions cannot constitute substantial evidence supporting the ALJ's decision.

Bluelinx's assertion the *New England Journal of Medicine* article is inapplicable is unconvincing. In the February 18, 2022, Order overruling Bluelinx's Petition for Reconsideration, the ALJ expressly found Dr. Wunder's opinion that the October 25, 2019, surgery caused a sudden cardiac event persuasive. In making that finding, the ALJ stated he relied upon "the literature cited by Dr. Wunder and his opinion that surgical procedures increase the risk of sudden cardiac death within three days after the procedure." The article from the *New England Journal of Medicine*, upon which the ALJ relied in part, is entitled *Cardiac Complications in Patients Undergoing Major Noncardic Surgery* and begins with the following sentence:

> Although major noncardiac surgery has the potential to improve the quality and prolong the duration of a patient's life, surgery may also precipitate complications such as death from cardiac causes, myocardial infarction or injury, cardiac arrest, or congestive heart failure.

The ALJ could reasonably surmise the purpose of the article is to address potential cardiac complications arising from major non-cardiac surgery. Bluelinx's assertion in its Petition for Reconsideration and on appeal that the article does not apply to the facts in this case since Williams underwent minor non-cardiac surgery is unsupported by the medical evidence in the record. Dr. Corl's letters of

June 15, 2021, and August 15, 2021, do not characterize the October 25, 2019, surgery as minor surgery. Rather, Dr. Corl's letters characterized the surgery as "uncomplicated successful elective outpatient left ankle surgery." Dr. Corl's characterization of the surgery does not equate to an opinion that Williams underwent minor surgery. The surgical records of OrthoCincy, substantiated by the records of St. Elizabeth Healthcare, reflect a diagnosis of left insertional Achilles tendinitis. The procedures performed were as follows: 1) left insertional Achilles debridement and repair, and fixation of Haglund's deformity and; 2) left flexor hallucis longus transfer. An Arthrex Achilles SpeedBridge and biotenodesis screw were implanted. Williams was administered general and regional anesthesia. As no medical evidence supports Bluelinx's argument that Williams underwent minor surgery, the argument must be rejected.

Bluelinx also argues the *New England Journal of Medicine* article only relates to high-risk surgery; however, a review of the article does not support this assertion. Nothing in the *New England Journal of Medicine* article specifically indicates its primary purpose is to address cardiac complications arising from high-risk non-cardiac surgeries. Consequently, we reject Bluelinx's argument that the *New England Journal of Medicine* article is inapplicable due to Williams undergoing "minor surgery" or because the article addresses cardiac complications arising from high-risk surgeries.

Moreover, the ALJ was free to conclude the *New England Journal of Medicine* article cited by and relied upon by Dr. Wunder is germane to the issue of whether the October 25, 2019, surgery resulted in Williams' death. Bluelinx's

characterization of the subject matter purportedly addressed by the article and its argument regarding the applicability of the article is not supported by any medical evidence in the record. Rather, its entire argument is based upon Bluelinx's counsel's interpretation of the article. Given the nature of article, only a medical expert could address the nature of the surgery Williams underwent and the applicability of the article. Notably, Bluelinx did not introduce any medical evidence after the Estate filed Dr. Wunder's November 1, 2021, letter with the attached *New England Journal of Medicine* article supporting its argument that the article is inapplicable. Stated another way, there is no medical evidence in the record which would support a finding the October 25, 2019, surgery was minor, and the *New England Journal of Medicine* article relates solely to high-risk non-cardiac surgeries. Consequently, the ALJ was free to infer the *New England Journal of Medicine* article is applicable to the case *sub judice* since no contradictory medical opinions concerning its applicability were proffered by Bluelinx.

In summary, the ALJ relied upon Dr. Wunder's opinion and the information contained within the *New England Journal of Medicine* article attached to his report in finding the October 25, 2019, surgical procedures increased the risk of sudden cardiac death within the first three days after the surgery. Significantly, Bluelinx offered no medical evidence challenging the applicability of the article or the opinions expressed by Dr. Wunder based in part upon the *New England Journal of Medicine* article. Thus, the ALJ could reasonably conclude the article is relevant and material to the facts in this case and the opinions of Dr. Wunder and the *New England Journal of Medicine* article constitute probative medical evidence concerning

the cause of Williams' death. Therefore, the opinions of Dr. Wunder and the *New England Journal of Medicine* article constitute substantial evidence supporting the ALJ's determination.

Finally, concerning Bluelinx's third argument, we have already determined Dr. Wunder's opinions and the *New England Journal of Medicine* article constitute substantial evidence supporting a finding that the surgery in question was the proximate or direct cause of Williams' death. Dr. Wunder's opinions were specifically couched in terms of reasonable medical probability. Further, Dr. Corl's deposition testimony establishes non-cardiac surgery in certain cases may result in a sudden cardiac event. Drs. Corl and Wunder agreed that surgery involving the use of anesthesia can result in post-operative complications. Thus, there is substantial medical evidence in the form of Dr. Wunder's opinions, the *New England Journal of Medicine* article, and Dr. Corl's opinions allowing the ALJ to conclude Williams' death was ultimately caused by the non-cardiac surgery of October 25, 2019. We reject Bluelinx's argument the ALJ relied upon unfounded and contradictory evidence, particularly in light of the portions of Dr. Corl's deposition testimony that lend credence to Dr. Wunder's opinions. Since the ALJ's decision is supported by substantial evidence and a contrary result is not compelled, this Board is without authority to disturb the decision.

Accordingly, the January 18, 2022, Opinion, Award, and Order and the February 18, 2022, Order overruling the Petition for Reconsideration are **AFFIRMED**. However, this Board is permitted to *sua sponte* reach issues even if unpreserved. KRS 342.285(2)(c); KRS 342.285(3); George Humfleet Mobile Homes

v. Christman, 125 S.W.3d 288 (Ky. 2004). Since the parties stipulated Williams sustained a work-related ankle injury for which he underwent treatment including surgery, as a matter of law, an award of medical benefits is statutorily mandated. This Board is charged with ensuring all awards are in accordance with the statute. The award is not in accordance with the statute because the ALJ failed to award medical benefits for the treatment of Williams' work injury. Therefore, we **REMAND** the claim for entry of an amended decision awarding medical benefits in accordance with the statute and case law.

ALL CONCUR.

COUNSEL FOR PETITIONER:

HON MARK BUSH **LMS**
250 GRANDVIEW DR STE 550
FORT MITCHELL KY 41017

COUNSEL FOR RESPONDENT:

HON HALEY STAMM **LMS**
2500 CHAMBER CTR DR STE 300
FORT MITCHELL KY 41017

ADMINISTRATIVE LAW JUDGE:

HON W GREG HARVEY **LMS**
MAYO-UNDERWOOD BUILDING
500 MERO ST 3RD FLOOR
FRANKFORT KY 40601