File Number: 062270339
nodfoi-factual (stress)-D-I

U.S. DEPARTMENT OF LABOR

OFFICE OF WORKERS' COMP PROGRAMS
PO BOX 8300 DISTRICT 6 JAC
LONDON, KY 40742-8300
Phone: (904) 357-4777

March 10, 2011

Date of Injury: 01/22/2011
Employee: KRISTIN M. NOE

KRISTIN M NOE
1626 NW 143RD WAY
PEMBROKE PINES, FL 33028

Dear Ms. NOE:

NOTICE OF DECISION

Your claim for compensation is denied as the evidence is not sufficient to establish that you sustained an injury as defined by the Federal Employees' Compensation Act (FECA).

On 01/23/2011, you filed a claim for Traumatic Injury indicating you sustained an emotional condition as a result of your employment as an Air Traffic Control Specialist with the Department of Transportation in Miami, FL. Specifically, you stated that your emotional condition occurred due to an operational error in your air traffic control duties.

Along with your claim, you submitted a medical report dated 1/27/11.

The evidence submitted was insufficient to establish your claim because the injury, accident or employment factor alleged must have actually occurred.

On 02/08/2011, this office advised you of the deficiencies in your claim and provided you the opportunity to submit additional evidence. Specifically, you were asked to submit a written statement and to describe in detail the employment related condition(s) or incident(s) which you believe contributed to your illness. Your agency was also asked to provide a written statement concerning these conditions and incidents. You were provided 30 days to submit the requested information.

In response to our development letters, we received the following evidence:

Medical reports dated 2/2/11, 2/5/11, 2/7/11, and 2/9/11
Attending physician's report dated 2/9/11
Your written statement dated 2/18/11
Agency written statements dated 2/9/11 and 2/16/11

In order for a claim to be accepted under the Federal Employees' Compensation Act (FECA), the claim must meet 5 basic elements. The claim must:

(1) Be Timely Filed.
(2) Be made by a Federal Civil Employee.
(3) Establish Fact of Injury, which has both a factual and medical component. Factually, employment incident(s) alleged must have actually occurred. Medically, a medical condition must be diagnosed in connection with the specified employment incident.

(4) Establish Performance of Duty. The medical condition must have arisen during the course of employment and within the scope of compensable work factors.
(5) Establish Causal Relationship, which means the medical evidence establishes that the diagnosed condition is causally related to the accepted employment factors.

You have established that you are a Federal civilian employee who filed a timely claim; however, after a thorough review of all evidence, your claim is denied because the factual component of the third basic element, Fact of Injury, has not been met. Under the Federal Employee's Compensation Act, you must establish a factual basis to support your claim and the evidence does not support that you actually experienced the employment incident(s) alleged to have occurred.

You alleged the following incident: You were involved in an operational error; an aircraft under your control came within close proximity of another aircraft.

The office finds that the alleged incident did not occur because your agency has provided evidence that you were not actually responsible for the control of the aircraft and that although the proximity of the aircraft to other aircraft in a terminal radar environment was not within standards there was no danger to the aircraft or its' passengers. Your agency, in a written statement dated 2/16/11, indicates that at the time of the alleged incident that you were not responsible but were assisting the air radar controller who was responsible for the involved aircraft. Also your agency has provided information that the separation from other aircraft was 2.68 nautical miles lateral and 0 feet vertical or 2.5 nautical miles lateral and 500 feet vertical depending upon the measurement reference. Although the separation standard is 1000 feet vertically or 3 nautical miles laterally the aircraft and its' passengers were not in danger as they made their approach for landing.

Based on these findings, your claim is denied on the factual component of the third basic element, Fact of Injury, because the evidence does not support that the injury and/or events occurred. The requirements have not been met for establishing that you sustained an injury as defined by the FECA. Medical treatment is not authorized and prior authorization, if any, is terminated.

Your employing agency will charge any previously paid Continuation of Pay to your sick and/or annual leave balance or declare it an overpayment.

If you disagree with this decision, you should carefully review the attached appeal rights and pursue whichever avenue is appropriate to your situation.

Sincerely,

Stephen Cory
Claims Examiner

Enclosure: Appeal Rights

DEPARTMENT OF TRANSPORTATION
FEDERAL AVIATION ADMINISTRATION
WORKERS' COMP DIV-AHL-100
800 INDEP AVE, SW, RM 521,(AHP-500)
WASHINGTON, DC 20591

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FEDERAL EMPLOYEES' COMPENSATION ACT APPEAL RIGHTS

If you disagree with the attached decision, you have the right to request an appeal. If you wish to request an appeal, you should review these appeal rights carefully and decide which appeal to request. There are 3 different types of appeal: HEARING (this includes either an Oral Hearing, or a Review of the Written Record), RECONSIDERATION, and ECAB REVIEW. YOU MAY ONLY REQUEST ONE TYPE OF APPEAL AT THIS TIME.

Place an "X" on the attached form indicating which appeal you are requesting. Complete the information requested at the bottom of the form. Place the form on top of any material you are submitting. Then mail the form with attachments to the address listed for the type of appeal that you select. Always write the type of appeal you are requesting on the outside of the envelope ("HEARING REQUEST", "RECONSIDERATION REQUEST", or "ECAB REVIEW"). Your appeal rights are as follows:

1. HEARING: If your injury occurred on or after July 4, 1966, and you have not requested reconsideration, as described below, you may request a **Hearing**. To protect your right to a hearing, any request for a hearing must be made before any request for reconsideration by the District Office (5 U.S.C. 8124(b)(1)). **Any hearing request must also be made in writing, within 30 calendar days after the date of this decision, as determined by the postmark of your letter.** (20 C.F.R. 10.616). There are two forms of hearing. You may request either one or the other, but not both.
a. One form of Hearing is an **Oral Hearing.** An informal oral hearing is conducted by a hearing representative at a location near your home or by teleconference/videoconference. You may present oral testimony and written evidence in support of your claim. Any person authorized by you in writing may represent you at an oral hearing. At the discretion of the hearing representative, an oral hearing may be conducted by teleconference or videoconference.
b. The other form of a Hearing is a **Review of the Written Record.** This is also conducted by a hearing representative. You may submit additional written evidence, which must be sent with your request for review. You will not be asked to attend or give oral testimony.

2. RECONSIDERATION: If you have additional evidence or legal argument that you believe will establish your claim, you may request, in writing, that OWCP reconsider this decision. **The request must be made within one calendar year of the date of the decision**, clearly state the grounds upon which reconsideration is being requested, and be accompanied by relevant evidence not previously submitted. This evidence might include medical reports, sworn statements, or a legal argument not previously made, which apply directly to the issue addressed by this decision. In order to ensure that you receive an independent evaluation of the new evidence, persons other than those who made this determination will reconsider your case. (20 C.F.R. 10.605-610)

3. REVIEW BY THE EMPLOYEES' COMPENSATION APPEALS BOARD (ECAB): If you believe that all available evidence that would establish your claim has already been submitted, you have the right to request review by the ECAB (20 C.F.R. 10.625). The ECAB will review only the evidence received prior to the date of this decision (20 C.F.R. Part 501). Effective November 19, 2008, ECAB has changed its Rules of Procedure on the time limit to appeal and has eliminated its practice of allowing one year to file an appeal. **Request for review by the ECAB must be made within 180 days from the date of this decision.** More information on the new Rules is available at www.dol.gov/ecab.

If you request reconsideration or a hearing (either oral or review of the written record), OWCP will issue a decision that includes your right to further administrative review of that decision.

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APPEAL REQUEST FORM

If you decide to appeal this decision, read these instructions carefully. You must specify which procedure you request by checking one of the options listed below. Place this form on top of any materials you submit. **Be sure to mail this form, along with any additional materials, to the appropriate address. YOU MAY ONLY REQUEST ONE TYPE OF APPEAL AT THIS TIME.**

_____ **ORAL HEARING**

Depending on your geographical location, the issue involved in your case, the number of hearing requests in your area, and at the discretion of the hearing representative, we may expedite your appeal by providing you a telephone hearing or videoconference. **Please check here if you would prefer a telephone hearing.** _____

_____ **REVIEW OF THE WRITTEN RECORD**

For each of these options, you must submit this form within 30 calendar days of the date of the decision. You may also submit additional written evidence with your request. **You must mail your request to:**

Branch of Hearings and Review
Office of Workers' Compensation Programs
P. O. Box 37117
Washington, DC 20013-7117

_____ **RECONSIDERATION:**

Submit your request within 1 calendar year of the date of the decision. You must state the grounds upon which reconsideration is being requested. Your request must also include relevant new evidence or legal argument not previously made. **Mail your request to:**

DOL DFEC Central Mailroom
P. O. Box 8300
London, KY 40742

_____ **ECAB APPEAL:**

Submit this form within 180 calendar days of the date of the decision. No additional evidence after the date of OWCP's decision will be reviewed. To expedite the processing of your ECAB appeal, you may include a completed copy of the AB 1 form used by ECAB to docket appeals available on the Department of Labor Web Site at www.dol.gov/ecab. **You must mail your request to:**

Employees' Compensation Appeals Board
200 Constitution Avenue NW, Room S-5220
Washington, DC 20210

SIGNATURE_____TODAY'S DATE_____
PRINTED NAME_____DECISION DATE_____
ADDRESS_____PHONE_____
CITY _____STATE_____ZIP_____