Current Issues in the Workers' Compensation System

June 10, 2019

9:00 a.m. – 11:00 a.m.

Connecticut Convention Center
Hartford, CT

CT Bar Institute Inc.

CT: 2.0 CLE Credits (General)
NY: 2.0 CLE Credits (AOP)

Seminar Materials Sponsored by

Lawyers' Principles of Professionalism

As a lawyer I must strive to make our system of justice work fairly and efficiently. In order to carry out that responsibility, not only will I comply with the letter and spirit of the disciplinary standards applicable to all lawyers, but I will also conduct myself in accordance with the following Principles of Professionalism when dealing with my client, opposing parties, their counsel, the courts and the general public.

Civility and courtesy are the hallmarks of professionalism and should not be equated with weakness;

I will endeavor to be courteous and civil, both in oral and in written communications;

I will not knowingly make statements of fact or of law that are untrue;

I will agree to reasonable requests for extensions of time or for waiver of procedural formalities when the legitimate interests of my client will not be adversely affected;

I will refrain from causing unreasonable delays;

I will endeavor to consult with opposing counsel before scheduling depositions and meetings and before rescheduling hearings, and I will cooperate with opposing counsel when scheduling changes are requested;

When scheduled hearings or depositions have to be canceled, I will notify opposing counsel, and if appropriate, the court (or other tribunal) as early as possible;

Before dates for hearings or trials are set, or if that is not feasible, immediately after such dates have been set, I will attempt to verify the availability of key participants and witnesses so that I can promptly notify the court (or other tribunal) and opposing counsel of any likely problem in that regard;

I will refrain from utilizing litigation or any other course of conduct to harass the opposing party;

I will refrain from engaging in excessive and abusive discovery, and I will comply with all reasonable discovery requests;

In depositions and other proceedings, and in negotiations, I will conduct myself with dignity, avoid making groundless objections and refrain from engaging I acts of rudeness or disrespect;

I will not serve motions and pleadings on the other party or counsel at such time or in such manner as will unfairly limit the other party's opportunity to respond;

In business transactions I will not quarrel over matters of form or style, but will concentrate on matters of substance and content;

I will be a vigorous and zealous advocate on behalf of my client, while recognizing, as an officer of the court, that excessive zeal may be detrimental to my client's interests as well as to the proper functioning of our system of justice;

While I must consider my client's decision concerning the objectives of the representation, I nevertheless will counsel my client that a willingness to initiate or engage in settlement discussions is consistent with zealous and effective representation;

Where consistent with my client's interests, I will communicate with opposing counsel in an effort to avoid litigation and to resolve litigation that has actually commenced;

I will withdraw voluntarily claims or defense when it becomes apparent that they do not have merit or are superfluous;

I will not file frivolous motions;

I will make every effort to agree with other counsel, as early as possible, on a voluntary exchange of information and on a plan for discovery;

I will attempt to resolve, by agreement, my objections to matters contained in my opponent's pleadings and discovery requests;

In civil matters, I will stipulate to facts as to which there is no genuine dispute;

I will endeavor to be punctual in attending court hearings, conferences, meetings and depositions;

I will at all times be candid with the court and its personnel;

I will remember that, in addition to commitment to my client's cause, my responsibilities as a lawyer include a devotion to the public good;

I will endeavor to keep myself current in the areas in which I practice and when necessary, will associate with, or refer my client to, counsel knowledgeable in another field of practice;

I will be mindful of the fact that, as a member of a self-regulating profession, it is incumbent on me to report violations by fellow lawyers as required by the Rules of Professional Conduct;

I will be mindful of the need to protect the image of the legal profession in the eyes of the public and will be so guided when considering methods and content of advertising;

I will be mindful that the law is a learned profession and that among its desirable goals are devotion to public service, improvement of administration of justice, and the contribution of uncompensated time and civic influence on behalf of those persons who cannot afford adequate legal assistance;

I will endeavor to ensure that all persons, regardless of race, age, gender, disability, national origin, religion, sexual orientation, color, or creed receive fair and equal treatment under the law, and will always conduct myself in such a way as to promote equality and justice for all.

It is understood that nothing in these Principles shall be deemed to supersede, supplement or in any way amend the Rules of Professional Conduct, alter existing standards of conduct against which lawyer conduct might be judged or become a basis for the imposition of civil liability of any kind.

--Adopted by the Connecticut Bar Association House of Delegates on June 6, 1994

Faculty Biographies

Chairman **Stephen Morelli** received his Bachelor of Arts degree from the University of Connecticut in 1983 and his law degree from the University of Connecticut School of Law in 1986. He is admitted to the practice of law in both Connecticut's and California's State and Federal Courts.

After graduating from law school he entered the Peace Corps as an ESL instructor in Thailand. Subsequent to that service he was admitted to practice law in California and worked for a private practice in California. In 1995 he returned to Connecticut, working in private practice, until his appointment as a Workers' Compensation Commissioner, in August of 2012. Chairman Morelli has also served four terms on the Berlin Town Council and three terms as Deputy Mayor of the Town of Berlin. While his private practice in Connecticut was varied, the majority of Chairman Morelli's experience was in the area of employment law. Prior to beginning his current role as the Workers' Compensation Commission Chairman in May 2018, Chairman Morelli served in the New Britain, Norwich, Hartford and Waterbury District Offices.

John P. Clarkson is the Workers' Compensation Practice Group Leader at the Law Offices of Dean E. Weddal, the Travelers Staff Counsel office in Hartford. He received the BA in Religion and Greek from Connecticut College in 1976 and a JD from the University of Connecticut School of Law in 1979. Attorney Clarkson stayed on at the law school for a one-year appointment as a Legal Writing and Moot court instructor from 1979 to 1980 after which he served as counsel to the Connecticut Freedom of Information Commissioner from 1980 to 1981. He joined his present firm, then known as the Law Offices of Geoffrey Naab, in 1981, where he handled a mixed caseload including auto, property, civil rights, product liability, uninsured motorist, subrogation and workers' compensation claims in state and federal courts and administrative agencies at all levels. Attorney Clarkson left the firm in 1991 to join the Middletown firm of Poliner, Poliner & Antin, where he represented personal injury plaintiffs and workers' compensation claimants for eight years. In 1999 he returned to Travelers to take his present position as Workers' Compensation Practice Group leader. Attorney Clarkson has published articles in the *Connecticut Law Review*, *Connecticut Bar Journal* and the *Compensation Quarterly* and is a speaker on workers' compensation issues at continuing legal education and insurance and human resources trade group seminars.

Francis "Bud" X. Drapeau is a partner in the firm of Leighton, Katz & Drapeau with a principal office in Vernon. His practice consists primarily of representing claimants in the workers' compensation forum and on appeal. He is currently chairman of the Workers' Compensation Section of the CBA. Attorney Drapeau is a Board Certified Workers' Compensation Specialist. He has lectured on various workers' compensation topics for both the Connecticut Bar Association and the Connecticut Trial Lawyers Association.

Mr. Drapeau received his B.A. degree from Fairfield University and his Juris Doctorate from Western New England College School of Law.

He was admitted to practice in the State of Connecticut in 1991.

He has been a contributor in both the Practice Tips and Point-Counterpoint sections of the Compensation Quarterly.

He is a member of the Workers' Compensation Section of the Connecticut Bar Association, the Connecticut Trial Lawyers Association, and the Tolland County Bar Association of which he is past President. For fourteen years he sat on the Examining Committee for Board Certification as a Workers' Compensation Specialist.

Lucas D. Strunk, a 1979 graduate of the College of the Holy Cross, is a partner in the firm Strunk Dodge Aiken Zovas, LLC of Rocky Hill, Connecticut. Attorney Strunk focuses on the defense of workers' compensation matters. A graduate of the University of Connecticut School of Law, he was admitted to the Connecticut Bar in 1982.

Attorney Strunk is a member of the American Bar Association and the Mashantucket Pequot Bar Association. He is a member of the Connecticut Bar Association and serves on the executive committee of the Workers' Compensation Section. He is currently the Committee's Legislative Liaison. Attorney Strunk has argued successfully on numerous occasions before the State's Supreme and Appellate Courts.

Attorney Strunk also practices under the Longshore and Harbor Workers' Compensation Act and is admitted to practice in the Second Circuit Court of Appeals. He is further authorized to practice before the United States Supreme Court.

Attorney Strunk has contributed articles to the *Workers' Compensation Quarterly* and has spoken on issues associated with workers' compensation at various seminars, including those sponsored by the Connecticut Bar Association. He regularly presents to clients on topical issues associated with the substance and procedures of the workers' compensation system.

Attorney Strunk is certified by the Connecticut Bar Association as a specialist in Workers' Compensation. He has an AV preeminent rating by Martindale Hubbell and has been named to the peer nominated Best Lawyers and New England Super Lawyers. Attorney Strunk is a fellow in the National College of Workers' Compensation Lawyers and is a contributing author to the continuing Connecticut Practice Series, "Workers' Compensation Law." (Thomson-West 2008).

Current Issues in the Workers' Compensation System (CLC2019-A10)

Agenda

9:00 – 9:20 a.m.	Chairman's Address Speaker: **Chairman Stephen Morelli**
9:20 – 9:40 a.m.	Legislative Update Speaker: **Luke Strunk**
9:40 – 10:15 a.m.	Case Law Update Speaker: **Jack Clarkson**
10:15 – 10:20 a.m.	Introduction of Incoming Chair Speaker: **Colette Griffin**
10:20 – 10:25 a.m.	Introduction of Pomeranz-O'Brien Award The Workers' Compensation Section initiated the Pomeranz-O'Brien Award to honor attorneys who have contributed to the workers' compensation system and/or community by exemplary service that has gone above and beyond that displayed by his or her peers and were truly extraordinary. Speaker: **Bud Drapeau**
10:25 – 10:35 a.m.	**Angelo Sevarino**
10:35 – 10:45 a.m.	**William Brown**
10:45 – 10:55 a.m.	**Diane Duhamel**
10:55 – 11:00 a.m.	Presentation of Pomeranz-O'Brien Award

2019 LEGISLATIVE REPORT

Lucas D. Strunk
Strunk Dodge Aiken Zovas, LLC
200 Corporate Place, Suite 100
Rocky Hill, CT 06067
(860)785-4500
lstrunk@ctworkcomp.com

This year's legislative session has addressed a number of workers' compensation related legislative proposals. As of the writing of this paper, the legislature has not yet concluded its work. The 2019 session is scheduled to conclude at midnight on June 5th. The hope is that the dust will settle and final legislation will be available for review at the time of the Connecticut legal conference on June 10th.

At this point, four bills remain active as will be outlined herein.

1.) The legislation attracting a great deal of attention and media coverage is **SUBSTITUTE SENATE BILL 164 "An Act Including Certain Mental or Emotional Impairments within the Definition of "Personal Injury" under the Workers' Compensation Statutes."** I have attached a copy of Substitute Senate Bill 164 which reworks the post-traumatic stress disorder (PTSD) legislation previously subject to debate over the last six years. This bill as last amended in the Senate has passed both chambers and awaits final formatting for submission to the Governor for signature.

The legislation truly represents a compromise by the many stakeholders involved in the debate at the legislature over the past several years.

The legislation provides that effective July 1, 2019, Section 31-275 will be amended to allow police officers, municipal constables, parole officers, and firefighters, both paid and volunteer, to receive limited workers' compensation benefits for PTSD.

In order to be eligible for benefits, a board certified mental health professional, psychiatrist or psychologist who has experience in the diagnosis and treating of PTSD must make the diagnosis consistent with the most recent edition of the DSM.

Eligibility is triggered by a "qualifying event" in which the claimant in the line of duty:

a) Views a deceased minor;

b) Witnesses the death of a person or an incident involving the death of a person;

c) Witnesses an injury to a person who subsequently dies before or upon admission at a hospital as a result of the injury and not as a result of any other intervening cause;

d) Has physical contact with or treats an injured person who subsequently dies before or upon admission at a hospital as a result of the injury and not as a result of other intervening cause;

e) Carries an injured person who subsequently dies before or upon admission at a hospital as a result of the injury and not as a result of any other intervening cause; or

f) Witnesses a traumatic physical injury that results in the loss of a vital body part or a vital body function that results in permanent disfigurement of the victim.

The role of the qualifying event in causing the PTSD must be viewed as a substantial factor. That factor, however, is subject to there not being another event or source of stress that was the primary cause of the PTSD.

The law will still contain exclusions that the disorder not result from disciplinary action, work evaluation, job transfer, layoff, demotion, promotion, termination, retirement or similar action of the officer or firefighter.

Mental health professionals will need to comply with any workers' compensation guidelines for approved medical providers including but not limited to guidelines on release of past or contemporaneous medical records.

The notice provisions of Section 31-294c will also now provide for notice of claims for PTSD. The provisions applicable to these claims, however, will allow for the standard contest of the claim within 28 days after receipt of proper notice but will allow for a without prejudice payment within 28 days and thereafter allow 180 days to contest the claim.

The benefits available to the claimant will be paid under Section 31-307 temporary total or 31-308 temporary partial for a maximum of 52 weeks from the date of diagnosis. No

benefits, however, will be awarded beyond 4 years from the date of the qualifying event that formed the basis for the personal injury.

The weekly benefit when combined with other benefits available to the claimant shall not exceed the average weekly wage paid to such officer or firefighter.

The new law specifically excludes any claim for permanent partial disability benefits under Section 31-308(b) or Section 31-308a.

Of note is that Section 31-294h is not repealed. That section addresses other mental or emotional impairments arising out of the officer's use of deadly force or being subjected to deadly force in the line of duty. Similarly, firefighters who develop PTSD from witnessing the death of another firefighter while engaged in the line of duty shall be entitled to treatment. This section therefore continues to provide an option in certain situations that would not be limited to 4 years of care.

The bill itself was almost derailed in the senate by last minute questions regarding emergency services personnel. As a result, a provision was added that the Labor and Public Employees Committee examine the feasibility of expanding the provisions of the new law to EMS personnel and Department of Correction officers. This examination is to be undertaken to include consultation with all stakeholders to the legislation including representatives of the workers' compensation commission. Any further action will require a bill in the next session that apparently could provide these additional workers with a retroactive protection for qualifying events after July 1, 2019.

Incorporated in the new legislation is also some job protection provisions that had been pending in another bill before the legislature. This section prohibits a police officer from being discharged, disciplined or penalized because he or she receives mental health services or surrenders his or her firearm to seek such services. The provision does not apply to officers who seek or receive mental health care services to avoid disciplinary action or who refuse to submit to mental health examination. The bill also addresses the return of weapons or ammunition to an officer; prohibits a civil action against a law enforcement unit in the case of an officer using personal firearms under certain conditions. Please see the bill for the specific additional provisions. Of note is that the Mohegan and Mashantucket Pequot police units are included in this aspect of the new law but not included in the PTSD component.

2.) Also pending on the senate calendar is **SUBSTITUTE HOUSE BILL 5883 "An Act Concerning Workers' Compensation Insurance Coverage for Detoxification for Certain Injured Employees, Local and Regional Board of Education Employee Notices and Reimbursement of Lost Wages for Appearance at a Deposition."** This bill reflects a combination of various pending legislation and would be effective October 1, 2019. The law in effect codifies the current practice relative to detoxification should the claimant who as a result of a compensable injury develops an opioid dependency. The statute creates detoxification as medically necessary treatment in cases where the opioid drugs are

prescribed as medical treatment for the injury for a continuous period of not less than one year.

The bill will also amend Section 31-294c to clarify that employees of a local or regional board of education shall send notice of claim to the local or regional board by whom they are employed. This clarifies the confusion that developed in some municipalities relative to filing of claims with the town clerk.

The third section of this bill amends Section 31-312(b) in that the claimant who appears at deposition shall be entitled to reimbursement of wages lost by reason of the appearance if not then receiving compensation at the time of the appearance.

3.) The third piece of legislation also pending on the senate calendar contains the commission and section proposals relative to technical changes. It is entitled **"An Act Concerning Minor and Technical Changes to the Workers' Compensation Act" (HOUSE BILL 7241).**

The bill effective October 1, 2019 reflects that: 1) compensation commissioner will now be noted as administrative law judge; 2) Section 31-280a will be amended such that the advisory board shall meet at least once in each calendar quarter rather than twice; 3) reference to a full-time salaried director of the statistical division of the workers' compensation commission at 31-283f of the statute will be deleted; 4) Section 31-349 will be amended to delete the references to transfer to the Second Injury Fund as a result of a previous disability and removes the notice provisions associated therewith (Section 31-354 and Section 31-355a of the statutes are also amended to reflect this change); and 5) Sections 31-276a, 31-298a (the medical lung panel in the case of occupational disease), 31-304 (pertaining to the destruction of workers' compensation agreements filed in Superior Court), and 31-276a (which had placed the commission within the Department of Labor for administrative purposes) are all repealed.

4.) The fourth bill of concern and monitored by a number of stakeholders to the system was **HOUSE BILL 6916 "An Act Expanding Remedies and Potential Liability for Unreasonable, Contested or Delayed Workers' Compensation Claims."** The bill which sought to make interest and attorney's fees mandatory in the case of undue delay or unreasonable contest and which sought to reestablish civil claims against insurers and third party administrators ultimately was reworked such that it now establishes a task force to study the issue of contested claims, undue delay, and the law regarding bad faith handling of workers' compensation claims. The bill outlines the detail of the issues to be studied.

The task force will include representatives of the various stakeholders and legislators including a physician that treats and one who performs respondents' medical evaluations. The bill is currently pending on the senate calendar. The original bill was subject of fiscal note which reflected costs associated with additional formal hearings at $650,000.00 in fiscal year 20, as well as $683,000.00 in salaries and fringe benefits associated with the

staffing for those formal hearings. Fiscal note also referenced the costs to defend suits and the state's liability for claims against its TPA.

The task force, to be formed by August 1, 2019, is to report back to the legislature by January 1, 2020.

In other legislation the house and senate confirmed the nomination of Commissioners Pedro Segarra and Toni Fatone and confirmed the nomination of Karen Welch as a member of the advisory board. Congratulations to the three of them.

As noted above, please be certain to determine the status of the above legislation upon completion of the January 2019 session.

General Assembly

Amendment

January Session, 2019

LCO No. **9712**

SB00164097 12SDO

Offered by:

SEN. LOONEY, 11th Dist.
SEN. DUFF, 25th Dist.
REP. ARESIMOWICZ, 30th Dist.
REP. RITTER M., 1st Dist.
SEN. FASANO, 34th Dist.
SEN. WITKOS, 8th Dist.
REP. KLARIDES, 114th Dist.
REP. CANDELORA, 86th Dist.
SEN. OSTEN, 19th Dist.
SEN. KUSHNER, 24th Dist.
REP. PORTER, 94th Dist.
SEN. MINER, 30th Dist.
REP. POLLETTA, 68th Dist.
REP. HALL, 7th Dist.
SEN. WINFIELD, 10th Dist.
REP. STAFSTROM, 129th Dist.
SEN. KISSEL, 7th Dist.
REP. REBIMBAS, 70th Dist.
SEN. BERGSTEIN, 36th Dist.
REP. BLUMENTHAL, 147th Dist.
SEN. BRADLEY, 23rd Dist.
REP. VERRENGIA, 20th Dist.
SEN. HWANG, 28th Dist.
REP. SREDZINSKI, 112th Dist.
REP. PAOLILLO, 97th Dist.

To: Subst. Senate Bill No. **164** File No. 362 Cal. No. 202

(As Amended by Senate Amendment Schedule "A")

"AN ACT INCLUDING CERTAIN MENTAL OR EMOTIONAL IMPAIRMENTS WITHIN THE DEFINITION OF "PERSONAL INJURY" UNDER THE WORKERS' COMPENSATION STATUTES."

Strike everything after the enacting clause and substitute the following in lieu thereof:

"Section 1. Subdivision (16) of section 31-275 of the general statutes

is repealed and the following is substituted in lieu thereof (*Effective July 1, 2019*):

(16) (A) "Personal injury" or "injury" includes, in addition to accidental injury that may be definitely located as to the time when and the place where the accident occurred, an injury to an employee that is causally connected with the employee's employment and is the direct result of repetitive trauma or repetitive acts incident to such employment, and occupational disease.

(B) "Personal injury" or "injury" shall not be construed to include:

(i) An injury to an employee that results from the employee's voluntary participation in any activity the major purpose of which is social or recreational, including, but not limited to, athletic events, parties and picnics, whether or not the employer pays some or all of the cost of such activity;

(ii) A mental or emotional impairment, unless such impairment (I) arises from a physical injury or occupational disease, (II) in the case of a police officer of the Division of State Police within the Department of Emergency Services and Public Protection, an organized local police department or a municipal constabulary, arises from such police officer's use of deadly force or subjection to deadly force in the line of duty, regardless of whether such police officer is physically injured, provided such police officer is the subject of an attempt by another person to cause such police officer serious physical injury or death through the use of deadly force, and such police officer reasonably believes such police officer to be the subject of such an attempt, or (III) in the case of a police officer, parole officer or firefighter, is [diagnosed as] a diagnosis of post-traumatic stress disorder [by a licensed and board certified mental health professional, determined by such professional to be originating from the firefighter witnessing the death of another firefighter while engaged in the line of duty and not subject to any other exclusion in this section] as defined in section 2 of this act that meets all the requirements of section 2 of this act. As used in this

clause, [("police officer" means a member of the Division of State Police within the Department of Emergency Services and Public Protection, an organized local police department or a municipal constabulary, "firefighter" means a uniformed member of a municipal paid or volunteer fire department, and] "in the line of duty" means any action that a police officer [or firefighter] is obligated or authorized by law, rule, regulation or written condition of employment service to perform, or for which the police officer or firefighter is compensated by the public entity such officer serves;

(iii) A mental or emotional impairment that results from a personnel action, including, but not limited to, a transfer, promotion, demotion or termination; or

(iv) Notwithstanding the provisions of subparagraph (B)(i) of this subdivision, "personal injury" or "injury" includes injuries to employees of local or regional boards of education resulting from participation in a school-sponsored activity but does not include any injury incurred while going to or from such activity. As used in this clause, "school-sponsored activity" means any activity sponsored, recognized or authorized by a board of education and includes activities conducted on or off school property and "participation" means acting as a chaperone, advisor, supervisor or instructor at the request of an administrator with supervisory authority over the employee.

Sec. 2. (NEW) (*Effective July 1, 2019*) (a) As used in this section:

(1) "Firefighter" has the same meaning as provided in section 7-313g of the general statutes;

(2) "In the line of duty" means any action that a police officer, parole officer or firefighter is obligated or authorized by law, rule, regulation or written condition of employment service to perform, or for which the officer or firefighter is compensated by the public entity such officer or firefighter serves, except that, in the case of a volunteer firefighter, such action or service constitutes fire duties, as defined in

subsection (b) of section 7-314b of the general statutes;

(3) "Mental health professional" means a board-certified psychiatrist or a psychologist licensed pursuant to chapter 383 of the general statutes, who has experience diagnosing and treating post-traumatic stress disorder;

(4) "Parole officer" means an employee of the Department of Correction who supervises inmates in the community after their release from prison on parole or under another prison release program;

(5) "Police officer" has the same meaning as provided in section 7-294a of the general statutes, except that "police officer" does not include an officer of a law enforcement unit of the Mashantucket Pequot Tribe or the Mohegan Tribe of Indians of Connecticut;

(6) "Post-traumatic stress disorder" means a disorder that meets the diagnostic criteria for post-traumatic stress disorder as specified in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders"; and

(7) "Qualifying event" means an event occurring in the line of duty on or after July 1, 2019, in which a police officer, parole officer or firefighter:

(A) Views a deceased minor;

(B) Witnesses the death of a person or an incident involving the death of a person;

(C) Witnesses an injury to a person who subsequently dies before or upon admission at a hospital as a result of the injury and not as a result of any other intervening cause;

(D) Has physical contact with and treats an injured person who subsequently dies before or upon admission at a hospital as a result of the injury and not as a result of any other intervening cause;

(E) Carries an injured person who subsequently dies before or upon admission at a hospital as a result of the injury and not as a result of any other intervening cause; or

(F) Witnesses a traumatic physical injury that results in the loss of a vital body part or a vital body function that results in permanent disfigurement of the victim.

(b) A diagnosis of post-traumatic stress disorder is compensable as a personal injury as described in subparagraph (B)(ii)(III) of subdivision (16) of section 31-275 of the general statutes, as amended by this act, if a mental health professional examines a police officer, parole officer or firefighter and diagnoses the officer or firefighter with post-traumatic stress disorder as a direct result of a qualifying event, provided (1) the post-traumatic stress disorder resulted from the officer or firefighter acting in the line of duty and, in the case of a firefighter, such firefighter complied with Federal Occupational Safety and Health Act standards adopted pursuant to 29 CFR 1910.134 and 29 CFR 1910.156, (2) a qualifying event was a substantial factor in causing the disorder, (3) such qualifying event, and not another event or source of stress, was the primary cause of the post-traumatic stress disorder, and (4) the post-traumatic stress disorder did not result from any disciplinary action, work evaluation, job transfer, layoff, demotion, promotion, termination, retirement or similar action of the officer or firefighter. Any such mental health professional shall comply with any workers' compensation guidelines for approved medical providers, including, but not limited to, guidelines on release of past or contemporaneous medical records.

(c) Whenever liability to pay compensation is contested by the employer, the employer shall file with the commissioner, on or before the twenty-eighth day after the employer has received a written notice of claim, a notice in accordance with a form prescribed by the chairperson of the Workers' Compensation Commission stating that the right to compensation is contested, the name of the claimant, the name of the employer, the date of the alleged injury and the specific

grounds on which the right to compensation is contested. The employer shall send a copy of the notice to the employee in accordance with section 31-321 of the general statutes. If the employer or the employer's legal representative fails to file the notice contesting liability on or before the twenty-eighth day after receiving the written notice of claim, the employer shall commence payment of compensation for such injury on or before the twenty-eighth day after receiving the written notice of claim, but the employer may contest the employee's right to receive compensation on any grounds or the extent of the employee's disability within one hundred eighty days from the receipt of the written notice of claim and any benefits paid during the one hundred eighty days shall be considered payments without prejudice, provided the employer shall not be required to commence payment of compensation when the written notice of claim has not been properly served in accordance with section 31-321 of the general statutes or when the written notice of claim fails to include a warning that the employer (1) if the employer has commenced payment for the alleged injury on or before the twenty-eighth day after receiving a written notice of claim, shall be precluded from contesting liability unless a notice contesting liability is filed within one hundred eighty days from the receipt of the written notice of claim, and (2) shall be conclusively presumed to have accepted the compensability of the alleged injury unless the employer either files a notice contesting liability on or before the twenty-eighth day after receiving a written notice of claim or commences payment for the alleged injury on or before such twenty-eighth day. An employer shall be entitled, if the employer prevails, to reimbursement from the claimant of any compensation paid by the employer on and after the date the commissioner receives written notice from the employer or the employer's legal representative, in accordance with the form prescribed by the chairperson of the Workers' Compensation Commission, stating that the right to compensation is contested. Notwithstanding the provisions of this subsection, an employer who fails to contest liability for an alleged injury on or before the twenty-eighth day after receiving a written notice of claim and who fails to

commence payment for the alleged injury on or before such twenty-eighth day, shall be conclusively presumed to have accepted the compensability of the alleged injury. If an employer has opted to post an address of where notice of a claim for compensation by an employee shall be sent, as described in subsection (a) of section 31-294c of the general statutes, the twenty-eight-day period set forth in this subsection shall begin on the date when such employer receives written notice of a claim for compensation at such posted address.

(d) Notwithstanding any provision of chapter 568 of the general statutes, workers' compensation benefits for any police officer, parole officer or firefighter for a personal injury described in subparagraph (B)(ii)(III) of subdivision (16) of section 31-275 of the general statutes, as amended by this act, shall (1) include any combination of medical treatment prescribed by a board-certified psychiatrist or a licensed psychologist, temporary total incapacity benefits under section 31-307 of the general statutes and temporary partial incapacity benefits under subsection (a) of section 31-308 of the general statutes, and (2) be provided for a maximum of fifty-two weeks from the date of diagnosis. No medical treatment, temporary total incapacity benefits under section 31-307 of the general statutes or temporary partial incapacity benefits under subsection (a) of section 31-308 of the general statutes shall be awarded beyond four years from the date of the qualifying event that formed the basis for the personal injury. The weekly benefits received by an officer or a firefighter pursuant to section 31-307 of the general statutes or subsection (a) of section 31-308 of the general statutes, when combined with other benefits including, but not limited to, contributory and noncontributory retirement benefits, Social Security benefits, benefits under a long-term or short-term disability plan, but not including payments for medical care, shall not exceed the average weekly wage paid to such officer or firefighter. An officer or firefighter receiving benefits pursuant to this subsection shall not be entitled to benefits pursuant to subsection (b) of section 31-308 of the general statutes or section 31-308a of the general statutes.

Sec. 3. Section 31-294h of the general statutes is repealed and the

following is substituted in lieu thereof (*Effective July 1, 2019*):

Notwithstanding any provision of this chapter, workers' compensation benefits for any [(1)] police officer, as [defined] described in subparagraph [(B)(ii)] (B)(ii)(II) of subdivision (16) of section 31-275, as amended by this act, who suffers a mental or emotional impairment arising from such police officer's use of deadly force or subjection to deadly force in the line of duty, [or (2) firefighter, as defined in subparagraph (B)(ii) of subdivision (16) of section 31-275, who suffers a mental or emotional impairment diagnosed as post-traumatic stress disorder originating from the firefighter witnessing the death of another firefighter while engaged in the line of duty,] shall be limited to treatment by a psychologist or a psychiatrist who is on the approved list of practicing physicians established by the [chairman] chairperson of the Workers' Compensation Commission pursuant to section 31-280.

Sec. 4. (NEW) (*Effective October 1, 2019*) (a) No law enforcement unit, as defined in section 7-294a of the general statutes, shall discharge, discipline, discriminate against or otherwise penalize a police officer, as defined in section 7-294a of the general statutes, who is employed by such law enforcement unit solely because the police officer seeks or receives mental health care services or surrenders his or her firearm, ammunition or electronic defense weapon used in the performance of the police officer's official duties to such law enforcement unit during the time the police officer receives mental health care services. The provisions of this subsection shall not be applicable to a police officer who (1) seeks or receives mental health care services to avoid disciplinary action by such law enforcement unit, or (2) refuses to submit himself or herself to an examination as provided in subsection (b) of this section.

(b) Prior to returning to a police officer his or her surrendered firearm, ammunition or electronic defense weapon used in the performance of the police officer's official duties, such law enforcement unit shall request the police officer to submit himself or herself to an

examination by a mental health professional, as defined in section 2 of this act. The examination shall be performed to determine whether the police officer is ready to report for official duty and shall be paid for by such law enforcement unit.

(c) No civil action may be brought against a law enforcement unit for damages arising from an act or omission of a police officer employed by the unit with respect to the officer's use of his or her personal firearm, if (1) the officer seeks or receives mental health care services and surrenders to such unit his or her firearm, ammunition or electronic defense weapon used in the performance of the police officer's official duties, and (2) such act or omission occurs during the time period the officer has surrendered his or her firearm, ammunition or electronic defense weapon or within six months of the date of surrendering his or her firearm, ammunition or electronic defense weapon, whichever is longer.

Sec. 5. Section 53a-217 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2019*):

(a) A person is guilty of criminal possession of a firearm, ammunition or an electronic defense weapon when such person possesses a firearm, ammunition or an electronic defense weapon and (1) has been convicted of a felony committed prior to, on or after October 1, 2013, or of a violation of section 21a-279, 53a-58, 53a-61, 53a-61a, 53a-62, 53a-63, 53a-96, 53a-175, 53a-176, 53a-178 or 53a-181d committed on or after October 1, 2013, (2) has been convicted as delinquent for the commission of a serious juvenile offense, as defined in section 46b-120, (3) has been discharged from custody within the preceding twenty years after having been found not guilty of a crime by reason of mental disease or defect pursuant to section 53a-13, (4) knows that such person is subject to (A) a restraining or protective order of a court of this state that has been issued against such person, after notice has been provided to such person, in a case involving the use, attempted use or threatened use of physical force against another person, or (B) a foreign order of protection, as defined in section 46b-

15a, that has been issued against such person in a case involving the use, attempted use or threatened use of physical force against another person, (5) (A) has been confined on or after October 1, 2013, in a hospital for persons with psychiatric disabilities, as defined in section 17a-495, within the preceding sixty months by order of a probate court, or with respect to any person who holds a valid permit or certificate that was issued or renewed under the provisions of section 29-28 or 29-36f in effect prior to October 1, 2013, such person has been confined in such hospital within the preceding twelve months, or (B) has been voluntarily admitted on or after October 1, 2013, to a hospital for persons with psychiatric disabilities, as defined in section 17a-495, within the preceding six months for care and treatment of a psychiatric disability, [and not] unless the person (i) was voluntarily admitted solely for being an alcohol-dependent person or a drug-dependent person as those terms are defined in section 17a-680, or (ii) is a police officer who was voluntarily admitted and had his or her firearm, ammunition or electronic defense weapon used in the performance of the police officer's official duties returned in accordance with section 4 of this act, (6) knows that such person is subject to a firearms seizure order issued pursuant to subsection (d) of section 29-38c after notice and an opportunity to be heard has been provided to such person, or (7) is prohibited from shipping, transporting, possessing or receiving a firearm pursuant to 18 USC 922(g)(4). For the purposes of this section, "convicted" means having a judgment of conviction entered by a court of competent jurisdiction, "ammunition" means a loaded cartridge, consisting of a primed case, propellant or projectile, designed for use in any firearm, and a motor vehicle violation for which a sentence to a term of imprisonment of more than one year may be imposed shall be deemed an unclassified felony.

(b) Criminal possession of a firearm, ammunition or an electronic defense weapon is a class C felony, for which two years of the sentence imposed may not be suspended or reduced by the court, and five thousand dollars of the fine imposed may not be remitted or reduced by the court unless the court states on the record its reasons for

remitting or reducing such fine.

Sec. 6. Section 53a-217c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2019*):

(a) A person is guilty of criminal possession of a pistol or revolver when such person possesses a pistol or revolver, as defined in section 29-27, and (1) has been convicted of a felony committed prior to, on or after October 1, 2013, or of a violation of section 21a-279, 53a-58, 53a-61, 53a-61a, 53a-62, 53a-63, 53a-96, 53a-175, 53a-176, 53a-178 or 53a-181d committed on or after October 1, 1994, (2) has been convicted as delinquent for the commission of a serious juvenile offense, as defined in section 46b-120, (3) has been discharged from custody within the preceding twenty years after having been found not guilty of a crime by reason of mental disease or defect pursuant to section 53a-13, (4) (A) has been confined prior to October 1, 2013, in a hospital for persons with psychiatric disabilities, as defined in section 17a-495, within the preceding twelve months by order of a probate court, or has been confined on or after October 1, 2013, in a hospital for persons with psychiatric disabilities, as defined in section 17a-495, within the preceding sixty months by order of a probate court, or, with respect to any person who holds a valid permit or certificate that was issued or renewed under the provisions of section 29-28 or 29-36f in effect prior to October 1, 2013, such person has been confined in such hospital within the preceding twelve months, or (B) has been voluntarily admitted on or after October 1, 2013, to a hospital for persons with psychiatric disabilities, as defined in section 17a-495, within the preceding six months for care and treatment of a psychiatric disability, [and not] unless the person (i) was voluntarily admitted solely for being an alcohol-dependent person or a drug-dependent person as those terms are defined in section 17a-680, or (ii) is a police officer who was voluntarily admitted and had his or her firearm, ammunition or electronic defense weapon used in the performance of the police officer's official duties returned in accordance with section 4 of this act, (5) knows that such person is subject to (A) a restraining or protective order of a court of this state that has been issued against such person,

after notice has been provided to such person, in a case involving the use, attempted use or threatened use of physical force against another person, or (B) a foreign order of protection, as defined in section 46b-15a, that has been issued against such person in a case involving the use, attempted use or threatened use of physical force against another person, (6) knows that such person is subject to a firearms seizure order issued pursuant to subsection (d) of section 29-38c after notice and an opportunity to be heard has been provided to such person, (7) is prohibited from shipping, transporting, possessing or receiving a firearm pursuant to 18 USC 922(g)(4), or (8) is an alien illegally or unlawfully in the United States. For the purposes of this section, "convicted" means having a judgment of conviction entered by a court of competent jurisdiction.

(b) Criminal possession of a pistol or revolver is a class C felony, for which two years of the sentence imposed may not be suspended or reduced by the court, and five thousand dollars of the fine imposed may not be remitted or reduced by the court unless the court states on the record its reasons for remitting or reducing such fine.

Sec. 7. (NEW) (*Effective July 1, 2019*) (a) Not later than January 1, 2020, the Police Officer Standards and Training Council, established under section 7-294b of the general statutes, the Department of Correction and the Commission on Fire Prevention and Control shall develop and promulgate a model critical incident and peer support policy to support the mental health care and wellness of police officers, as defined in section 7-294a of the general statutes, parole officers, as defined in section 2 of this act, and firefighters, as defined in section 2 of this act.

(b) Not later than July 1, 2020, each law enforcement unit as defined in section 7-294a of the general statutes, the Department of Correction as employer of parole officers, each municipal or state paid or volunteer fire department and each municipal entity employing a fire marshal, deputy fire marshal, fire investigator, fire inspector or other class of investigator or inspector for whom the State Fire Marshal and

the Codes and Standards Committee, acting jointly, have adopted minimum standards of qualification pursuant to section 29-298 of the general statutes, shall (1) adopt and maintain a written policy that meets or exceeds the standards of the model policy developed pursuant to subsection (a) of this section; (2) make peer support available to such officers and firefighters; and (3) refer an officer or firefighter, as appropriate, seeking mental health care services to a mental health professional, as defined in section 2 of this act.

Sec. 8. (NEW) (*Effective July 1, 2019*) Each police basic training program conducted or administered by the Division of State Police within the Department of Emergency Services and Public Protection, the Police Officer Standards and Training Council established under section 7-294b of the general statutes or a municipal police department in this state shall provide, in consultation with the Department of Mental Health and Addiction Services, resilience and self-care technique training for any individual who begins basic training as a police officer, as defined in section 7-294a of the general statutes, on or after January 1, 2020.

Sec. 9. (NEW) (*Effective July 1, 2019*) In consultation with the Department of Mental Health and Addiction Services, the Department of Correction shall provide resilience and self-care technique training for each parole officer, as defined in section 2 of this act, hired on or after January 1, 2020.

Sec. 10. (NEW) (*Effective July 1, 2019*) In consultation with the Department of Mental Health and Addiction Services, the Commission on Fire Prevention and Control, the State Fire Marshal and the Codes and Standards Committee and any other state or municipal entity providing training to a firefighter, as defined in section 2 of this act, shall provide resilience and self-care technique training for any individual who begins initial training as a firefighter on or after January 1, 2020.

Sec. 11. (NEW) (*Effective July 1, 2019*) Not later than December 1,

2020, the chairperson of the Workers' Compensation Commission shall report on the number of claims filed with the commission for benefits for post-traumatic stress disorder pursuant to section 2 of this act. The chairperson shall submit such report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committees of the General Assembly having cognizance of matters relating to the judiciary, labor and public employees and public safety and security.

Sec. 12. Section 2 of substitute senate bill 921 of the current session is repealed. (*Effective June 30, 2019*)"

This act shall take effect as follows and shall amend the following sections:		
Section 1	*July 1, 2019*	31-275(16)
Sec. 2	*July 1, 2019*	New section
Sec. 3	*July 1, 2019*	31-294h
Sec. 4	*October 1, 2019*	New section
Sec. 5	*October 1, 2019*	53a-217
Sec. 6	*October 1, 2019*	53a-217c
Sec. 7	*July 1, 2019*	New section
Sec. 8	*July 1, 2019*	New section
Sec. 9	*July 1, 2019*	New section
Sec. 10	*July 1, 2019*	New section
Sec. 11	*July 1, 2019*	New section
Sec. 12	*June 30, 2019*	Repealer section

General Assembly

Amendment

January Session, 2019

LCO No. **10166**

* S B 0 0 1 6 4 1 0 1 6 6 S D O *

Offered by:

SEN. LOONEY, 11th Dist.
SEN. DUFF, 25th Dist.
SEN. FASANO, 34th Dist.
SEN. WITKOS, 8th Dist.
SEN. KUSHNER, 24th Dist.
SEN. OSTEN, 19th Dist.
SEN. ANWAR, 3rd Dist.
SEN. BERGSTEIN, 36th Dist.
SEN. BERTHEL, 32nd Dist.
SEN. BIZZARRO, 6th Dist.
SEN. BRADLEY, 23rd Dist.
SEN. CASSANO, 4th Dist.
SEN. CHAMPAGNE, 35th Dist.
SEN. COHEN, 12th Dist.
SEN. DAUGHERTY ABRAMS, 13th Dist.
SEN. FLEXER, 29th Dist.
SEN. FONFARA, 1st Dist.
SEN. FORMICA, 20th Dist.
SEN. HARTLEY, 15th Dist.
SEN. HASKELL, 26th Dist.
SEN. HWANG, 28th Dist.
SEN. KELLY, 21st Dist.
SEN. KISSEL, 7th Dist.
SEN. LEONE, 27th Dist.
SEN. LESSER, 9th Dist.
SEN. LOGAN, 17th Dist.
SEN. MARONEY, 14th Dist.
SEN. MARTIN, 31st Dist.
SEN. MCCRORY, 2nd Dist.
SEN. MINER, 30th Dist.
SEN. MOORE, 22nd Dist.
SEN. NEEDLEMAN, 33rd Dist.
SEN. SAMPSON, 16th Dist.
SEN. SLAP, 5th Dist.
SEN. SOMERS, 18th Dist.
SEN. WINFIELD, 10th Dist.

To: Subst. Senate Bill No. **164** File No. 362 Cal. No. 202

(As Amended by Senate Amendment Schedules "A" and "B")

"AN ACT INCLUDING CERTAIN MENTAL OR EMOTIONAL IMPAIRMENTS WITHIN THE DEFINITION OF "PERSONAL INJURY" UNDER THE WORKERS' COMPENSATION STATUTES."

Strike section 11 in its entirety and substitute the following in lieu thereof:

"Sec. 11. (*Effective July 1, 2019*) Not later than February 1, 2020, the joint standing committee of the General Assembly having cognizance of matters relating to labor and public employees shall complete an examination of the feasibility of expanding the availability of benefits for post-traumatic stress disorder pursuant to section 2 of this act to emergency medical services personnel, as defined in section 20-206jj of the general statutes, and Department of Correction employees who are not otherwise eligible for benefits pursuant to section 2 of this act. In conducting such examination the committee shall consult with representatives of the Workers' Compensation Commission, workers' compensation claimants, employers, insurers and municipalities and may consult with other individuals the committee deems appropriate. If the committee determines it is feasible to expand the benefits available under section 2 of this act during the next legislative session, said committee shall originate a bill making emergency medical services personnel and Department of Correction employees eligible for such benefits based on the criteria described in section 2 of this act and based on any qualifying event, as defined in section 2 of this act, occurring on or after July 1, 2019."

House of Representatives

General Assembly

File No. 468

January Session, 2019

Substitute House Bill No. 5883

House of Representatives, April 8, 2019

The Committee on Labor and Public Employees reported through REP. PORTER, R. of the 94th Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

AN ACT CONCERNING WORKERS' COMPENSATION INSURANCE COVERAGE FOR DETOXIFICATION FOR CERTAIN INJURED EMPLOYEES, LOCAL AND REGIONAL BOARD OF EDUCATION EMPLOYEE NOTICES AND REIMBURSEMENT OF LOST WAGES FOR APPEARANCE AT A DEPOSITION.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Subdivision (12) of section 31-275 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2019*):

(12) "Medical and surgical aid or hospital and nursing service", when requested by an injured employee and approved by the commissioner, includes (A) treatment by prayer or spiritual means through the application or use of the principles, tenets or teachings of any established church without the use of any drug or material remedy, provided sanitary and quarantine regulations are complied with, and provided all those ministering to the injured employee are bona fide members of such church, and (B) detoxification treatment for

an injured employee who, as a result of a personal injury arising out of and in the course of his or her employment, consumes opioid drugs prescribed in the course of medical treatment for such injury for a continuous period of not less than one year.

Sec. 2. Subsection (a) of section 31-294c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2019*):

(a) No proceedings for compensation under the provisions of this chapter shall be maintained unless a written notice of claim for compensation is given within one year from the date of the accident or within three years from the first manifestation of a symptom of the occupational disease, as the case may be, which caused the personal injury, provided, if death has resulted within two years from the date of the accident or first manifestation of a symptom of the occupational disease, a dependent or dependents, or the legal representative of the deceased employee, may make claim for compensation within the two-year period or within one year from the date of death, whichever is later. Notice of claim for compensation may be given to the employer or any commissioner and shall state, in simple language, the date and place of the accident and the nature of the injury resulting from the accident, or the date of the first manifestation of a symptom of the occupational disease and the nature of the disease, as the case may be, and the name and address of the employee and of the person in whose interest compensation is claimed. An employee of the state shall send a copy of the notice to the Commissioner of Administrative Services. An employee of a municipality shall send a copy of the notice to the town clerk of the municipality in which he or she is employed, and in the case of an employee of a local or regional board of education, shall send a copy of the notice to the local or regional board of education that employs the employee. An employer, other than the state or a municipality, may opt to post a copy of where notice of a claim for compensation shall be sent by an employee in the workplace location where other labor law posters required by the Labor Department are prominently displayed. In addition, an employer, opting to post where

notice of a claim for compensation by an employee shall be sent, shall forward the address of where notice of a claim for compensation shall be sent to the Workers' Compensation Commission and the commission shall post such address on its Internet web site. An employer shall be responsible for verifying that information posted at a workplace location is consistent with the information posted on the commission's Internet web site. If an employee, other than an employee of the state or a municipality, opts to mail to his or her employer the written notice of a claim for compensation required under the provisions of this section, such written notice shall be sent by the employee to the employer by certified mail. As used in this section, "manifestation of a symptom" means manifestation to an employee claiming compensation, or to some other person standing in such relation to him that the knowledge of the person would be imputed to him, in a manner that is or should be recognized by him as symptomatic of the occupational disease for which compensation is claimed.

Sec. 3. Subsection (b) of section 31-312 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2019*):

(b) When a claimant is given notice to appear at a conference, deposition or [an] informal hearing before a commissioner and does appear, he shall be entitled to reimbursement of wages lost by reason of the appearance if he is not then receiving compensation for the appearance as provided in this subsection. When liability or extent of disability is contested by formal hearing before the commissioner, the claimant shall be entitled, if he prevails on final judgment, to payment for services rendered him by a competent physician or surgeon for examination, x-ray, medical tests and testimony in connection with the claim, the commissioner to determine the reasonableness of the charges, and he shall be entitled to receive payment of one-fifth of the weekly compensation, as computed in accordance with section 31-310, for each day, or part thereof, that he is in attendance at the formal hearing if he is not then receiving compensation.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*October 1, 2019*	31-275(12)
Sec. 2	*October 1, 2019*	31-294c(a)
Sec. 3	*October 1, 2019*	31-312(b)

LAB *Joint Favorable Subst.*

House of Representatives

File No. 906

General Assembly

January Session, 2019

(Reprint of File No. 294)

House Bill No. 7241
As Amended by House Amendment
Schedule "A"

Approved by the Legislative Commissioner
May 16, 2019

AN ACT CONCERNING MINOR AND TECHNICAL CHANGES TO THE WORKERS' COMPENSATION ACT.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (NEW) (*Effective October 1, 2019*) (a) (1) Wherever the words "workers' compensation commissioner", "compensation commissioner" or "commissioner" are used to denote a workers' compensation commissioner in the following sections of the general statutes, the words "administrative law judge" shall be substituted in lieu thereof: 4-186, 5-170, 5-192h, 17b-341, 19a-641, 28-14, 29-4a, 31-275, 31-276, 31-277, 31-278, 31-279, 31-280, 31-280a, as amended by this act, 31-280b, 31-282, 31-283, 31-283d, 31-283e, 31-283f, as amended by this act, 31-284c, 31-286, 31-286a, 31-286b, 31-288, 31-289a, 31-290a, 31-293, 31-294b, 31-294c, 31-294d, 31-294e, 31-294f, 31-296, 31-296a, 31-297, 31-297a, 31-298, 31-299, 31-299a, 31-299b, 31-300, 31-301, 31-301c, 31-301d, 31-302, 31-306, 31-306b, 31-307a, 31-308, 31-308a, 31-310, 31-312, 31-313, 31-315, 31-316, 31-318, 31-321, 31-323, 31-326, 31-327, 31-329, 31-341, 31-342, 31-343, 31-349, as amended by this act, 31-349b, 31-349c, 31-353, 31-355, 38a-470, 38a-500, 38a-527, 46b-231, 51-49, 51-49a, 51-49b, 51-49c,

51-49d, 51-49g, 51-49h, 51-49i, 51-49j, 51-50, 51-50a, 51-50b, 51-51, 51-51h, 51-51i, 51-51k, 51-51*l*, 51-51m, 51-51n, 51-51o, 51-51p, 51-51q, 51-51r, 51-51s, 51-63 and 52-149a.

(2) Wherever the words "workers' compensation commissioner", "compensation commissioner" or "commissioner" are used to denote a workers' compensation commissioner in any public act of the 2019 session, the words "administrative law judge" shall be substituted in lieu thereof.

(b) The Legislative Commissioners' Office shall, in codifying said sections of the general statutes pursuant to subdivision (1) of subsection (a) of this section or any public act of the 2019 session pursuant to subdivision (2) of subsection (a) of this section, make such technical, grammatical and punctuation changes as are necessary to carry out the purposes of this section.

Sec. 2. Subsection (c) of section 31-280a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2019*):

(c) The advisory board shall meet at least [twice] once in each calendar quarter and at such other times as the chairman or the chairman of the Workers' Compensation Commission deem necessary. All actions of the advisory board shall require the affirmative vote of six members of the advisory board. The advisory board may bring any matter related to the operation of the workers' compensation system to the attention of the chairman of the Workers' Compensation Commission. The advisory board may adopt any rules of procedure that the board deems necessary to carry out its duties under this chapter.

Sec. 3. Subsection (a) of section 31-283f of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2019*):

(a) A Statistical Division shall be established within the Workers'

Compensation Commission. The division shall compile and maintain statistics concerning occupational injuries and diseases, voluntary agreements, status of claims and commissioners' dockets. [The division shall be administered by a full-time salaried director who shall be appointed by the chairman of the Workers' Compensation Commission under the provisions of chapter 67. The director shall report to the chairman.]

Sec. 4. Section 31-349 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2019*):

[(a)] The fact that an employee has suffered a previous disability, shall not preclude him from compensation for a second injury, nor preclude compensation for death resulting from the second injury. If an employee having a previous disability incurs a second disability from a second injury resulting in a permanent disability caused by both the previous disability and the second injury which is materially and substantially greater than the disability that would have resulted from the second injury alone, he shall receive compensation for (1) the entire amount of disability, including total disability, less any compensation payable or paid with respect to the previous disability, and (2) necessary medical care, as provided in this chapter, notwithstanding the fact that part of the disability was due to a previous disability. For purposes of this [subsection,] section "compensation payable or paid with respect to the previous disability" includes compensation payable or paid pursuant to the provisions of this chapter, as well as any other compensation payable or paid in connection with the previous disability, regardless of the source of such compensation.

[(b) As a condition precedent to the liability of the Second Injury Fund, the employer or its insurer shall: (1) Notify the custodian of the fund by certified mail no later than three calendar years after the date of injury or no later than ninety days after completion of payments for the first one hundred and four weeks of disability, whichever is earlier, of its intent to transfer liability for the claim to the Second Injury Fund;

(2) include with the notification (A) copies of all medical reports, (B) an accounting of all benefits paid, (C) copies of all findings, awards and approved voluntary agreements, (D) the employer's or insurer's estimate of the reserve amount to ultimate value for the claim, (E) a two-thousand-dollar notification fee payable to the custodian to cover the fund's costs in evaluating the claim proposed to be transferred and (F) such other material as the custodian may require. The employer by whom the employee is employed at the time of the second injury, or its insurer, shall in the first instance pay all awards of compensation and all medical expenses provided by this chapter for the first one hundred four weeks of disability. Failure on the part of the employer or an insurer to comply does not relieve the employer or insurer of its obligation to continue furnishing compensation under the provisions of this chapter. The custodian of the fund shall, by certified mail, notify a self-insured employer or an insurer, as applicable, of the rejection of the claim within ninety days after receiving the completed notification. Any claim which is not rejected pursuant to this section shall be deemed accepted, unless the custodian notifies the self-insured employer or the insurer within the ninety-day period that up to an additional ninety days is necessary to determine if the claim for transfer will be accepted. If the claim is accepted for transfer, the custodian shall file with the workers' compensation commissioner for the district in which the claim was filed, a form indicating that the claim has been transferred to the Second Injury Fund and the date that such claim was transferred and shall refund fifteen hundred dollars of the notification fee to the self-insured employer or the insurer, as applicable. A copy of the form shall be mailed to the self-insured employer or the insurer and to the claimant. No further action by the commissioner shall be required to transfer said claim. If the custodian rejects the claim of the employer or its insurer, the question shall be submitted by certified mail within thirty days of the receipt of the notice of rejection by the employer or its insurer to the commissioner having jurisdiction, and the employer or insurer shall continue furnishing compensation until the outcome is finally decided. Claims not submitted to the commissioner within said time period shall be

deemed withdrawn with prejudice. If the employer or insurer prevails, or if the custodian accepts the claim all payments made beyond the one-hundred-four-week period shall be reimbursed to the employer or insurer by the Second Injury Fund.

(c) If the second injury of an employee results in the death of the employee, and it is determined that the death would not have occurred except for a preexisting permanent physical impairment, the employer or its insurer shall, in the first instance, pay the funeral expense described in this chapter, and shall pay death benefits as may be due for the first one hundred four weeks. The employer or its insurer may thereafter transfer liability for the death benefits to the Second Injury Fund in accordance with the procedures set forth in subsection (b) of this section.

(d) Notwithstanding the provisions of this section, no injury which occurs on or after July 1, 1995, shall serve as a basis for transfer of a claim to the Second Injury Fund under this section. All such claims shall remain the responsibility of the employer or its insurer under the provisions of this section.

(e) All claims for transfer of injuries for which the fund has been notified prior to July 1, 1995, shall be deemed withdrawn with prejudice, unless the employer or its insurer notifies the custodian of the fund by certified mail prior to October 1, 1995, of its intention to pursue transfer pursuant to the provisions of this section. No notification fee shall be required for notices submitted pursuant to this subsection. This subsection shall not apply to notices submitted prior to July 1, 1995, in response to the custodian's request, issued on March 15, 1995, for voluntary resubmission of notices.

(f) No claim, where the custodian of the Second Injury Fund was served with a valid notice of intent to transfer under this section, shall be eligible for transfer to the Second Injury Fund unless all requirements for transfer, including payment of the one hundred and four weeks of benefits by the employer or its insurer, have been

completed prior to July 1, 1999. All claims, pursuant to this section, not eligible for transfer to the fund on or before July 1, 1999, will remain the responsibility of the employer or its insurer.]

Sec. 5. Subsection (a) of section 31-354 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2019*):

(a) There shall be a fund to be known as the Second Injury Fund. Each employer, other than the state, shall, within thirty days after notice given by the State Treasurer, pay to the State Treasurer for the use of the state a sum in payment of his liability under this chapter which shall be calculated in accordance with the Second Injury Fund surcharge base, as defined in section 31-349g, [and shall be assessed in accordance with subsection (f) of section 31-349,] sections 31-349g, 31-349h and 31-349i, this section, section 31-354b and sections 8 and 9 of public act 96-242. Such sum shall be an amount sufficient to (1) pay the debt service on state revenue bond obligations authorized to be issued under and for the purposes set forth in section 31-354b including reserve and covenant coverage requirements, (2) provide for costs and expenses of operating the Second Injury Fund, and (3) pay Second Injury Fund stipulations on claims settled by the custodian or other benefits payable out of the Second Injury Fund and not funded through state revenue bond obligations and shall be determined in accordance with the regulations adopted pursuant to the provisions of section 31-349g. The custodian shall establish a factor for the annual surcharge that caps such surcharge for the fiscal years ending June 30, 1996, 1997 and 1998. In determining such factor the custodian shall consider the funding mechanism authorized by [subsection (f) of section 31-349,] sections 31-349g, 31-349h and 31-349i, this section, section 31-354b and sections 8 and 9 of public act 96-242, recognize that an acceptable level of employer assessment is important to the vitality of the economy of the state and nevertheless shall assure provision of services to injured workers that enhances their ability to return to work and improve their quality of life. In any event, such factor shall not exceed, with respect to insured employers, a rate of fifteen per cent on

the Second Injury Fund surcharge base with respect to workers' compensation and employers' liability policies and, with respect to self-insured employers, a comparable percentage limitation representing their pro rata share of any assessment. Any employer or any insurance company acting as collection agent for the custodian of the Second Injury Fund who fails to pay in accordance with such regulations shall pay a penalty to the State Treasurer of fifteen per cent on the unpaid assessment or surcharge or fifty dollars, whichever is greater. Interest at the rate of six per cent per annum shall be charged on any amounts owed on assessment audits or surcharge audits. For self-insured employers interest shall accrue thirty days after notice from the Second Injury Fund of the unpaid audit assessment. For insurance companies, the interest shall accrue from the date of the notice of audit errors or deficiencies as determined by the date postmarked by the United States Postal Service. The State Treasurer shall notify each employer of the penalty or interest provision with the notice of assessment. Any partial payments made to the fund shall be first applied to any unpaid penalty, then to any unpaid interest and the remainder, if any, to the unpaid assessment or surcharge. Interest or penalties shall be applied if assessment or surcharge reports or payments are postmarked by the United States Postal Service after the designated due date. The sums received shall be accounted for separately and apart from all other state moneys and the faith and credit of the state of Connecticut is pledged for their safekeeping. The State Treasurer shall be the custodian of the fund and all disbursements from the fund shall be made by the Treasurer or the Treasurer's deputies. The moneys of the fund shall be invested by the Treasurer in accordance with applicable law and section 8 of public act 96-242. Interest, income and dividends from the investments shall be credited to the fund. Each employer, each private insurance carrier acting on behalf of any employer and each interlocal risk management agency acting on behalf of any employer shall annually, on or before April first, report to the State Treasurer, in the form prescribed by the State Treasurer, the amount of money expended by or on behalf of the employer in payments for the preceding calendar year. Each private

insurance carrier, each self-insurance group and each interlocal risk management agency shall submit annually, on or before April first, to the State Treasurer, in the form prescribed by the State Treasurer, a report of the total Second Injury Fund surcharge base collected in the preceding calendar year and a report of the projected total Second Injury Fund surcharge base for the current calendar year. The fund shall be used to provide the benefits set forth in section 31-306 for adjustments in the compensation rate and payment of certain death benefits, in section 31-307b for adjustments where there are relapses after a return to work, in section 31-307c for totally disabled persons injured prior to October 1, 1953, in section 31-349, as amended by this act, for disabled or handicapped employees and in section 31-355 for the payment of benefits due injured employees whose employers or insurance carriers have failed to pay the compensation, and medical expenses required by this chapter, or any other compensation payable from the fund as may be required by any provision contained in this chapter or any other statute and to reimburse employers or insurance carriers for payments made under subsection (b) of section 31-307a. The assessment required by this section is a condition of doing business in this state and failure to pay the assessment, when due, shall result in the denial of the privilege of doing business in this state or to self-insure under section 31-284. Any administrative or other costs or expenses incurred by the State Treasurer in connection with carrying out the provisions of this part, including the hiring of necessary employees, shall be paid from the fund. The State Treasurer may adopt regulations, in accordance with the provisions of chapter 54, prescribing the practices, policies and procedures to be followed in the administration of the Second Injury Fund.

Sec. 6. Subsection (a) of section 31-355a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2019*):

(a) Whenever the Second Injury Fund is required, pursuant to section 31-355 [or subsection (c) of section 31-349,] to pay benefits or compensation mandated by the provisions of this chapter for any

employer or insurer who fails or is unable to make such payments, the amount so paid by the fund shall be collectible by any means provided by law for the collection of any tax due the state of Connecticut or any subdivision thereof, including any means provided by section 12-35. Tax warrants referred to in said section 12-35 may be signed by the State Treasurer.

Sec. 7. Sections 31-276a, 31-298a and 31-304 of the general statutes are repealed. (*Effective October 1, 2019*)

This act shall take effect as follows and shall amend the following sections:		
Section 1	*October 1, 2019*	New section
Sec. 2	*October 1, 2019*	31-280a(c)
Sec. 3	*October 1, 2019*	31-283f(a)
Sec. 4	*October 1, 2019*	31-349
Sec. 5	*October 1, 2019*	31-354(a)
Sec. 6	*October 1, 2019*	31-355a(a)
Sec. 7	*October 1, 2019*	Repealer section

General Assembly

Amendment

January Session, 2019

LCO No. **9426**

HB06916094 26HDO

Offered by:

REP. PORTER, 94th Dist.
SEN. KUSHNER, 24th Dist.
REP. JOHNSON, 49th Dist.
REP. CURREY, 11th Dist.
REP. WINKLER, 56th Dist.
REP. ARNONE, 58th Dist.

To: House Bill No. **6916** File No. 475 Cal. No. 300

"AN ACT EXPANDING REMEDIES AND POTENTIAL LIABILITY FOR UNREASONABLY CONTESTED OR DELAYED WORKERS' COMPENSATION CLAIMS."

Strike everything after the enacting clause and substitute the following in lieu thereof:

"Section 1. (*Effective from passage*) (a) There is established a task force to (1) identify the extent of unreasonably contested or delayed workers' compensation claims, (2) study methods to expand remedies regarding potential liability for unreasonably contested or delayed workers' compensation claims, and (3) clarify the law regarding bad faith handling of workers' compensation claims. Such study shall include, but need not be limited to, an examination of: (A) How such claims are handled when an injured worker is covered by employee benefit health insurance, (B) whether an employee benefit plan should make payments during the time period the Workers' Compensation Commission takes to determine whether the worker's injury is work

related, (C) how claims are handled when an injured worker's employer does not provide an employee benefit health insurance plan, (D) the Workers' Compensation Commissioner's authority to fine an insurance company for unreasonably contested claims or undue delay, particularly when such undue delay may cause permanent injury to an employee, (E) delays caused by the failure of medical professionals to follow the Professional Guide for Attorneys, Physicians and Other Health Care Practitioners Guidelines for Cooperation, or to provide respondents with a complete and accurate medical history, including, but not limited to, all relevant medical records requested, (F) whether benefits are paid to injured workers or on behalf of injured workers without prejudice during a period of contest, and the frequency with which (i) said benefits are reimbursed in cases in which the underlying injury is deemed not compensable, (ii) the treatment paid for without prejudice is deemed unreasonable or unnecessary, or (iii) indemnity was paid during a period of time in which the injured worker is deemed to have been capable of working and work was available, (G) remedies when an undue delay in payment causes unnecessarily long delays in medical treatment, resulting in loss of employment, (H) types of systems that may be created to obtain data regarding reasonable treatment and recovery timeframes, and (I) best methods to prevent unfair claim-handling practices that violate the Connecticut Unfair Insurance Practices Act, as amended from time to time, including, but not limited to, the following:

(i) Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue; (ii) failing to acknowledge and act with reasonable promptness upon communications with respect to claims arising out of and in the course of employment under insurance policies and third-party administration contracts; (iii) failing to adopt and implement reasonable standards for the prompt investigation of claims arising out of and in the course of employment to which such insurance policies and third-party administration contracts shall respond; (iv) refusing to pay benefits without conducting a reasonable and timely investigation based upon all available information; (v)

failing to affirm or deny coverage of benefits within a reasonable time after submission of a request for such benefits has been submitted; (vi) not attempting in good faith to effectuate prompt, fair and equitable provision of benefits for claims in which liability has become reasonably clear; (vii) attempting to settle claims on the basis of an application that was altered without notice to or knowledge or consent of the insured; (viii) making known to beneficiaries of such insurance policies or third-party contracts of administration pursuant to this section a policy of appealing from decisions of a workers' compensation commissioner or administrative law judge in favor of such beneficiaries for the purpose of compelling the acceptance of settlements or compromises in an amount less than the amount awarded in decisions; (ix) delaying the investigation or payment of claims by requiring a beneficiary or health care provider to submit a preliminary claim report and then requiring the subsequent submission of formal proof-of-loss forms, both of which submissions contain substantially the same information; or (x) failing to promptly provide a reasonable written explanation for the denial of a claim or for an offer of a compromise and settlement in relation to the facts or applicable law.

(b) The task force shall consist of the following members:

(1) Two appointed by the speaker of the House of Representatives, one of whom is an attorney and a member of the Connecticut Trial Lawyers Association, who has experience in workers' compensation cases, and one of whom is an attorney and a member of the Connecticut Defense Lawyers Association, who primarily represents respondents in workers' compensation cases;

(2) Two appointed by the president pro tempore of the Senate, one of whom is a representative of physicians who treat workers' compensation claims patients and one of whom is a physician who performs respondents' medical examinations in workers' compensation cases;

(3) Two appointed by the majority leader of the House of Representatives, one of whom shall be a member of the General Assembly, and one of whom is an injured worker;

(4) Two appointed by the majority leader of the Senate, one of whom shall be a member of the Workers' Compensation Legal Advisory Panel or the Workers' Compensation Medical Advisory Panel, whomever of which is available for any scheduled meeting, and one of whom is a member of the Connecticut State Medical Society;

(5) Two appointed by the minority leader of the House of Representatives, one of whom shall be a representative of the business community, and one of whom is an injured worker;

(6) Two appointed by the minority leader of the Senate, one of whom shall represent a workers' compensation insurance carrier and one of whom shall be a representative of industry;

(7) The chairperson of the Workers' Compensation Commission, or the chairperson's designee;

(8) The Insurance Commissioner, or the commissioner's designee;

(9) The Commissioner of Social Services, or the commissioner's designee; and

(10) The Commissioner of Administrative Services, or the commissioner's designee;

(c) Any member of the task force appointed under subdivision (1), (2), (5) or (6) of subsection (b) of this section may be a member of the General Assembly.

(d) All appointments to the task force shall be made not later than August 1, 2019. Any vacancy shall be filled by the appointing authority.

(e) The speaker of the House of Representatives and the president

pro tempore of the Senate shall select the chairpersons of the task force from among the members of the task force. Such chairpersons shall schedule the first meeting of the task force, which shall be held not later than sixty days after the effective date of this section.

(f) The administrative staff of the joint standing committee of the General Assembly having cognizance of matters relating to labor shall serve as administrative staff of the task force.

(g) Not later than January 1, 2020, the task force shall submit a report on its findings and recommendations to the joint standing committee of the General Assembly having cognizance of matters relating to labor, in accordance with the provisions of section 11-4a of the general statutes. The task force shall terminate on the date that it submits such report or January 1, 2020, whichever is later."

This act shall take effect as follows and shall amend the following sections:		
Section 1	*from passage*	New section

REVIEW

OF

APPELLATE LITIGATION

JUNE 1, 2018 THROUGH MAY 31, 2019

CONNECTICUT BAR ASSOCIATION
WORKERS' COMPENSATION SECTION
JUNE 10, 2019
HARTFORD, CONNECTICUT

Chairman Stephen M. Morelli
Workers' Compensation Commission

Section Head: Francis X. Drapeau, Esq.

John P. Clarkson
Law Offices of Cynthia Garraty
300 Windsor Street
Hartford, CT 06145-2138
Phone No.: (860) 954-0874
Fax No.: (860) 277-9438

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INTRODUCTION

Meditation on the import of *Dominguez v. New York Sports Club*

Be good. If you can't be good, be careful. If you can't be careful, name it after me.

-Anonymous

This year's summary, my thirteenth, addresses cases from the Connecticut Supreme Court, Appellate Court and Compensation Review Board decided between June 1, 2018 and May 31, 2019. I have discussed all substantive Supreme and Appellate Court decisions, and nearly all CRB opinions, omitting memoranda, purely fact driven cases and a handful that bored me.

This booklet is strictly a short-cut reference tool. Although I have done my utmost to provide accurate and objective summaries, there may be instances in which I failed on one or both counts. As always, the editorial comments, whether overtly labeled as such or covertly interspersed between the lines, are purely my own, and reflect my peculiar idiosyncrasies rather than the official policy of the CBA or my employer. All of this is a roundabout way of saying that practitioners should read the cases for themselves.

When reviewing CRB cases, I sometimes had paper printouts of the decisions as posted in the Commission website and other times worked from Word documents of the Opinions themselves. In a spirit of full disclosure, I am compelled to confess that when I referenced page numbers from the decisions, I indiscriminately used the pagination from whichever format I happened to have before me.

I also thank my secretary, Cindy Levesque for giving the manuscript a good start and finish, my wife for her patience, and finally, Lisa, Julie and Graham Clarkson, as well as my newest colleague, Joe Cogguillo, for proofreading assistance that helped make this year's review possible.

PROOFREADER'S NOTE

MY DRAGON
(a legal disclaimer)

I have a software program
it's called Dragon VRT,
and everything he hears me say
my Dragon types for me.

He always spells correctly,
butt is earrings knot quiet write,
handsome type owes awl ways lip bye
though wise urge with alm eyesight.

So it really doesn't help much
that my Dragon is precocious.
They call it user error
when your proofreading's atrocious!

-by Jack Clarkson
(with apologies to Robert Louis Stevenson)

I. JURISDICTION

A. Procedure for Resolving Jurisdiction Issues- Bifurcation

The respondents in *DeJesus v. R.P.M. Enterprises, Inc.*, 6201 CRB-1-17-7 (November 8, 2018), unsuccessfully argued that it was improper for the trial commissioner to bifurcate the claim and hold a separate hearing on the issue of jurisdiction. The CRB was not persuaded. "It is well-settled that a trial commissioner must address issues of subject matter jurisdiction prior to considering the merits of the claim." Id., at 9. "It is equally well-settled that a trial commissioner retains the discretion to decide when to bifurcate proceeding; as such, we do not find it erroneous the commissioner's decision to bifurcate the jurisdictional issue in the present matter." Id., at 10, citing *Martinez-McCord v. Judicial Branch*, 5055 CRB-7-06-2 (February 1, 2007).

B. Independent Contractors

The CRB affirmed the trial commissioner's determination that the claimant was an independent contractor rather than an employee in *Ayala-Lopez v. FMP Transport, LLC*, 6275 CRB-4-18-5 (May 23, 2019). The alleged employer, FMP Transport, was a trucking company that provided delivery services for the United States Postal Service (USPS), using both independent contractors and employees as drivers. The claimant owned her own truck and began her relationship with FMP as an independent contractor, doing business as Lumy's Star Trucking, LLC, but claimed that her status changed to that of an employee after her truck broke down and FMP rented a truck that she used to continue hauling mail. Among the factors considered by the commissioner, FMP paid the claimant $30 per hour for her deliveries plus an additional $5.05 per hour attributed to a health and welfare benefit that FMP paid to all drivers at the direction of the USPS. During the time period when claimant operated her own truck, FMP combined the health and welfare benefit with her hourly rate of pay. When she began to drive the rented truck, FMP continued to issue payments to Lumy's, but adjusted the amount paid to $25 per hour. The claimant was free to take any day off as long as there was a substitute driver. She did not need FMP's permission to use a substitute driver, but they did request that she notify them when using a substitute. When substitutes were used, it was the claimant who paid them, usually in cash, and the health and welfare benefit was to be paid to the substitute driver. As mentioned above, FMP had drivers who are employees. They were paid biweekly with taxes withheld for Social Security and Medicare with their withholdings reflected on W-2 forms. FMP's payments to Lumy's were documented with 1099 Forms and included no withholdings. Considering the various factors as a whole, the trial commissioner concluded that the claimant was an independent contractor. The CRB found no error.

In *DeJesus v. R.P.M. Enterprises, Inc.*, 6201 CRB-1-17-7 (November 8, 2018), the CRB upheld the trial commissioner's determination that an employer-employee relationship existed for a long time worker at a used auto parts/scrap yard who was hired to work Monday through Saturday between the hours of 8 AM and 4 PM, initially paid $60-$75 per day, and received a $600

Christmas bonus for many years. During the year prior to his injury, he was paid $100 per week day and $50 for Saturdays. His job duties included removing parts from cars, changing oil and tires, picking up cars, and traveling to properties owned by the proprietor to shovel snow and do yard work. He testified that he used tools owned by the junkyard and also indicated that his work activities were directed by the owner, the owner's son, and a manager, all three of whom had control over his work activities. The business proprietor claimed that the claimant's employment relationship was that of an independent contractor and submitted into evidence independent contractor agreements. He paid the claimant cash "off the books" at claimant's request.

The trial commissioner concluded that the claimant had established proof of an employer-employee relationship, and the respondent appealed arguing that the trial commissioner's determination was inconsistent with *Rodriguez v. E.D. Construction a/k/a E.D. Construction, Inc.*, 5316 CRB-7-08-1 (May 11, 2009), aff'd 126 Conn. App. 717 (2011), cert. denied 301 Conn. 904 (2011), in which the claimant executed an independent contractor agreement and was found to be an independent contractor. Upon review, however, the CRB found a, as it did in *Veilleux v. Dehm Drywall, LLC*, 6057 CRB-8-15-12 (September 26, 2016), that the independent contractor agreement was only one of a number of factors considered in *Rodriguez. "*In *Rodriguez* the claimant was injured while working as a roofer. The respondent defended the claim on the grounds the claimant was an independent contractor and pointed to the claimant using his own tools at the job site, not having taxes withheld by the respondent, not being supervised by the respondent at the time of his injury and engaging in his own business working for other firms.… The respondent introduced evidence of the claimant working for others as an independent contractor.… The trial commissioner concluded the claimant failed to prove there was an employer-employee relationship and this board affirmed that decision." The Appellate Court affirmed this decision [remarking] 'we cannot conclude that the commissioner incorrectly applied the right to control test when he determined that the plaintiff was not an employee of the defendant at the time of the accident.'… This decision rested on the factors cited by the trial commissioner evidencing independent contractor status such as the claimant performing work for others, working in an autonomous manner, obtaining his own insurance, and receiving a 1099 form regarding tax liability.…" (Internal citations omitted.) *Veilleux*, supra.

Turning to the present case, the CRB noted that the claimant testified he was paid cash by the respondents and could not leave the premises unless someone gave him a ride, that he was not given a Form 1099 at year's end, that on the day of his injury, he was under the managers direction regarding which tasks to perform, that others had set up the car on which he was working, that he did not earn wages working for other employers during the period for which he worked for the respondent, that he worked at a set schedule, that he would occasionally travel with the owner and/or manager to pick up cars for work at their homes, that he did not use his own tools, and that the owner testified that he had spent "thousands of miles on the road" with the claimant traveling to obtain junk cars for the facility. The CRB stated, "The foregoing demonstrates that there were material differences between the testimony of the claimant in the present matter and that of the claimant in *Rodriguez*." *DeJesus*, at 17. To the extent that there was a factual dispute regarding the degree of control exercised by the respondent, "[i]n this

matter, the trial commissioner deemed the claimant more credible than the respondents' witness, Marion, Sr., with regard to the claimant's testimony that the respondent-employers controlled his activities. This testimony provided a sufficient basis for the trial commissioner to conclude that an employer-employee relationship existed, notwithstanding the provisions of the independent contractor agreements." Id., at 18.

C. Piercing the Corporate Veil

DeJesus v. R.P.M. Enterprises, Inc., 6201 CRB-1-17-7 (November 8, 2018), is discussed above in §§ I.A. and 1.B. In addition to the issues discussed in those sections and elsewhere below, the CRB stated the final issue for their consideration was whether the evidentiary record (see § I.B. for summary, provided a sufficient basis for the trial commissioner to "pierce the corporate veil" and find Marion, Sr., Responsible in an individual capacity. The CRB found guidance in *Naples v. Keystone Building & Development Corp.*, 295 Conn. 214 (2010), in which the Supreme Court observed, "Courts will… Disregard the fiction of a separate entity to pierce the shield of immunity afforded by the corporate structure in a situation in which the corporate entity has been so controlled and dominated that justice requires liability to be imposed on the real actor…." Id., 231, quoting *Angelo Tomasso, Inc. v. Armor Construction & Paving, Inc.*, 187 Conn. 544, 552 (1982). The CRB reviewed the record and found that testimony that Marion, Sr. paid the claimant in cash, issued payments to the claimant's wife drawn on the business, R.P.M., that claimant worked at Marion, Sr.'s home and at the home of his mother, that Marion, Sr. owned R.P.M., that R.P.M. does not have a separate bank account, that Marion, Sr. paid the claimant for work performed on personal residences, that Marion, Sr. used R.P.M. funds to pay for his own personal expenses, and that R.P.M. had no employees. "In light of this factual foundation, we conclude that the commissioner reasonably inferred that R.P.M. and Marion, Sr. were essentially alter ego's and, as such, Marion Sr. could not rely upon the protection of the corporate veil as a defense against liability." *DeJesus*, at 19.

D. Post Hearing Evidence and Proceedings Affecting Jurisdiction

See discussion of *McGrath v. Western Connecticut State University*, 6231 CRB-7-17-11 (November 28, 2018), below in § VI.B.

II. PROCEEDING BEFORE WORKERS' COMPENSATION COMMISSION

A. Conduct of Hearings:

In *Quinones v. R.W. Thompson, Co., Inc.*, 188 Conn. App. 93 (2019), the Appellate Court was faced with procedural issues arising from a formal hearing on a Motion to Preclude that was suspended as a result of the death of the trial commissioner, Clifton Thompson, which occurred after the hearing but before the parties submitted posttrial briefs. The Workers' Compensation Commission offered the parties the choice of having a hearing de novo or requesting the

commission to assign a substitute commissioner to decide the case on the basis of the transcript, exhibits and as yet unfiled briefs. In separate letters, the claimant's counsel responded by objecting to a trial de novo and stating that the decision should be tendered upon review of the record; the respondents, counsel stated they had no objection to the matter being reassigned to a new commissioner for a decision on the papers.

The substitute commissioner scheduled a formal hearing to open the record for articulation of the parties' positions and arguments. The claimant filed an objection to the commissioner's order to open the formal hearing. When a hearing was scheduled, the commissioner heard the claimant's objection and ruled that he had the authority to open the record and was recalling the claimant for further questioning. The claimant thereafter filed an appeal to the CRB challenging the right of the commissioner to open the record and take further evidence. The Board issued a decision concluding that the matter was not ripe for review. The commissioner then held a formal hearing and issued a ruling denying the claimant's Motion to Preclude. The claimant then filed a second appeal to the CRB, this time arguing that the trial commissioner improperly opened the record in contravention of what the claimant characterized as a stipulation between the parties that the matter would be decided on the record from the hearing conducted by Commissioner Thompson and the briefs of the parties. The CRB found that there was no stipulation between the parties, and even if there was a stipulation, the new commissioner had the authority to open the record.

On appeal to the Appellate Court, the claimant argued that the trial commissioner improperly opened the record. Specifically, the claimant argued that he and the defendant stipulated that the case would be decided on the record before the former commissioner, and that the new commissioner improperly ignored that stipulation and conducted a hearing de novo.

The Appellate Court disagreed. The court began by rejecting the claimant's characterization that the commissioner's opening of the record was a hearing de novo. After the matter was assigned to him, the new commissioner reviewed the record and concluded that there was not enough evidence for him to make a decision. As a result, he opened the record and question the claimant solely about payments he received during the so-called "safe harbor" period. The Appellate Court also rejected the claimant's characterization of two letters the parties sent separately to the commission as a stipulation. With respect to the purported stipulation, the Appellate Court stated, "Upon review of the evidence, we conclude that the board did not clearly air in finding that the [letters of the parties] did not constitute a contract between the parties that could be considered a stipulation. There was no firm understanding between the parties nor a quid pro quo, just a statement by the parties of their respective positions at that time. We also agree with the board that, even if a stipulation existed between the parties, such a stipulation would not prohibit the commissioner from opening the record." Id., at 102.

The court then addressed the question of the appropriate course of proceedings after the death of the presiding commissioner and found "Upon the death, disability or resignation of a judge… During the pendency of a trial or hearing to the court, a successor judge should take the following steps pursuant to the authority granted by [General Statutes] § 51-183f: (1) become

familiar with the entire existing record, including, but not necessarily limited to, transcripts of all testimony and all documentary evidence previously admitted; (2) determine, on the basis of such record and any further proceedings as the court deems necessary, whether the matter may be completed without prejudice to the parties; (3) if the court finds that the matter may not be completed without prejudice to the parties it should declare a mistrial, but if the court finds that the matter may be completed without prejudice to the parties then; (4) upon request of any party, or *upon the court's own request, recall any witness whose testimony is material and disputed and who is available to testify without due burden*; (5) take any other steps reasonably necessary to complete the proceeding; and (6) render a decision based on the successor judge's own findings of fact and conclusions of law." (Emphasis added by *Quinones* court.) Id., at 102, citing *Stevens v. Hartford Accident & Indemnity Co.*, 29 Conn. App. 378, 386 (1992).

Applying those principles to the present case, Appellate Court found that "the commissioner recalled the claimant as a witness so he could hear evidence he believed essential to a proper evaluation of the case.… It was fully within the commissioner's power and authority to do so. See General Statutes § 31-278." The court further observed, "the commissioner is not bound by common law or statutory rules of evidence or procedure. He may make inquiry in the manner best calculated to do so to ascertain the rights of the parties and to carry out the spirit of the act through oral testimony or written or printed records." *Delgaizo v. Veeder-Root, Inc.*, 133 Conn. 664, 667-68 (1947).

Finally, the Appellate Court noted that the claimant did not provide, nor did the court find, any support for claimant's contention that a stipulation, assuming that one existed, could limit the commissioner's power. Therefore, the court concluded that the CRB correctly determined that it was not improper for the successor commissioner to have opened the record. The Appellate Court's analysis and ruling on the preclusion issue are discussed below in § V.G.

Cortes v. State Judicial Branch, 6195 CRB-2-17-5 (July 20, 2018), is a peculiar case in which the CRB took the extraordinary step of remanding the matter for a trial de novo after the board expressed itself unable to ascertain the manner in which the trial commissioner arrived at his conclusions. The Board stated it was "confused by [the trial commissioner's] conclusion that one critical witness was 'marginally credible' while another critical witness was 'partially credible'. Without a more specific explanation regarding which elements of the witness testimony the trial commissioner deemed reliable, we are unable to pass judgment on the validity of the relief granted in the Finding & Award. We are also troubled by the fact that we cannot find support in the record for certain factual findings reached by the trial commissioner as well as the fact that the trial commissioner does appear to have adopted the claimant's proposed findings verbatim.… Given that we conclude that the deficiencies of the Finding & Award are too substantial to be addressed by a remand of the matter, we vacate the Finding & and Award in order that a *formal* hearing be scheduled on this claim." Id., at 2-3.

Jackson v. Yale University, 6273 CRB-5-18-5 (April 4, 2019), is a battle of the experts cases in which the CRB affirmed the trial commissioner's conclusion that the claimant's current back

problems, need for surgery, and disability were the result of a 10-year-old accepted work injury. Citing *O'Reilly v. General Dynamics Corp.*, 52 Conn. App. 813 (1999), for the proposition that "It is the trial commissioner's function to assess the weight and credibility of medical reports and testimony.…," id., at 818, quoting *Gillis v. White Oak Corp.*, 49 Conn. App. 630, 637, cert. denied, 247 Conn. 919 (1998), the board noted that the trial commissioner's conclusion was supported by expert medical evidence including the opinion of the CME examiner. Thus, the CRB found no error. "If the trier is not persuaded by the claimant's evidence, there is nothing that this board can do to override that decision on appeal." *Jackson*, at 10, quoting *Wierzbicki v. Federal Reserve Bank of Boston*, 4147 CRB-1-99-11 (December 19, 2000), appeal dismissed A.C. 21533 (June 14, 2001).

The CRB ruled in *Mellado v. Anthony Urbano/Earth Materials, L.L.C.*, 6187 CRB-3-17-4 (January 15, 2019), that the trial commissioner committed reversible error by basing an award of benefits against the employer based solely on a stipulation of facts between the claimant and the Second Injury Fund to which the employer was not a party and for which there was no underlying supporting testimony offered.

B. Due Process Concerns:

In *Mikucka v. St. Lucian's Residence, Inc.*, 183 Conn. App. 147 (2018), the Appellate Court upheld a CRB decision affirming the trial commissioner's order granting a Form 36 for maximum medical improvement. The appeal arose from a formal hearing on claimant's objection to the Form 36 at which claimant's counsel conceded that she had no medical evidence disputing that the claimant had reached maximum medical improvement but instead sought to establish that the claimant was vocationally disabled as contemplated by *Osterlund v. State*, 135 Conn. 498 (1949).

At the formal hearing, the trial commissioner informed claimant's counsel that the *Osterlund* issue was not listed on the hearing notice and was not among the issues to be determined in the present proceedings but offered to address the issue in a separate hearing in two or three weeks. Claimant's counsel persisted in her attempt to present the *Osterlund* vocational total disability argument in the initial formal hearing and never pursued the vocational total disability claim in a follow-up hearing as recommended by the trial commissioner. The trial commissioner determined that the claimant had reached maximum medical improvement and that she had a work capacity and granted the Form 36 accordingly.

The CRB affirmed the commissioner's decision, noting that on the date of the formal hearing the respondents were prepared to proceed with their arguments in favor of granting the Form 36 and the claimant had not offered notice to the commissioner or the respondents that she was pursuing a claim for continuing TT benefits based on an *Osterlund* theory. Under the circumstances, the CRB found the trial commissioner essentially was obliged, pursuant to *Martinez-McCord v. State*, 5055 CRB-7-06-2 (February 1, 2007), to bifurcate the issues, ruling on the issue that was

properly before it in the present hearing and addressing the balance of the issues at a later proceeding.

On appeal to the Appellate Court, the claimant argued first that the trial commissioner, by not allowing her to present evidence to prove that she did not have a work capacity, violated her right to due process.

The Appellate Court rejected this argument. "The plaintiff's due process claim is meritless because the commissioner's decision to not allow her to present evidence in support of her *Osterlund* claim on that particular day did not prejudicially affect her substantive rights. The commissioner repeatedly invited the plaintiff to return for a hearing in three weeks to present evidence that she was vocationally totally disabled. The plaintiff inexplicably declined the commissioner's invitation to do so. Thus, she cannot demonstrate how she was harmed by the commissioner's decision to not let her present evidence regarding a potential vocational disability at the [initial] hearing when she could have returned three weeks later to pursue this claim."

The claimant further argued, relying on *O'Connor v. Med-Center Home Health Care, Inc.*, 140 Conn. App. 542, cert. Denied 308 Conn. 942 (2013), that she could have rebutted the Form 36 seeking to terminate her TT benefits on the basis of her reaching MMI by either showing that she was medically or vocationally totally disabled. The Appellate Court agreed that this was a correct statement of the law, but went on to explain:

> The plaintiff, however, fails to acknowledge a key distinction between the present case and *O'Connor*. In *O'Connor*, the plaintiff litigated her vocation based disability claim over a four session hearing. In the present case, the commissioner offered the plaintiff the opportunity to litigate this issue. As previously stated, the plaintiff elected not to pursue this claim. The plaintiff cannot, now on appeal, rely on *O'Connor* to argue that the commissioner should have undergone a holistic evaluation of her work capacity when, unlike the plaintiff in *O'Connor*, she never presented this claim despite the commissioner's invitation to do so. It is important to note that the commissioner's decision to bifurcate the plaintiff's claim protected the defendants' due process rights. At workers compensation hearings, 'no matter shall be decided unless the parties have fair notice that it will be presented insufficient time to prepare themselves upon the issue.'

Micucka, at 162-63, citing *Osterlund v. State*, 129 Conn. at 596.

The claimant's second argument in support of her appeal was that the trial commissioner erred in determining that she was not totally disabled. The Appellate Court found that that inasmuch as she had failed to avail herself of the commissioner's invitation to pursue her *Osterlund*-related claim in a bifurcated proceeding, that issue was not ripe for review.

The CRB ruled in *DeJesus v. R.P.M. Enterprises, Inc.*, 6201 CRB-1-17-7 (November 8, 2018), that the trial commissioner did not violate the due process rights of Robert M. Marion, Sr., a putative sole proprietor employer who was not initially named as a party in the case but who was added as a respondent at the formal hearing when counsel for the Second Injury Fund specially moved to add him as a party respondent in his "individual, personal capacity." The CRB noted that the trial commissioner indicated on the record that hearing notices had been sent to Marion in his personal capacity, the Fund had served him with a subpoena, that Marion attended and extensively testified at a hearing in which the issues focused on his financial management of his business, and that his business was represented by counsel. Marion argued relying on *Balkus v. Terry Steam Turbine Co.* 167 Conn. 170 (1974), that he was deprived of due process because the trial commissioner ordered relief against him although he was not originally named as a party to the claim. The CRB, however, found that in *Mosman v. Sikorsky Aircraft Corp.*, 4180 CRB-4-00-1 (March 1, 2001), the board recognized "that a party may be apprised that a given claim is at issue by other means, such as the statements of the parties at trial, the evidence they have introduced, or the papers they have filed." Id. "Under the totality of the circumstances, we are persuaded that Marion, Sr., had ample reason to believe he was potentially facing personal liability. The present matter is therefore consistent with *Valiante v. Burns Construction Company*, 5393 CRB-4-08-11 (October 15, 2009), in which '[a]ny confusion as to the scope of the issues and the remedy under consideration by the tribunal was clearly resolved on the record prior to the conclusion of the formal hearing.' Id. As a result, we do not find that the trial commissioner's decision to attribute personal liability to Marion, Sr., constituted a due process violation." *DeJesus*, at 12.

C. Collateral Estoppel

Section 31-51bb provides, "no employee shall be denied the right to pursue, in a court of competent jurisdiction, a cause of action arising under the state or federal Constitution or under a state statute solely because the employee is covered by a collective bargaining agreement. Nothing in this section shall be construed to give an employee the right to pursue a cause of action in a court of competent jurisdiction for breach of any provision of a collective bargaining agreement or other claims dependent upon the provisions of a collective bargaining agreement." In the 1993 case of *Genovese v. Gallo Wine Merchants, Inc.,* 226 Conn. 475, 493 (1993), the Supreme Court held that under § 31-51bb, principles of collateral estoppel do not bar a claimant, who had previously brought a grievance pursuant to a collective bargaining agreement, from filing a § 31-290a civil action in Superior Court.

In *Williams v. City of New Haven*, 329 Conn. 366 (2018), the Supreme Court found that § 31-55bb likewise permits an aggrieved claimant to file a § 31-290a claim before the Workers' Compensation Commission, upholding a decision of the CRB permitting the claimant to file a claim alleging that the employer violated § 31-290a by wrongfully terminating his employment in retaliation for bringing a workers compensation claim notwithstanding that the State Board of Mediation and Arbitration previously ruled on a similar issue in an arbitration proceeding brought pursuant to a collective bargaining agreement between the parties. The dispute arose

from a scenario that practitioners may find cautionary and instructive. The claimant was a municipal employee with an accepted claim for a shoulder injury who was released for light duty work for eight hours per day. The employer City had light duty work available for the claimant from 7 AM to 3 PM. When the claimant returned to work, he asked that his hours be changed to 5 AM to 1 PM, because those were his hours before his injury and because the change would enable him to work at his second job. He was informed the city could not accommodate his request because the location of his light duty assignment did not open until 7 AM and the City did not want him to work without supervision. The claimant responded to this by contacting his treating physician, explaining the situation and his doctor changed his work status report to restrict his hours to four or five hours of work per day. This led to Form 36 litigation during which the treating physician was deposed and testified that he reduced the claimant's work hours to accommodate his desire to work at his second job and that there was no medical reason for the restriction.

Several things occurred thereafter. First, the commissioner granted the city's request to reduce the claimant's workers compensation benefits for the dates in question; second, the city took action to terminate the claimant's employment for committing workers compensation fraud; third the State Mediation and Arbitration board concluded that the city had just cause to terminate the claimant because his receipt of workers' compensation benefits was the result of "intentional deceit" and his conduct "amounted to theft"; and fourth, the claimant filed an unsuccessful civil action seeking to vacate the arbitration award.

Meanwhile, the claimant filed a § 31-290a claim with the Workers' Compensation Commission alleging that he had been wrongfully discharged by the city in retaliation for bringing a workers compensation claim. The city moved to dismiss the claim on collateral estoppel grounds, but the trial commissioner ruled that under § 31-55bb and *Genovese*, supra, the claimant was entitled to pursue his § 31-290a claim despite his prior submission of a related claim for arbitration. The trial commissioner further concluded that the issue raised in his claim to the commission, i.e., whether the city retaliated against him for filing a workers' compensation claim, was separate and distinct from the issue raised in the arbitration proceedings, i.e., whether he had committed workers compensation fraud. The CRB agreed with the trial commissioner that the issues were different and affirmed his decision.

On appeal to the Appellate Court, the City argued that Genovese did not apply because § 31-51bb applies only to statutory causes of action pursued "in a court of competent jurisdiction." In the alternative, the city contended that the claimant's rights under § 31-51bb were satisfied because he pursued a Superior Court application to vacate the arbitration award. Finally, the city argued that the CRB in correctly determined that the issues raised in his § 31-290a claim were different from those raised in the arbitration proceedings pursuant to the collective bargaining agreement.

With respect to the City's contention that § 31-51bb applies only to proceedings brought in a court, as opposed to an administrative tribunal, the Appellate Court found that both parties'

interpretations of the statute was ambiguous and, therefore, considered extra-textual evidence of its meaning. After a lengthy review of the administrative history of the statute and considering the problem that the statute was intended to address, the court concluded that concluded that "although the ordinary rules of evidence and procedure do not apply in proceedings before the commission, it has expertise in the area of workers' compensation law that the state board does not have, thereby increasing the likelihood of a correct decision in a claim brought pursuant to § 31-290a. Indeed, because the commissioner and the review board have greater expertise in this area than the *courts*, it would be odd if § 31-51bb was intended to prevent the application of principles of collateral estoppel to workers compensation claims brought in court but not before the commission." Id., at 384.

The Appellate Court likewise rejected the city's claim that the claimant's § 31-51bb rights were satisfied by his Superior Court action to vacate the arbitrator's decision. The court had previously identified that the primary "purpose of § 31-51bb was to give employees covered by a collective bargaining agreement the same right to bring a statutory cause of action as other employees." Thus, because judicial review of an arbitration award is limited to determining whether the award conformed with the submission and whether the arbitrator manifestly disregarded the law, "an application to vacate an arbitration award that resulted from proceedings provided for in a collective bargaining agreement is not equivalent to the right to file a claim with the [Workers' Compensation Commission] pursuant to § 31-290a, which includes their right to subsequent judicial review under a more liberal standard." Id., at 385. The Appellate Court did not reach the question of whether the CRB improperly determined that the issue raised in the arbitration hearing was different from the issue raised in the § 31-290a claim because even if the issue were the same, the claim to the commission would not be precluded.

In *Filosi v. Electric Boat Corp.*, 330 Conn. 231 (2018), the Supreme Court applied the principles of *Birnie v. Electric Boat Corp.*, 288 Conn. 392 (2008), and *Lafayette v. General Dynamics Corp.*, 255 Conn. 762 (2001), to affirm a decision of the CRB, which determined that when a federal Administrative Law Judge in a Longshore Act claim between the same parties issued a decision and order finding the decedent's "disability and death, a direct result of his lung cancer, causally linked to his asbestos exposure" at the respondent employer, the employer was precluded from relitigating the causation issue in state workers' compensation proceedings.

The claimant first litigated a federal Longshore Act claim, and later pursued a formal hearing under the Connecticut Worker's Compensation Act. In the federal proceedings, the ALJ did not clearly articulate the standard governing the causation issue under the Longshore Act, but expressly relied upon a report from an expert witness who stated that occupational asbestos exposure sustained by the decedent in more than thirty years of work at the respondent's shipyard was "a substantial contributing cause to the development of his lung cancer."

The trial commissioner in the state proceedings determined that collateral estoppel doctrine did not preclude the respondents from challenging causation because the ALJ had not defined the causal connection standard required under the Longshore Act, proceeded to hear the claim on its

merits, and dismissed the claim after finding that the decedent's "smoking history was more than sufficient to fully explain his development of lung cancer." The CRB reversed, finding pursuant to *Lafayette* the ALJ "essentially followed the same process that a trial commissioner would have to adhere to in order to make a finding of a compensable injury under the state Act."

On further appeal, the Supreme Court reviewed the doctrine of collateral estoppel, applying the following analysis from *Birnie*, supra, "the common-law doctrine of collateral estoppel, or issue preclusion, embodies a judicial policy in favor of judicial economy, the stability of former judgments and finality.… Collateral estoppel… Prohibits the relitigation of an issue when that issue was *actually litigated* and *necessarily determined* in a prior action between the same parties upon a different claim.… For an issue to be subject to collateral estoppel, it must have been *fully and fairly litigated in the first action.* An issue is *actually litigated* if it is properly raised… Submitted for determination, and in fact determined.… In issue is *necessarily determined* if, in the absence of a determination of the issue, the judgment could not have been validly rendered.… If an issue had been determined, but the judgment is not dependent upon the determination of the issue, the parties may relitigate the issue in a subsequent action. Findings on nonessential issues usually have the characteristics of dicta." *Filosi*, 330 Conn. at 242, citing *Lafayette*, 255 Conn. At 772-73.

In applying these principles, the court then looked to *Birnie* for guidance on how to harmonize the federal and state causation standards. "With respect to whether an injury is compensable under the Longshore Act, we determined in *Birnie* that 'there is no universal causation standard that is applied in every case for compensation under the Longshore Act 'because it may vary depending on, for example, whether the claimant suffers from an injury or from a disease, or the particular circumstances of the claimant's employment.' (Footnote omitted.) *Birnie v. Electric Boat Corp.,* supra, 288 Conn. 414-15. Accordingly, in determining whether a decision under the Longshore Act is entitled to preclusive effect in the state act proceeding, the dispositive question is 'whether the standard *as applied by* the federal administrative law judge differs from the substantial factor standard to such an extent that the application of the collateral estoppel doctrine would [undermine] the rationale of the decision.' (Emphasis in original; internal quotation marks omitted.) Id., 395 n.2." *Filosi*, at 245.

After examining the record of the present case, the *Filosi* court concluded that the finding of compensability in the Longshore claim had a preclusive effect in the state claim because the ALJ applied a substantial factor standard. "Although the administrative law judge did not expressly state as a matter of law that he was applying a substantial factor standard of causation, he nevertheless specifically credited the opinion of Welch, the root plaintiff's medical expert, who stated in her report that [occupational asbestos exposure] was 'a substantial contributing cause to the development of his lung cancer.'" Id., at 245-46.

The CRB ruled in *Lent v. City of Stamford*, 6222 CRB-5-17-9 (December 7, 2018), that the trial commissioner committed error by applying the doctrine of collateral estoppel and dismissing the claimant's claim via a Motion to Dismiss without conducting an evidentiary formal hearing. The

claimant contended that he fractured his hand in a work-related fall. The respondents contended that the fracture was a self-inflicted injury that occurred when the claimant became angry and punched a locker or metal door. The trial commissioner convened a formal hearing at which the sole witness to testify in the first session was a medical witness for the claimant. The hearing was adjourned prior to completion of the witness's cross examination. Before the next session of the hearing, the respondents filed a Motion to Dismiss attaching a decision of the Connecticut State Board of Mediation and Arbitration and a decision of the State of Connecticut Employment Security Appeals Division adopting the theory of causation advanced by the respondents and finding that the respondents had just cause to terminate the claimant from employment. The trial commissioner granted the respondent's motion without scheduling a hearing affording the claimant the opportunity to offer arguments or evidence challenging the dismissal sought by the respondents. Claimant argued that the trial commissioner's dismissal must be vacated noting that pursuant to the provisions of §§ 31-249g(b) and 31-51bb, it is improper to apply a decision of either the Arbitration Board or the Employment Board in a manner that denies the claimant the right to seek redress in another forum. The CRB agreed, noting that the commissioner made no factual determinations regarding the manner in which the Arbitration Board or the Employment Board conducted their hearings and made no affirmative determination that either of the decisions was the result of a fully contested hearing utilizing a standard of proof similar to that required in Worker's Compensation claims. As a result, the board concluded that the claimant must be presented with the opportunity to challenge the decisions from the Arbitration Board or Employment Board before granting those decisions preclusive effect.

III. MEDICAL/LEGAL EVIDENTIARY ISSUES

A. Sufficiency of Medical Evidence

In General: *Diaz v. Department of Social Services*, 184 Conn. App. 538 (2018), is a weight and sufficiency case involving a claimant who filed a repetitive trauma claim alleging and back injuries that she and attributed to improper ergonomics at her workstation that aggravated conditions arising from non-work motor vehicle accidents in 1990 and 2008 for which her physicians recommended cervical disc surgery that she declined to undergo. The respondents accepted the claim, issued a jurisdictional VA, and paid various benefits to the claimant, including specific indemnity benefits, but declined to authorize surgery. The claimant ultimately underwent cervical disc surgery and a subsequent trigger thumb release.

The respondents denied liability for the operations on medical causation grounds and a formal hearing ensued at which the trial commissioner found that the surgery was medically reasonable and necessary, but that the claimant had failed to prove that her work-related injury was a substantial factor in the need for her operations. The CRB affirmed, noting "It was the [claimant's] burden to persuade the trial commissioner that her workplace conditions were a substantial contributing factor in her need for surgery and resultant medical conditions. We believe that on the record herein a reasonable factfinder could be left unpersuaded." Id., at 546.

On appeal, the Appellate Court reviewed the record and found a dispute in medical opinion. The claimant's primary care physician and one of her treating neurosurgeons opined that improper ergonomics at her workstation were a substantial factor in her need for surgery. A second treating neurosurgeon stated that he was unable to reach a conclusion and a respondents' neurosurgical examiner concluded that there was no evidence to support a connection between the ergonomics at her workstation and her need for surgery. The Appellate Court stated, "In Connecticut traditional concepts of proximate cause constitute the rule for determining … causation [in workers' compensation cases].… [T]he test of proximate cause is whether the [employer's] conduct is a substantial factor in bringing about the [employee's] injuries.… [Our Supreme Court] as determined proximate cause as [a]n actual cause that is a substantial factor in the resulting harm…. The question of proximate causation… belongs to the trier of fact because causation is essentially a factual issue.… It is axiomatic that, in reaching that determination, the commissioner often is required to draw an inference from what he is found to be the basic facts.… But the scope of judicial review of that inference is sharply limited…. If supported by evidence and not inconsistent with the law, the… [c]ommissioner's inference that an injury did or did not arise out of and in the course of employment is conclusive. No reviewing court can then set aside that inference because the opposite one is thought to be more reasonable; nor can the opposite inference be substituted by the court because of a belief that the one chosen by the… [c]ommissioner is factually questionable.… Only if no reasonable factfinder could have resolved the proximate cause issue as the commissioner resolved it will the commissioner's decision be reversed by a reviewing court." Id, at 551-52, citing *Turrell v. Department of Mental Health & Addiction Services*, 144 Conn. App. 834, 844-45, cert. denied, 310 Conn. 930 (2013). Applying those principles to the present case, the Appellate Court found that the trial commissioner's determination was supported by the evidence and not inconsistent with the law.

The CRB reviewed the conflicting medical evidence introduced in *Bajramovic v. First Student*, 6225 CRB-1-17-10 (October 1, 2018), and found that the trial commissioner's dismissal of a claim arising from a work-related motor vehicle accident was supported by the evidence based upon findings that the impact was minimal, that the medical opinion upon which claimant relied to establish her claim was offered by a physician who did not see the claimant for the first time until some six months after the MVA and stated in his causation report that his opinion was "based on the history obtained," that the trial commissioner specifically found that the claimant was not a credible witness, and that contemporaneous records from treating physicians did not mention the MVA as part of the claimant's pertinent history.

The CRB affirmed the trial commissioner's Finding & Award in *Fernandes v. Town of Darien/Board of Education*, 6211 CRB-3-17-8 (November 2, 2018). This was fact-based weight and sufficiency case that was notable because the record contained the transcript of a deposition of the claimant's treating physician in which the doctor's testimony regarding causation was arguably insufficient to establish a prima facie claim, but the physician later provided a written causation opinion in which he revised his opinion and stated with reasonable medical probability that the claimant's injury was a direct result of the injuries sustained while at work. The trial

commissioner expressly chose to rely on the doctor's revised written causation opinion rather than his deposition testimony. The CRB stated that it was "well within his discretion to do so," id., at 8, citing *Williams v. Bantam Supply Co., Inc.*, 5132 CRB-5-06-09 (August 30, 2007), for the proposition that it is within the discretion of the trial commissioner to accept some, but not all of a physician's opinion.

Bard v. Grade A ShopRite of Southbury, 6194 CRB-1-17-5 (October 3, 2018), the CRB rejected the claimant's appeal and affirmed the trial commissioner's award of one week of TT benefits and zero TP benefits. The trial commissioner stated in his Finding and Dismissal that he did not find the claimant's formal hearing testimony credible and did not believe he demonstrated that he was willing to perform light duty work at any time since the date of his injury. In response to the claimant's contention that the trial commissioner failed to credit "uncontroverted" medical evidence supporting disability, the CRB cited authorities including *Anderson v. Target Capital Partners*, 5615 CRB-6-10-12 (January 3, 2012), for the proposition that when a trial commissioner does not find the claimant credible, the commissioner is entitled to conclude any medical evidence which relied on the claimant's statements was also unreliable. "This tribunal has previously held that when a claimant is deemed not credible, his claim is subject to dismissal." *Bard*, at 11 citing *Pupuri v. Benny's Home Service, LLC*, 5697 CRB-2-11-11 (November 5, 2012); and *Toroveci v. Globe Tool & Metal Stamping Co., Inc.*, 5253 CRB-6-07-7 (July 22, 2008).

The CRB employed an analysis similar to *Bard* in affirming the trial commissioner's dismissal in *Casella v. O & G Industries*, 6017 CRB-4-15-5 (June 27, 2018), wherein the claimant argued that the trial commissioner erroneously failed to articulate why she did not find credible or persuasive the witnesses who supported his claim and further argued that it was error for the trial commissioner not to cite the opinion of one of the favorable physicians in her conclusions, relying on *Bode v. Connecticut Mason Contractors*, The Learning Corridor, 130 Conn. App. 672, cert. denied, 302 Conn. 942 (2011), wherein the Appellate Court overturned the trial commissioner's determination that the claimant was not in vocationally disabled because the claimant had presented evidence that he was disabled, this evidence was uncontroverted, and the trial commissioner failed to opine on its merit.

The CRB rejected the claimant's *Bode* argument, noting that in the present case the trial commissioner made 35 factual findings discussing the evidence and opinions from seven different medical providers and to vocational experts. "Unlike the situation in *Bode*, the trial commissioner in the present matter did not fail to consider the merits of an uncontroverted medical opinion; in fact, claimant's evidence was extensively disputed by the respondents and the trial commissioner reached a reasoned determination after considering the totality of the evidence." Id., at 11. As for the one doctor the trial commissioner did not discuss, the Board noted at the outset that the appropriate vehicle to address that concern would have been a Motion to Correct, and that in any event, they did not believe the trial commissioner would have been obligated to grant either a Motion to Correct or a Motion for Articulation relative to the inclusion or omission of any of her conclusions. Although the claimant contended that the trial

commissioner was obligated to offer a detailed explanation as to why she found the causation opinions of the doctors favorable to the claimant unpersuasive and appeared to disregard another favorable physician, "such an argument does not reflect the proper legal standard. In *Anderson v. Target Capital Partners*, 5615 CRB-6-10-12 (January 3, 2012), this board stated:

> In many ways this case is similar to *Biehn v. Bridgeport*, 5232 CRB-4-07-6 (September 11, 2008) where the claimant sought a detailed explanation as to why her claim was denied. As we held in *Biehn*, the decision's rationale was clear enough that an articulation was not necessary since the decision was unambiguous. In the present matter the trial commissioner clearly stated he did not find the claimant fully credible and did not find his treating physicians persuasive. We find that this sufficiently complies with Administrative Regulation § 31-301-3 where a commissioner's findings must detail the facts that he or she found in the conclusions based on the facts he or she reached. 'Thus, by the express terms of § 31-301-3 of the regulations, the scope of the commissioner's finding and award is limited to the "ultimate, relevant and material facts essential to the case."' *Cable v. Bic Corp.*, 270 Conn. 443, 440 (2004), *quoting Luciana v. New Canaan Cemetery Assn.*, 3644 CRB-7-97-7 (August 12, 1998). *Biehn,* supra. The trial commissioner's findings are therefore consistent with the legal standard promulgated by the Supreme Court in *Cable*, supra, and must be sustained on appeal.

Id.

Similarly, in *Spillane v. Yale University*, 6192 CRB-5-17-4 (August 9, 2018), the CRB relied on *Anderson*, supra, to uphold the trial commissioner's dismissal when the commissioner found that the claimant's testimony was not credible and that the medical opinions of the respondent's examiner were more persuasive and credible than those of the treating physician.

The CRB reached a similar result in *Sullivan v. Town of Clinton*, 6175 CRB-3-17-1 (August 7, 2018), upholding the trial commissioner's dismissal based on findings that the claimant was not credible, and that the RME and CME physicians, both of whom described the claimant as a "symptom magnifier," were more credible than the claimant's treating physician.

Collin v. United Technologies Corporation, 6278 CRB-8-18-5 (May 13, 2019), is an otherwise unremarkable "battle of the experts" case in which the CRB affirmed the trial commissioner's dismissal of a repetitive trauma hand injury claim. One unusual wrinkle in the matter is that one of the experts deemed credible by the trial commissioner was an RME physician who had the opportunity to tour the employer's facilities and examine the claimant's workstation and inspect the machine the claimant implicated as the cause of his injury. One of the claimant's arguments on appeal was that the trial commissioner

improperly failed to discuss the opinions of the claimant's treating physician. The CRB acknowledged that the trial commissioner did not address the treating physician's opinions but noted that claimant directed the commissioner's attention to the issue by filing a Motion to Correct. The trial commissioner denied the motion, from the Board inferred that the trier did not deem the treater's opinion credible.

JPC comment: In juxtaposition to these cases, which appear to allow the trial commissioners significant leeway regarding the degree of detail required to explain the basis of their decisions, see the discussion of Cortes v. State Judicial Branch*, 6195 CRB-2-17-5 (July 20, 2018) above in §II.A.*

The CRB affirmed the trial commissioner's dismissal of *Francis v. Baymont Inn & Suites*, 6239 CRB-1-18-1 (December 11, 2018). The claimant alleged that she injured her back setting up tables for a banquet, but the record of the formal hearing showed that the contemporaneous history the claimant provided to her first treating physician contained no reference to the alleged occurrence but rather discussed a 10-day history of back pain and a motor vehicle accident. Much later in the course of her treatment, the claimant came into the care of a chiropractor who offered a causation opinion in the claimant's favor. The trial commissioner's Finding and Dismissal recited an extensive history of prior and subsequent claims, reviewed the medical evidence, and reviewed the claimant's medical records, which showed more or less continuous medical treatment with no reference to the alleged occurrence. The claimant testified in the formal hearing that the reason she did not seek immediate follow-up care was because of an unpaid medical bill balance with her treating physician, but the record discloses that claimant had been treating with the same doctor for other unrelated conditions at the same time she claimed to be unable to afford care for the alleged work injury, with respect to which the trial commissioner specifically found the claimant's testimony was not credible.

B. Sufficiency of Vocational Expert Evidence

The claimants in *Pereira v. State of Connecticut/Department of Developmental Services*, 6204 CRB-3-17-6 (August 1, 2018), and *Ayna v. Graebel/CT Movers, Inc.,* 6204 CRB-3-17-6 (August 1, 2018), sought to establish that they were totally disabled under the disability standard set forth in *Osterlund v. State*, 135 Conn. 498 (1949). Both were "battle of the experts" cases in which the claimants and respondents presented testimony by vocational experts with conflicting opinions regarding the claimants' work capacity. Both cases also involved conflicting medical evidence regarding the claimant's work capacity. The trial commissioner in *Pereira* found the claimant credible, found that the claimant's vocational expert was more credible than the respondents' vocational expert and found that medical opinions in support of the claimant's position were more credible than those supporting the employer, and awarded the claimant TT benefits accordingly. The trial commissioner in *Ayna* found that the claimant was not a credible witness, found that the respondents' vocational expert was more credible than the claimant's expert and found that the medical opinions offered by the respondents in support of their position were more

credible than those offered by the claimant, and dismissed the claimant's *Osterlund* claim accordingly. These were essentially weight and sufficiency cases in which the CRB found the trial commissioners offered detailed rationales for their respective conclusions, determined that neither commissioner committed an abuse of discretion, and affirmed both of their decisions.

C. Use of Video Surveillance

In *Dominguez-Sanchez v. Ta Caislean, Inc., d/b/a TLC Lawn and Landscaping Service*, 6266 CRB-5-18-4 (March 28, 2019), the CRB ruled that the trial commissioner did not violate the claimant's due process rights or commit error by admitting a surveillance video presented by the respondents at the formal hearing that was not made available to the claimant prior to the hearing. "Claimant argues that 'it is typical in this [area] of practice that the surveillance evidence is provided to the claimant for review.' Claimant's Brief, p. 4. However, the standard for appellate review is not whether something is 'typical.' The pertinent inquiry is whether the commissioner erred in admitting the video into evidence and utilizing it as a basis for her decision. We are not persuaded that her decision to do so constituted error." Id., at 9. The claimant argued that the video was inadmissible pursuant to *Catale v. Physicians Health Services*, 4495 CRB-4-02-2 (March 5, 2003), in which the CRB ruled it was error to admit a video into evidence without testimony regarding the date or location where it had been filmed. The *Dominguez-Sanchez* Board found that in the present matter, the videographer responsible for filming the surveillance video testified at the formal hearing, authenticated the video, and offered testimony as to where and when it had been filmed, and that claimant's counsel had the opportunity to cross-examine the witness. As a result, the board concluded that "the concerns which led this tribunal to conclude that the surveillance video in *Catale* was inadmissible are not present in the matter at bar." Id., at 10. Instead, the Board found the circumstances of the present case "indistinguishable" from *Nisbet v. Xerox Corporation*, 5867 CRB-7-13-7 (July 17, 2014), in which claimant objected to the admission of a surveillance video and its presentation to a vocational expert. The CRB in *Nisbet* disagreed, noting the claimant had the opportunity to cross-examine the witness.

D. Proximate Causation

The CRB reviewed principles of proximate causation in affirming the trial commissioner's dismissal of *Mauriello v. Craftsman Litho*, 6256 CRB-5-18-3 (March 22, 2019). The issue arose in the context of the trial commissioner's interpretation of CME testimony as unsupportive of the claimant's contention that his compensable 1986 back injury and resulting 2005 back surgery were substantial factors in his need for hip replacement surgery in 2016. The Board cited *Tartaglino v. Department of Correction*, 55 Conn. App. 190, 195 (1999), cert. denied, 251 Conn. 929 (1999), for the proposition that "[t]he trier may accept or reject, in whole or in part, the testimony of an expert," and that it was well within a commissioner's discretion to disregard the conclusion of a commissioner's examiner when the record contains other medical opinions which are supportive of a different conclusion. In the course of its decision, the Board stated the following:

It is axiomatic that the proximate cause standard requires a determination of whether an incident that arose out of and in the course of employment was a' 'substantial factor' in the claimed injury. The meaning of the term 'substantial factor' was thought to be a matter of settled law until our Supreme Court issued its opinion in *Birnie* [*v. Electric Boat Corp.*, 288 Conn. 392 (2008)].

In *Birnie*, the court reviewed the concept of proximate causation and held that '[i]n accordance with our case law, therefore, the substantial factor causation standard simply requires that the employment, or the risks incidental thereto, contribute to the development of the injury in *more than a de minimis way*.' (Emphasis in the original.) Id., 412-13 (footnote omitted). Subsequent to its decision in *Birnie*, our Supreme Court, in *Sapko v. State*, 305 Conn. 360 (2012), reviewed the legal landscape regarding proximate causation and the appellant's contention that the court had diminished the standard for proximate cause in *Birnie*. The *Sapko* court held that the proximate cause standard both pre-*Birnie* and post-*Birnie* was the same.

> [I]n reaching our conclusion in *Birnie*, we undertook an in-depth examination of the contributing and substantial factor standards to facilitate a comparison of the two tests. It was in this context that we observed that the substantial factor test requires that the employment contributed to the injury "in more than a de minimis way." Id., 413. The 'more than… de minimis' language is preceded, however, by statements explaining that 'the substantial factor standard is met if the employment *materially or essentially contributes* to bring about an injury'; (emphasis in original) id., 412; which, by contrast, 'does *not* connote that the employment must be the *major* contributing factor in bringing about the injury… nor that the employment must be the *sole* contributing factor in development of an injury.' (Citation omitted; emphasis in original.) Id. thus, it is evident that we did not intend to lower the threshold beyond that which previously had existed.

Id.

IV. APPEALS

A. Timeliness of Appeal

Section 31-301(a) requires that appeals be filed within 20 days after entry of an award by the commissioner, with the further provision that "[i]f a party files a motion subsequent to the

finding and award, order or decision, the twenty-day period for filing an appeal of an award or an order by the commissioner shall commence on the date of the decision on such motion." In *Hankard v. State Division of Criminal Justice/Office of the Chief State's Attorney*, 6226 CRB-8-17-10 (October 17, 2018), the respondents filed a post-trial "Respondent/Employer's Motion for Reconsideration/Motion for Clarification/Motion to Open Judgment," and, when that motion was denied, filed their Petition for Rreview within 20 days of the commissioner's denial order. The claimant pointed out that the appeal documents were filed more than 20 days after the trial commissioner's initial Findings and Orders, and argued pursuant to *Gonzalez v. Premier Limousine of Hartford*, 3635 CRB-4-11-3 (April 17, 2012), that only a post judgment Motion to Correct can toll the appeal period, and because the respondent filed a different post-judgment motion the appeal period expired and the repeal was untimely. The CRB ruled that *Gonzalez* addressed a different issue, ruling that a post-judgment motion filed by one party cannot toll the appeal period for the other. The Board ruled that the meaning of § 31-301(a) was plain, "filing 'a motion' within twenty days of the issuance of the finding serves to toll the appeal period to the Compensation Review Board until the trial commissioner acts on that motion. The statute does not articulate the specific information which must be included in such a motion." *Hankard*, at 8.

Similarly, in *Mangione v. Town of West Hartford*, 6268 CRB-6-18-4 (April 12, 1919), the CRB ruled that a timely Motion to Correct tolls the appeal period and the appellant can further extend the appeal period by filing a Motion for Extension of Time to file the Motion to Correct.

The CRB dismissed the claimant's appeal as untimely in *Tomaszek and Tomascek v. Norton's Auto & Marine Service, Inc.*, 6249 CRB-1-18-3 (March 1, 2019), after finding that the commissioner issued his Finding on February 8, 2018, the claimant did not file a Motion to Correct the Finding or any other post-judgment motion, but did file a Petition for Rreview on March 1, 2018, one day outside the statutory twenty-day deadline for filing appeals.

B. Motion to Correct

In *Diaz v. Department of Social Services*, 184 Conn. App. 538 (2018), the Appellate Court ruled that the CRB properly denied claimant's Motion to Correct, which it characterized as an effort to substitute findings supporting compensability with those reached by the trial commissioner. The Appellate Court agreed, stating "The plaintiff cannot expect the commissioner to substitute the plaintiff's conclusions for his own. Furthermore, this claim amounts to little more than a restatement of her previous claim, which we already have rejected [earlier in] this opinion. Because the findings of the commissioner were supported by the evidence and included all material facts as determined by him, we conclude that the board properly affirmed the commissioner's denial of the plaintiff's Motion to Correct." Id., at 558.

The trial commissioner in *Ayna v. Grabel/CT Movers, Inc.*, 6214 CRB-7-17-8 (March 6, 2019), granted an extension of time for claimant to file a Motion to Correct the findings, but then denied the claimant's motion in part because it sought to reargue the case by setting forth claimant's self-serving opinions in his favor, and in part because the motion failed to cite any specific pages

in the record or to set forth any relevant portions of the documentary evidence to support assertions that the trial commissioner's conclusions were incorrect or unsupportable as required by Regulation 31-301-4. When the claimant sought to address these deficiencies with an amended Motion to Correct, the trial commissioner denied the amended motion, the trial commissioner responded with an order stating, "Denied for untimeliness; no leave granted to file second Motion to Correct." The CRB reviewed the two motions to correct in some detail and concluded that the trial commissioner did not abuse her discretion by denying the amended Motion to Correct. "We believe that a completed motion to correct is one that comports with the format prescribed by Administrative Regulation § 31-301-4 and pertinent case law. We are not persuaded, and nor should the claimant have interpreted, that the granting of an extension of time represented the opportunity to submit a first draft of a motion to correct for the commissioner's consideration and then, upon learning of the motion's procedural deficiencies, to file a more refined motion to correct for the commissioner's review." Id., at 9-10.

C. Motion to Submit Additional Evidence

In *Diaz v. Department of Social Services*, 184 Conn. App. 538 (2018), the Appellate Court ruled that the CRB properly denied claimant's Motion to Submit Additional Evidence at the CRB level that was discovered in a freedom of information request made more than nine months after the formal hearing evidence was closed. With respect to such motions, the Appellate Court noted that the CRB is authorized to review additional evidence under limited circumstances established by § 31-301(b), according to the procedures established by § 31-301-9 of the Regulations of Connecticut State Agencies, which provide, in pertinent part, "If any party to an appeal shall allege that there were good reasons for failure to present it in the proceedings before the commissioner, he shall by written motion request an opportunity to present such evidence or testimony to the compensation review division, indicating in such motion the nature of such evidence or testimony, the basis of the claim of materiality, and the reasons why it was not presented in the proceedings before the commissioner.…" Id. The Appellate Court found that the documents the claimant sought to submit his additional evidence were in existence approximately four years before the formal hearing on her workers compensation claim. The Appellate Court determined that the CRB could have reasonably concluded that the claimant did not demonstrate that she had good reason for failing to present such evidence at the formal hearing. Thus, the Board did not abuse its discretion in denying the claimant's Motion to Submit Additional Evidence.

See discussion of *McGrath v. Western Connecticut State University*, 6231 CRB-7-17-11 (November 28, 2018), below in § VI.B.

V. STATUTORY SECTIONS – CHAPTER 568

A. § 31-275(1)-AOE/COE

1. Acts Incidental to Employment: The CRB in *Bagley v. Gardner Heights Health Care Center, Inc.*, 6140 CRB-4-16-10 (June 28, 2018), affirmed the trial commissioner's conclusion that the claimant CNA's injury arose out of and in the course of employment when she was injured while removing snow from her vehicle at the end of her workday after her employer had plowed in her car. The Board characterized the claimant's actions as "incidental to the employment," which the board described as a "quintessential factual determination." Id., at 6. The respondents acknowledged that the claimant was in a place where she could reasonably have been expected to be when she was injured but disputed whether the employer acquiesced in her decision to shovel out the car, arguing that snow removal was beyond the scope of the claimant's duties as a CNA, and the respondent employed maintenance staff to handle the task of shoveling snow. The CRB was not persuaded that the trial commissioner erred in concluding to the contrary. "It is clearly implied in any employment relationship that once an employee has completed his or her duties, he or she is able to leave the premises and return home. In the present matter, the claimant found she was unable to do so, and the trial commissioner concluded that the claimant's car had been plowed in by an agent of the respondent-employer. It would be unreasonable under these circumstances not to expect that the claimant might locate any tool at hand in order to extricate her car from the snow and return home." Id., at 7-8. The board likened the facts of the case to those of *Katz v. Katz*, 137 Conn. 134 (1950), in which the Supreme Court upheld an award of benefits to a worker whose employer ordinarily drove her home from work, but directed her to walk to a bus stop one evening after a snowstorm when the company parking lot had been plowed in, at which time she was struck by a passing vehicle on a public street.

2. Injury at Employee's Place of Abode: Section 31-275 (1)(E) states: "a personal injury shall not be deemed to arise out of the employment if the injury is sustained: (i) At the employee's place of abode, and (ii) while the employee is engaged in a preliminary act or acts in preparation for work unless such act or acts are undertaken at the express direction or request of the employer…." Id. In *Biggs v. Combined Insurance Company of America*, 6247 CRB-7-18-2 (April 12, 2019), the CRB affirmed the trial commissioner's dismissal of a claim because the injury occurred at home and not during the course of employment. The claimant was an insurance sales associate who maintained what she claimed was a home office in a sun porch where she had a desk, some file cabinets and a tote bag. She testified that she sold insurance policies by making appointments and going door-to-door on sales calls. She used her home desk to write thank you notes to individuals to whom she had sold policies and to review her folders and plan her sales calls for the day. She was required, however, to attend mandatory 9 AM morning meetings at various locations around the state at which the employer provided her and other sales associates with leads and referrals for new business. The claimant testified that she used the sun porch exclusively as a home office, did not use it for any other purpose, and that she did so with her employer's knowledge. She did not, however, claim the porch as a home office in

her tax returns. She testified this was because her salary was so low that she would not have been eligible to take the deduction for home office expenses. The claimant's injury occurred when she put her folders and binders into her tote bag and started walking from her sun porch to her car. The ground was icy and she slipped and injured her left hip while getting into her car.

The trial commissioner found that the claimant was a traveling salesperson who did not have a desk job and who used her sun porch for business at her own convenience, and that there was no convincing evidence that she had a home office at the behest of her employer or that her job required meeting clients at home. The commissioner deemed the claimant's failure to produce federal tax returns "a glaring deficiency in her case" and "a pivotal fact on the issue of compensability." The commissioner concluded that the claimant's workday actually commenced at 9 AM when the team meetings convened, and that her activities while in the driveway of her home constituted "a preparatory act for work," and accordingly concluded that the claimant's injuries did not arise out of or in the course of employment.

The CRB affirmed, distinguishing *Tutunjian v. Byrnes, Brooks & McNeil*, 5618 CRB-6-11-1 (March 21, 2012), wherein the CRB affirmed a finding and award by a commissioner who found credible the claimant's narrative that he had been directed by his employer to work from home on days when weather conditions made commuting unsafe and the claimant was injured while mailing a letter on such a day. The *Tutunjian* trial commissioner applied a three-prong test derived from *Matteau v. Mohegan Sun Casino*, 4998 CRB-2-05-9 (August 31, 2006), "in which a claimant must demonstrate [first] 'a regular and substantial quantity of work to be performed at home, [second] the continuing presence of work equipment in the home, and [third] special employment circumstances that make it necessary rather than personally convenient to work at home.'" Id., quoting *Labadie v. Norwalk Rehabilitation Services*, 4254 CRB-7-00-6 (June 21, 2001). Unlike *Tutunjian*, the claimant in the present matter presented no documentary evidence indicating that the employer had directed her to work from home. Moreover, her testimony did not reflect that there were any special employment circumstances in effect on the date of her injury obliging her to work out of her home. Rather, it appeared that she found it personally convenient to handle certain tasks at home.

The court looked further to *Baron v. Genlyte Thomas Group, LLC*, 132 Conn. App. 794, cert. denied, 303 Conn. 939 (2012), in which the Appellate Court upheld a decision concluding that an injury sustained by a salesman traveling between what he claimed was a home office and a work assignment was not compensable. As in the present case, the claimant did not claim his residence as a home office for tax purposes, the trial commissioner concluded he worked from home as a matter of personal convenience, and the trial commissioner credited testimony that the employer did not direct the claimant to set up a home office.

The claimant in *Biggs* argued that in light of current business trends which place an increased emphasis on the performance of job duties at home, the trial commissioner should have found her injury compensable. The CRB noted that the claimant in *Matteau* raised similar arguments some thirteen years ago and the legislature has not addressed the provisions of § 31-275(1)(E)

since. “Thus, in light of the ‘legislative acquiescence’ on the part of the General Assembly, it may be reasonably inferred that the legislature intended that injuries such as those sustained by the instant claimant should not be deemed compensable, and this Tribunal must act in a manner consistent with the legislature’s intentions.” *Biggs*, at 11.

B. § 31-275(10) [Definition of Employer] - Sole Member Limited Liability Company:

In *Gould v. City of Stamford*, 331 Conn. 289 (2019), the Supreme Court determined that the sole member of a single-member limited liability company (LLC) qualified as an employee of the LLC who was, therefore, eligible for concurrent employment benefits from the Second Injury Fund pursuant to § 31-310. The claimant, who was injured in the course of part-time employment with the City of Stamford, claimed that he was an employee of a single-member limited liability company for which he was the sole member. Relying upon Commission Memorandum No. 2003-02 stating that single-member LLC’s should be treated pursuant to the opt in/opt out provisions applicable to sole proprietors pursuant to § 31-275(10) and should therefore be presumed to be excluded from participation in the Act unless they have elected to be covered, the trial commissioner determined that the claimant was not an employee of the LLC for purposes of the act and, therefore, did not qualify for concurrent employment benefits. The CRB affirmed, after which the claimant appealed to the Appellate Court and the Supreme Court took the appeal on transfer pursuant to Conn. Gen. Stat. §51-199(c).

The Supreme Court reversed. Section 31-275(9)(A) defines an “employee” as “any person who “(i) Has entered into or works under any contract of service or apprenticeship with an employer, whether the contract contemplated the performance of duties within or without the state,” or “(ii) Is a sole proprietor or business proprietor who accepts the provisions of [the act] in accordance with subdivision (10).” Section 31-275(10) defines an “employer” as “any person, corporation, limited liability company, firm, partnership, voluntary association, joint stock association, the state and any public corporation within the state using the services of one or more employees for pay, or the legal representative of any such employer.…” The section further provides that “A person who is the sole proprietor of a business may accept the provisions of [the act] by notifying the commissioner, in writing, of his intent to do so. If such person accepts the provisions of [the act] he shall be considered to be an employer and shall insure his full liability in accordance with subdivision (2) of subsection (b) of § 31-284.”

The Supreme Court agreed with the claimant that “nothing in § 31-275(10) requires single-member limited liability companies to elect to accept the provisions of the act before their members are covered, and, therefore, the commission chairman had no authority to adopt [Memorandum No. 2003-02].” Id., at 307. After an extensive discussion of the differences between limited liability companies and sole proprietorships, the court concluded that the legislature’s choice not to include single-member limited liability companies in the opt in/opt out provision § 31-275(10) indicates that the legislature intended that single-member limited liability companies may be employers of their members.

The Supreme Court also reviewed the trial commissioner's determination that the claimant was not an employee of the LLC. The Second Injury Fund argued that the trial commissioner correctly determined that the claimant was not the LLC's employee because the claimant, not the LLC, had the right to control the means and methods used by used by the claimant and the performance of his duties. The Supreme Court recognized that the right to control test is the traditional test for determining the existence of an employer-employee relationship but noted that the test "generally has been used, however, to distinguish between an independent contractor and an employee, which is not the issue presented in this case." Id., at 314. Thus, the court framed the issue as "whether the sole member of a limited liability company who has the right to control the company and who also performs services for the company can be the company's employee. If the right to control test applied in this situation, then, contrary to the apparent legislative intent, the member of a single-member limited liability company could *never* be found to be the company's employee, because a single-member limited liability company can *only* exercise control over the member through the member." Id. The court found guidance in a Missouri Court of Appeals decision, *Lynn v. Lloyd A. Lynn, Inc.*, 493 S.W.2d 363 (Mo. App. 1973), in which the Missouri court found that the controllable services or right of control test was inappropriate for determining whether the sole owner and manager of a corporation was an employee of the corporation because owners are naturally apt to be under less control in the performance of their duties than the typical employee, but unlike independent contractors, they are intimately and permanently involved in the operation of the business. Instead of the traditional right to control analysis, the test should be, "If by reason of their employment they were subjected to the hazards of the occupation or industry, … They should be considered employees . . . . To hold that the decedent was not an employee at the time of his death because of the office he held and his stock ownership in the corporation is to disregard the separate and distinct legal identities of [the] decedent and [the corporation]. Since [the respondents] have failed to show that the separate identities were used as a subterfuge to defeat public convenience, for the perpetration of a fraud, or as a means to justify or wrong, [the court has] no reason to pierce the corporate veil in these proceedings." *Gould*, at 316, citing *Lynn*, at 366-67.

JPC comment: The Supreme Court in Gould *prefaced its analysis of the merits of the claim with the caveat that the Second Injury Fund argued only that the claimant was not an employee of the LLC, but "did* not *make the very different claim that* Intervale *[the LLC] has effectively been converted into a* sole proprietorship *because the plaintiff failed to observe the rules governing limited liability companies." Id., at 300 (emphasis in original).*

C. § 31-275(16)(B)(i) [Personal Injury- Social or Recreational Activity Exception]

In *Thomas v. City of Bridgeport*, 6206 CRB-3-17-7 (July 30, 2018), the CRB affirmed the trial commissioner's finding that a sports injury sustained while the claimant was "on the clock" was compensable. The trial commissioner, however, found that the claimant fractured his right femur while playing in a softball game during a picnic held by the city for all city employees during

work hours. The trial commissioner credited testimony from the claimant that he was recruited by a foreman to play because of his background as a cricket player, that his boss was intent on winning the game, and that he did not believe he could have refused to play and, if he had, failure to do so would have impacted his future employment. The respondents contended that the claimant's participation in the game was purely voluntary, that there were no employment consequences, and unsuccessfully sought a finding that the claimant was not entitled to compensation because the injury fell under the social or recreational activity exception to the definition of personal injury per § 31-275(16)(B)(i).

On appeal the respondents raised the same arguments and cited *Brown v. United Technologies Corp.*, 112 Conn. App. 492 (2009), *appeal dismissed*, 297 Conn. 54 (2010) (certification improvidently granted), as authority for reversing the decision. The CRB, however, distinguished *Brown*, in which the claimant was injured while pursuing "purely voluntary" power walks during her lunch break, and instead found the case indistinguishable from *Anderton v. WasteAway Services, LLC*, 91 Conn. App. 345 (2005), wherein the court found that the claimant had sustained a compensable "personal injury" based on findings by the trial commissioner that the claimant's injury arose out of a basketball game that was requested by the employers, played during working hours and that the claimant believed that he had to agree to play with his employers and that if he refused, his employers would not look favorably on him as an employee. Id., at 349. Thus, the CRB concluded, "As we can easily distinguish this case on the facts from *Brown* and cannot distinguish it on the law or the facts from *Anderton*, *stare decisis* leads us to affirm the Finding and Decision." *Thomas,* at 9.

D. § 31-291 [Principal Employers]

In *Barker v. All Roofs by Dominic*, 183 Conn. App. 612 (2018), cert. granted 330 Conn. 925 (2018), the Appellate Court affirmed the decisions of the trial commissioner and the CRB concluding that the City of Bridgeport was liable as a principal employer for injuries sustained by an employee of an uninsured subcontractor who fell from the roof of the city's transfer facility while working on a repair project contracted by the city with a general contractor that was also one insured. The city contended first, that § 31-291 does not apply to governmental entities because such entities are not engaged in any "trade or business" as contemplated by the statute. The Appellate Court found that this issue was specifically addressed and controlled by an early Supreme Court decision, *Massolini v. Driscoll*, 114 Conn. 546 (1932), wherein the Supreme Court stated, "The language of the statute is disjunctive – 'trade or business.' Both terms are, therefore, to be given their natural meaning, and are not used synonymously. 'Trade' commonly connotes the buying, selling or exchanging of commodities. 'Business,' however is a much broader term.… When applied to a public corporation, the term signifies the conduct of the usual affairs of the corporation." Id. at 553. The City contended that the Supreme Court decided *Massolini* incorrectly, an argument that the Appellate Court declined to address. As a fallback position, the City argued that the General Assembly abrogated the rule of *Massolini* by establishing the Second Injury Fund to provide benefits to injured workers whose employers failed to carry workers' compensation insurance. The Appellate Court rejected that argument on

the grounds first, that "there is nothing in the statute creating the Second Injury Fund that even refers to, much less purports to modify, the principal employer statute," *Barker*, 183 Conn. App. at 621; and second, because the Supreme Court has cited *Massolini* in the years since the Second Injury Fund was created. See, e.g., *Mancini v. Bureau of Public Works*, 167 Conn. 189 (1974) (finding public employer to be principal employer).

E. § 31-293 [Liability of Third Persons to Employer and Employee]

Section 31-293 governs the interplay or coordination of benefits between workers' compensation claims and third-party tort claims. If an employee's injury is caused by a third-party tortfeasor and if damages are recovered in a third-party civil action, the employer must be reimbursed from the net proceeds of the action after deducting attorney's fees and litigation expenses, for any workers' compensation benefits the employer has paid to or on behalf of the injured employee. In 2011, the legislature enacted P.A. 11-205, which amended § 31-293(a) to allow the employee, if the employee initiated the third-party action, to keep one third of the net proceeds due to the employer from that action, regardless of how much the employer is owed for reimbursement. The pertinent provision states "if the action has been brought by the employee, the claim of the employer shall be reduced by one third of the amount of the benefits to be reimbursed to the employer, unless otherwise agreed upon by the parties, which reduction shall inure solely to the benefit of the employee….." Conn. Gen. Stat. § 31-293(a). Case law interpreting § 31-293 long ago established that subsection (a) implicitly affords the employer a set off or credit, commonly known as a "moratorium" against future workers compensation liability in an amount equal to the net proceeds the employee received in the third-party action. See, e.g., *Enquist v. General Datacom*, 218 Conn. 19, 20-21 (1991). In *Callaghan v. Car Parts International*, LLC, 329 Conn. 564 (2018), the Supreme Court addressed the question of how the 2011 amendment allowing the claimant to keep one third of the net proceeds due to the employer applies to the employer's moratorium rights, and concluded that "the employee's one-third portion is not subject to the moratorium, and, as a result, the employer does not receive a credit against later arising benefits for the one-third portion paid to the employee." Id., at 568.

The *Callaghan* case arose from the following scenario. The claimant was injured in a work-related auto accident caused by a third party. He filed both a workers' compensation claim and a third-party tort claim that he eventually settled for $100,000, from which his net recovery after attorney fees and expenses was $66,000. At the time he settled the tort case, the employer had paid out some $74,000 in workers compensation benefits. Pursuant to the 2011 amendment to § 31-293, the claimant kept $22,000, representing his one-third share of the net proceeds, and paid over the remaining $44,000 to the employer. The employer then asserted a moratorium in the amount of the claimant's $22,000 net recovery and declined to pay additional workers' compensation benefits as they became due. This led to a formal hearing at which the trial commissioner concurred with the employer and allowed the moratorium. The CRB affirmed the trial commissioner's decision, concluding that because the text and legislative history of the 2011 amendment did not explicitly direct that the moratorium should not apply, it should continue.

Contrary to the conclusions of the commissioner and the CRB, the Supreme Court concluded that the moratorium does not apply to the one-third reduction in favor of the claimant. The 2011 amendment "clearly and unambiguously intended for the one-third reduction to be for the employee's sole benefit. Although we agreed that the added text and the legislative history concerning its enactment do not specifically address the moratorium, applying the moratorium to the reduction would erode the benefit conferred on the employee by P.A. 11-205. The moratorium would require the employee to use the proceeds from the one-third reduction to pay any future expenses that otherwise would be covered by workers' compensation benefits from the employer and, thus, contradict the clear directive that the 'reduction shall inure *solely* to the benefit of the employee." Id., at 570 (emphasis added by Supreme Court). In reaching its conclusion, the Supreme Court noted that according to § 31-293(a) the "claim of the employer" consists of "(1) the amount of any compensation which [the employer] has paid on account of the injury which is the subject of the [third-party action] and (2) an amount equal to the present worth of any probable future payments which [the employer] has by award become obligated to pay on account of the injury." Conn. Gen. Stat. § 31-293(a). The Supreme Court observed, "The employer's claim thus includes any benefits it has already paid at the time of the disposition of the third-party action and any further expenses that the employer has already become obligated to pay by the formal workers' compensation award." *Callaghan*, at 572. The court further explained, "Prior to the enactment of P.A. 11-205, General Statutes (Rev. to 2009) § 31-293(a) gave the employer's claim complete precedence over the employee's right to receive damages from a third party, after deducting litigation costs and attorney's fees.… The text added to § 31-293(a) by P.A. 11-205 altered this arrangement. The current text insures that, regardless of the amount of an employer's claim, an employee who has brought the third-party action will receive at least one third of the net proceeds due the employer. The text accomplishes this by reducing the employer's claim by one third of the amount the employer otherwise would receive as reimbursement and directing that this reduction instead 'shall inure solely to the benefit of the employee.' P.A. 11-205 thus creates a clear benefit in favor of the employee, to the detriment of the employer, by taking funds the employer otherwise would be entitled to receive and, instead, allowing them to pass to the injured employee, even if the net proceeds from the third-party action were not enough to reimburse the employer's claim." Id. at 572-73.

The court acknowledged that P.A. 11-205 is silent regarding whether an employer's moratorium should apply to the claimant's net recovery. The moratorium itself is not explicitly included in the statute either, but cases such as *Enquist*, supra, have interpreted the section to implicitly allow the moratorium as the functional equivalent of the statutory claim of the employer for "any future expenses that the employer has already become obligated to pay by the formal workers' compensation award." Conn. Gen. Stat. § 31-293(a). "If the moratorium were applied to the one-third reduction mandated by P.A. 11-205, the employee would be required to use the proceeds from the one-third reduction in lieu of future benefits that otherwise would be paid by the employer. Doing so would erode the benefit that the public act provides to the employee. . . . The moratorium would instead ultimately cause the one-third reduction to benefit the employer by relieving it of its obligation to pay future workers compensation benefits until the employee exhausted the proceeds he received. In our view, shifting the benefit away from the employee, by

requiring him to use the proceeds from the one-third reduction, would run contrary to the purpose and plain language of § 31-293(a), which evidences a clear intent for the employee alone to retain the benefit of the one-third reduction. By stating that the reduction was 'to inure solely to the benefit of the employee,' the legislature expressed a clear intention with P.A. 11-205 that the employee, and no one else, should enjoy the use of that portion of the third-party proceeds." Id., at 575-576.

Letaj v. ATMI, Inc., 6186 CRB-5-17-4 (January 11, 2019), addressed the question of whether in order to assert a valid lien pursuant to § 31-293, a respondent's written notice of lien must be sent directly to the named defendant in the third-party lawsuit, or whether sending such notice to legal counsel representing the interests of the third-party defendant is also valid. The trial commissioner ruled that the respondent-insurer never mailed its notice of lien directly to the named defendant and from that, concluded they had never perfected a lien on the proceeds of the third party claim and dismissed their claim for reimbursement. The CRB reversed, noting that in *Schreck v. Stamford*, 250 Conn. 592 (1999), the Supreme Court held that notice to a party's attorney is sufficient to serve as notice to the party.

F. § 31-294c [Notice of Claim]

1. In General: The CRB reversed the trial commissioner's dismissal pursuant to the statute of nonclaim in *Banks v HCR Manor Care, Inc.*, 6227 CRB-6-17-10 (October 3, 2018). The claimant, who last worked for the employer in 2008, filed a Form 30C in 2012 describing the injury and how it happened as follows: "Frontal Temporal Dementia. Job-related Stress, overworked, Compassion for her residents, dedication for her job, medication, lack of sleep, and not being aware of those problems, and the mental impairment that was caused by the physical and chemical functioning of the brain that caused a lack of logical judgment and reasoning." The claimant checked the box on the Form 30C indicating that the injury was related to occupational disease or repetitive trauma. The trial commissioner dismissed the claim on the ground that the Form 30C was filed beyond three years from the claimant's last day of work for the employer. The CRB observed that the Workers Compensation Act is silent regarding how to calculate the statute of limitations for repetitive trauma injuries, but that in *Discuillo v. Stone & Webster*, 242 Conn. 570 (1997), the Supreme Court held that for jurisdictional purposes repetitive trauma claims fall into one of two categories, either accidental injury or occupational disease, and that the trial commissioner must determine whether the facts of a case more closely resemble accidental injury or occupational disease.

The statute of limitations for accidental repetitive trauma claims is one year from the last date of last injurious exposure which, in this instance, would have been the final day of the claimant's employment in 2008. The statute of limitations for occupational disease set forth in § 31-294c(a), however, requires notice within three years "from the first manifestation of a symptom of the occupational disease," which the Supreme Court determined in *Ricigliano v. Ideal Forging Corp.*, 280 Conn. 723 (2006), means that the statute begins to run "when the claimant first learned that there was a causal connection between his disease and his employment." Id., at 745.

The CRB noted that in the present case the claimant contended that she did not become aware of her frontal temporal dementia diagnosis and its possible relationship until November 4, 2011 and that her Form 30C was filed on March 12, 2012, which was within three years of the date the claimant alleges she gained knowledge of the possible connection between her employment and her injury. "Although this Tribunal does not entertain formal pleadings, we must decide whether the claimant's notice of claim presents a colorable claim for occupational disease. In so doing, we must construe the jurisdictional facts stated by the claimant as true and 'in their most favorable light.…' See *Conboy v. State*, 292 Conn. 642, 651 (2009), quoting *Filippi v. Sullivan*, 273 Conn. 1, 8 (2005). Using that standard, we believe that the claimant should be given the opportunity to prove she suffered a compensable personal injury consistent with our Act's provisions for occupational disease.… What we determine in the present appeal, however, is not whether the claimant is entitled to benefits but, rather, whether she should be accorded the opportunity to demonstrate her eligibility for benefits pursuant to the occupational disease provisions of the Workers' Compensation Act." *Banks*, at 5.

2. Medical Care Exception: Subsection (c) of § 31-294c states that "Failure to provide a notice of claim under subsection (a) of this section shall not bar maintenance of the proceedings if , , , within a one-year period from the date of the accident or within a three-year period from the first manifestation of a symptom of the occupational disease, as the case may be, … an employee has been furnished, for the injury with respect to which compensation is claimed, with medical or surgical care as provided in § 31-294d." The claimant in *DeJesus v. R.P.M. Enterprises, Inc.*, 6201 CRB-1-17-7 (November 8, 2018), was an auto scrapyard employee who was trying to remove parts from a car that was lying on its side, propped up by a pipe, when the car fell onto him causing serious injuries. The claimant's coworkers went to locate means to transport him from the accident site, found a wet old mattress, placed him on the mattress and drove him to the hospital. Evidence at the formal hearing further indicated the owner of the business followed them to the hospital, although he and the coworker did not enter the hospital. The owner indicated he continued to pay the claimant $500 per week after the accident because he and the claimant were friends, and that he also purchased an electric wheelchair for the claimant and built a wheelchair ramp at the claimant's home. The respondent argued that merely transporting an employee to a hospital is an inadequate basis for establishing that the medical care exception had been satisfied and that they lacked actual knowledge of the nature of the injury.

The CRB, however, found the claim "indistinguishable" from *Wetmore v. Paul Frosolone and Seasonal Services of Connecticut, LLC*, 6176 CRB-5-17-2 (February 7, 2018), in which the board observed that "it should have been immediately apparent to the respondent that the claimant has sustained a serious work-related injury for which a claim for workers' compensation benefits was highly probable. The claimant had not sustained some form of idiopathic injury for which a claim under Chapter 568 was unlikely to be sought but, rather, had sustained a traumatic injury peculiar to the risks attendant in operating the respondent's lawn-mowing equipment." Id. Thus, the CRB concluded that the evidentiary record provided an

adequate basis for the commissioner's conclusion that the requirements for establishing the medical care exception had been satisfied.

G. § 31-294c [Preclusion]

In *Quinones v. R.W. Thompson, Co., Inc.*, 188 Conn. App. 93 (2019), the Appellate Court affirmed a CRB decision affirming the denial of a Motion to Preclude on a hearing commenced by the late Commissioner Clifton Thompson and concluded and decided by a substitute commissioner after Commissioner Thompson's death. The commissioner found that while the respondents did not file a Form 43, they commenced payment of benefits within 28 days and the claimant received benefits until the Commission approved a Form 36. The Appellate Court recognized the dilemma faced by employers who wish to accept a claim while preserving their rights to contest the extent of the claimant's disability. "The language of Form 43 indicates that it is to be used by employers who are contesting their liability to pay alleged compensation benefits. The form does not include a space for those employers who initially accept liability but may later, after investigation, choose to contest the extent of the disability. This distinction is not a superficial one, as an employer who is contesting liability is distinguishable from one who solely contests the extent of the disability.… Although we have no doubt that employers may have previously used Form 43 to disclaim only the extent of a disability and not liability, amending the form to suit their specific disclaimer needs, that procedure unfairly requires such employers either to amend the form or to state untruthfully their intention to contest liability in order to preserve their ability to later challenge the extent of disability. The legislature, however, designed preservation of such challenges by allowing an employer, *instead of filing a Form 43*, to commence payment of compensation for the alleged injury within the twenty-eight day period; and granting the employer who timely commences payment a one-year period in which to contest the employee's right to receive compensation on any grounds *or the extent of his disability*…." Id., at 107-108, citing *Dubrosky v. Boehringer Ingelheim Corp.*, 145 Conn. App. 261, 271-73, cert. denied, 310 Conn. 935 (2013). Applying these principles to the present claim, the Appellate Court concluded, "in the present case, the [employer] did not contest the liability of the [claimant's] injury and compensated him until the approval of a Form 36. Additionally, there was no reason for the [employer] to contest the extent of the [claimant's] injury until obtaining the information alleged in the Form 36, which was filed less than a year after receiving the [claimant's] Form 30C. … Considering the facts of the present case, the board did not misapply the law to the subordinate facts or draw and unreasonable conclusion. Therefore, we agree with the decision of the board." Id., at 108. This case also presents procedural issues arising from the death of the original trial commissioner during the pendency of the proceedings that are discussed above in § II.A.

In *Rivera v. Patient Care of Connecticut*, 188 Conn. 203 (2019), the Supreme Court upheld the decision of the CRB affirming a trial commissioner's decision approving a Form 36 based on a finding that the claimant had reached maximum medical improvement as to one of three injuries claimed in her case that was accepted by the respondents and for whom she had been collecting TT benefits. The claimant argued on appeal that the Board erred in affirming the trial

commissioner's ruling because the commissioner did not require the respondents to prove that she had a work capacity and improperly shifted the burden to her to prove that she did not. The appellate court held that because the commissioner limited his finding on the respondent's Form 36 to the issue of whether the claimant reached maximum medical improvement as to her injury, he did not need to address the issue of the claimant's work capacity. "The plaintiff claims that the board erred in affirming the commissioner's approval of the Form 36 because the commissioner failed to require the defendant to prove that she had a work capacity and improperly shifted the burden to her to prove that she did not have a work capacity. We disagree. As the board aptly noted, the defendant's Form 36 requested only a finding of maximum medical improvement as to the plaintiff's right lower extremity and a change to the plaintiff's disability designation as to her right lower extremity from temporary partial to permanent partial. The defendant did not seek any change to the plaintiff's incapacity benefits. Consequently, the commissioner did not need to address the issue of the plaintiff's work capacity. Accordingly, the plaintiff's claim that the burden of proving that she did not have a work capacity was improperly shifted to her is without merit." Id., at 207-208. The Appellate Court reached a similar conclusion *Mikucka v. St. Lucian's Residence, Inc.*, 183 Conn. App. 147 (2018), discussed above in § II.B.

In *Dominguez v. New York Sports Club*, 6210 CRB-7-17-8 (August 28, 2018), the CRB reversed a decision from the trial commissioner granting claimant's Motion to Preclude in part. The trial commissioner precluded the respondents from contesting compensability but permitted them to contest the extent of the claimant's disability pursuant to *Dubrosky v. Boehringer Ingelheim Corp.*, 145 Conn. App. 261 (2013), cert. denied, 310 Conn. 935 (2013). The commissioner's decision arose when the commissioner found that respondents filed a late Form 43 denying compensability for an injury for which the claimant had presented no medical bills and requested no indemnity benefits within the 28-day period thereby preventing the respondents from complying with the safe harbor provisions of 31-294c(b). The trial commissioner acknowledged that *Dubrosky* dealt with an accepted work injury while the present claim deals with a wholly denied injury but concluded that *Dubrosky* nonetheless applied. Thus, she ordered the respondents to accept the underlying injury but allowed them to contest the extent of disability.

The claimant appealed arguing that the trial commissioner erred in failing to grant the Motion to Preclude in full and that the claimant should be precluded from contesting the extent of the injury pursuant to *Donohue v. Veridiem, Inc.*, 291 Conn. 537 (2009) and *Harpaz v. Laidlaw Transit, Inc.*, 286 Conn. 102 (2008). The CRB agreed and reversed the trial commissioner's decision, stating they were "skeptical that the respondents' conduct in this matter constituted a 'good faith' contest which was limited to challenging the extent of the claimant's disability." Id., at p. 5. The Board began its analysis by first examining "what the disclaimer actually disclaims," and found that in their Form 43, the respondents contested whether the claimant sustained any injury in the course of employment, not the extent of that injury. The CRB reviewed cases involving the "safe harbor" provision including *Dubrosky* and the Supreme Court's earlier decision of *Adzima v. UAC/Norden Division*, 177 Conn. 107 (1979), and found that the common thread was that the

respondents, "either through documentation or through their conduct, had accepted the compensability of the underlying claim." *Dominguez*, at 7.

The respondents argued that they were confronted with the same "impossibility" defense the respondents faced in *Dubrosky*, given that the claimant neither presented any medical bills for payment nor demanded any indemnity benefits within the 28 day period. The CRB distinguished the present situation from *Dubrosky*, however, explaining "The point at which the two cases diverge, however, involves an action which was *not* impossible for the respondents in the present matter to take, to provide some sort of representation that they had accepted the compensability of the incident described in the claimant's Form 30C. The respondents in *Dubrosky* did do this; however, in the present matter, the respondents filed a Form 43 explicitly challenging the causation of the claimant's injury." *Dominguez*, at 9. "Although it is true that the claimant, for reasons unknown, did not seek payment for his medical treatment through the respondents' workers' compensation insurer or seek indemnity benefits for his lost time while treating for the injury, we are not persuaded that the respondents were prejudiced because they were somehow impeded in their ability to respond to and investigate the Form 30C later filed by the claimant." Id., at 11. Thus, "In the present matter, the claimant filed a jurisdictionally proper notice of claim and the respondents filed an untimely disclaimer denying liability. At no time did the respondents 'cure' the fact that it was no longer legally possible to contest compensability by proffering a voluntary agreement or providing another form of evidence that they had accepted the claim. Under these circumstances, we believe the present matter is distinguishable from *Dubrosky*, supra, and the directive of *Donohue*, supra, compels us to reverse the trial commissioner. Id., at 13.

The CRB reached the same result in *Salerno v. Lowe's Home Improvement Center*, 6101 CRB-6-16-5 (November 14, 2018), citing *Dominguez*, supra, in affirming the trial commissioner's decision granting preclusion after finding that the respondents did not file a Form 43 until some 18 months after receipt of claimant's Form 30C and that they did not pay the claimant for any of his lost time or for the medical treatment related to his injury at any time during the one year safe harbor period. The respondents invoked *Dubrosky*, supra, arguing that because the claimant did not seek indemnity benefits or submit medical bills within 28 days of filing his Form 30C, it was "impossible" for them to comply with the safe harbor provisions of §31-294c(b), and argued that the claimant obtained medical treatment through group health insurance. The CRB found these arguments "indistinguishable" from those the respondents raised unsuccessfully in *Dominguez*. "Having reviewed the matter, we believe that *Dubrosky* can be distinguished on the facts. Moreover, we are not willing to extend the 'safe harbor 'provision… to cases in which there is no evidence that the respondents ever accepted the compensability of the claim, either through their course of conduct or through written documentation." *Salerno*, at 2.

The CRB rejected the respondents' contention that it was inappropriate for the commissioner to order preclusion in the absence of medical evidence supportive of the claim and upheld the trial commissioner's order granting preclusion in *Cariello v. Home Health Care Services, Inc.*, 5959 CRB-8-14-9 (June 12, 2018). After a formal hearing in which the respondents argued

unsuccessfully that the Form 30C was too vague to warrant preclusion, the respondents contended on appeal that preclusion cannot be granted unless the claimant presents a prima facie claim, including medical evidence, to the commissioner. The CRB expressed itself "perplexed by this argument, since it is abundantly clear that the Supreme Court, in both *Harpaz* [*v. Laidlaw Transit, Inc.*, 286 Conn. 102 (2008) and *Donohue* [*v. Veridiem, Inc.*, 291 Conn. 537 (2009)], bifurcated the issue of whether a respondent should be precluded from defending a claim from the issue of whether a claimant has met the burden of proof that benefit should be awarded. . . . [I]n *Donohue*, supra, the court gave its imprimatur to a trial commissioner to conduct an inquiry when the commissioner is not persuaded by the evidence in the record. " Id., at 3-4.

In *Lefevre v. TPC Associates, Inc.*, 6255 CRB-4-18-3 (2019), the CRB affirmed the trial commissioner's order granting a Motion to Preclude, upholding the trial commissioner's conclusion that a $20,000 donation from the employer to a GoFundMe account established by the claimant's sister-in-law to solicit charitable contributions from the general public to assist the claimant's family did not constitute "compensation" for purposes of invoking the "safe harbor" provisions of § 31-294c. "We confess to being troubled by the factual circumstances of this exceedingly difficult claim and recognize that our decision in this matter may appear inequitable in light of the respondent-employer's generosity in making a voluntary and sizable donation to the claimant's GoFundMe page. Nevertheless, it is axiomatic that our workers' compensation system is 'a creature of statute,' and this commission 'must act strictly within its statutory authority, within constitutional limitations and in a lawful manner.… It cannot modify, abridge or otherwise change the statutory provisions, under which it acquires authority unless the statutes expressly granted that power.'" (Internal citation omitted by CRB.) Id., at 10, citing *Waterbury v. Commission on Human Rights & Opportunities*, 160 Conn. 226, 230 (1971).

H. § 31-294f [Respondent's Medical Examination]

In *Hankard v. State Division of Criminal Justice/Office of the Chief State's Attorney*, 6226 CRB-8-17-10 (October 17, 2018), the CRB rejected the respondent's contention that the trial commissioner erroneously refused to allow an RME into evidence in derogation of § 31-294f. The issue arose as a result of the following scenario. At a formal hearing held March 23, 2017, the respondent indicated that their examiner had conducted an RME on January 9, 2017. The claimant objected on the ground that on October 5, 2016, the trial commissioner had directed the respondent to initiate an RME within 15 days and the respondent had failed to comply with that order and had not scheduled their doctor's deposition until April 27, 2017. In response to claimant's objection, the trial commissioner asked respondent's counsel whether he possessed any evidence that would demonstrate that they had initiated the RME within 15 days. When respondent's counsel indicated they had no such evidence, the trial commissioner sustained the claimant's objection.

On appeal the respondent argued pursuant to *Bailey v. State*, 65 Conn. App. 592 (2001), that a respondent essentially has an unlimited right to present an RME, "A commissioner must always protect the substantial rights of the parties [which] include the right of the employer…

Independently to examine the claimant, to notice his deposition, and to insist on hearing his personal testimony at a formal hearing." Id., at 604. The respondent also challenged the trial commissioner's reliance on the Workers' Compensation Commission Payor/Provider Guidelines, § I.A.6.c. of which directs respondents to schedule an RME within 12 calendar days of the receipt of medical records.

The CRB endorsed claimant's citation of *Briggs v. American Medical Response*, 4302 CRB-3-00-9 (September 24, 2001), *appeal dismissed* A.C. 22383 (January 31, 2002), in which the Board "remarked that a respondent cannot rely on the court's analysis in *Bailey* to 'hold the case open indefinitely.' . . . In the present matter, the respondent had not deposed its expert as of the date of the formal hearing, the claimant asserted he was prejudiced by the delay, and the trial commissioner found the claimant's position meritorious. It is well-settled that pursuant to General Statutes § 31-298, trial commissioners retain a great deal of discretion in managing the proceedings before them, particularly with regard to evidentiary issues. . . . In order to reverse the trial commissioner's conclusion on this issue, we would need to determine that his decision constituted an abuse of discretion." *Hankard*, at 10-11, quoting *Briggs*.

The CRB found additional support for the trial commissioner's actions in *Goulbourne v. State/Department of Correction*, 5461 CRB-1-09-5 (May 12, 2010), *appeal withdrawn*, A.C. 32294 (June 30, 2011), wherein the trial commissioner refused to admit an RME into evidence because the respondents had originally defended the claim solely on jurisdictional grounds and the case was subsequently found to be jurisdictional invalid. The Board concluded that the trial commissioner could reasonably find that the respondent had not obtained its RME within a reasonable timeframe and, pursuant to § 31-298, bar the RME from being introduced as evidence. "The respondent was offered the opportunity to obtain an RME but failed to exercise its right in a reasonable manner. We conclude that this decision did not constitute an abuse of discretion and therefore find no error." *Hankard*, at 12.

I. § 31-296 [Voluntary Agreements]

In the course of the formal hearing for *Dominguez-Sanchez v. Ta Caislean, Inc., d/b/a TLC Lawn and Landscaping Service*, 6266 CRB-5-18-4 (March 28, 2019), the claimant submitted into evidence of a voluntary agreement that had never been presented to the Workers' Compensation Commission for approval and argued unsuccessfully that the respondents were estopped by this document from contesting the causation of the injuries it described. The CRB found no error, noting that the respondents had already filed a Form 43 contesting whether the claimant's injury occurred in the course of his employment. The CRB concluded, "In any event, even in cases in which claimant's attempt to assert preclusion, respondents are permitted to contest the extent of disability and the nexus between employment and the need for medical treatment if they have proffered a voluntary agreement to the claimant within the one-year 'safe harbor' period under § 31-294c(b). See *Grzeszczyk v. Stanley Works*, 5975 CRB-6-14-12 (December 9, 2015), *appeal withdrawn*, A.C. 38743 (June 15, 2016). We also note that in circumstances in which a voluntary agreement was agreed to by the parties but never approved by the commissioner, a party can

subsequently decide to rescind its approval. See *Snyder v. Gladeview HealthCare Center*, 5735 CRB-8-12-2 (February 27, 2013), aff'd, 149 Conn. App. 725, cert. denied 312 Conn. 918 (2014). It is axiomatic that the burden rests with a claimant to establish entitlement to benefits by presenting evidence which the commissioner deems persuasive. As such, we do not believe that the commissioner in the present matter erred by allowing the respondents to contest this claim." Id., 9-10 (some citations omitted).

J. § 31-303 [Late Payment Penalty]

In *Naveo v. Mastec, Inc.*, 6219 CRB-5-17-9 (August 30, 2018), the CRB affirmed the trial commissioner's decision not to apply a late payment penalty of a stipulation that correctly listed the street address and ZIP Code of the nonresident pro se claimant, but the town was incorrectly listed. The trial commissioner found that the claimant sent an email to the respondents 23 days after approval of the stipulation providing an address with the town name changed. One day after receipt of the claimant's email, the respondents sent payment via FedEx Express that the claimant received and cashed that same day. At the formal hearing on the penalty, the respondents also offered a USPS tracking sheet reflecting that the original payment was timely "Delivered, Left with Individual" at the address listed on the stipulation. Relying on *Marchand v. The Phineas Corp., d/b/a Sunrise Group*, 5687 CRB-2-11-10 (September 18, 2012), and *Melillo v. Bayer Corp.*, 5490 CRB-3-09-8 (September 15, 2010), in which the board held that respondents' initiation of payment within the statutory time frame did not trigger the penalty provision of § 31-303, the board concluded that the respondents' actions constituted initiation of payment that met the commencement requirement of the statute.

K. § 31 306 [Survivor's Benefits]

See § VI.C. below for discussion of cases discussing the availability of death benefits for § 7-433c heart and hypertension claims .

L. § 31-307(e) [Social Security Offset]

Dahle v. The Stop and Shop Supermarket Company, LLC, 185 Conn. App. 71 (2018), is an unusual case in which a pro se claimant claimed that she was entitled to temporary total disability benefits without a Social Security offset pursuant to § 31-307(e) notwithstanding that the issue had been resolved against her in a formal hearing in 2008 that was affirmed by the CRB in 2009 with no further appeal taken. In the present proceedings, the claimant contended that she should have been awarded benefits without the Social Security offset because errors and delays by the commissioner in 2008 and by the CRB in 2009 resulted in a delay in obtaining compensation which, as she understood it, made her subject to the offset. The present issue arose when, in 2014, the claimant underwent surgery that related back to her original injury, after which she received TT benefits subject to the Social Security offset. A formal hearing ensued at which the claimant alleged she was entitled to TT without the offset, that the prior decisions were incorrectly decided, and that because of delays in her medical treatment the commissioner

could order the respondents to pay TT benefits at the full rate without regard to the offset. The trial commissioner ruled that the offset applied, the CRB affirmed as did the Appellate Court in the present case. The Appellate Court ruled that the CRB properly refused to address claimant's arguments regarding "past incorrect evidence" and "new evidence," inasmuch as the CRB did not have the authority to "correct" findings from the 2008 decision that became final when the claimant did not appeal from the CRB decision affirming it. The pro se claimant further claimed that the offset should not apply because negligence by the prior trial commissioner and employer's representatives in the handling of her case "resulted in delays in treatment that made her subject to the offset." Although the claimant repeatedly insisted she was not seeking a waiver of the offset, the Appellate Court said that inasmuch as her claim was governed by the law on the date of injury which included the offset, her request for benefits without the offset is the functional equivalent of requesting a waiver. Inasmuch as the claimant provided no authority, and the Appellate Court found none, that support supports such a waiver, the CRB's decision was affirmed.

M. § 31-308(a) [Temporary Partial Disability]

In *Gould v. City of Stamford*, 331 Conn. 289 (2019), the Supreme Court determined that the sole member of a single-member limited liability company (LLC) qualified as an employee of the LLC who was, therefore, eligible for concurrent employment benefits from the Second Injury Fund pursuant to § 31-310. This case is discussed in greater detail above in § V.B.

N. § 31-308(b) [Permanent Partial Disability]

In an issue of first impression for Connecticut-- and apparently the United States-- the CRB affirmed the trial commissioner's finding that the claimant, who had undergone a heart transplant as a result of a compensable injury, was not entitled to specific indemnity benefits for a 100% permanent partial disability of his native heart but was entitled to an award for a 23% permanent partial disability of his transplanted heart. *Vitti v. City of Milford*, 6246 CRB-4-18-2 (January 17, 2019). Citing what the claimant argued was the plain meaning of § 31-308(a), which provides specific indemnity benefits for "the loss of the member or organ and the complete and permanent loss of use of the member or organ," id, the claimant compared the loss of the native heart has analogous to the amputation of a limb. In support of his position the claimant cited *Wrenn v. Connecticut Brass Co.*, 96 Conn. 35 (1921), in which the claimant sustained a severe fracture to his arm that surgeons unsuccessfully attempted to repair leaving the claimant with an arm that was rendered useless for industrial purposes, with regard to which the court wrote "All reasonable efforts should be used to save an injured arm or limb, and thus prevent the necessity for its amputation, or its complete loss of usefulness.… Then, unless something further must be done to improve or heal the member, there exists the condition described in the statute, 'the complete and permanent loss of the use of one arm,' and the specific compensation provided by statute is then due." Id., 36-37.

The CRB noted, however, that the *Wrenn* court also stated, "The loss of the arm through amputation occurs when the amputation takes place. The complete and permanent loss of the use of the arm occurs when no reasonable prognosis for complete or partial cure, and no improvement in the physical condition or appearance of the arm can be reasonably made. Until such time the specific compensation for the loss of the arm, or for the complete and permanent loss of its use, cannot be made." Id., 38. Applying those principles to the case before it, the CRB stated "in the present matter, the native heart was removed. However, unlike the state of the medical healing arts at the time of our supreme court's consideration of *Wrenn*, in the matter at bar, a heart transplant procedure did offer a 'reasonable prognosis for complete or partial cure.…' Id. Further, to the degree that the claimant's transplanted heart carried some degree of partial disability, our Act provided compensation for that condition." *Vitti*, at 5. The Board went on to acknowledge, "We understand the claimant's argument that the complete removal of the heart organ is in effect and amputation of the organ. However, unlike the amputation of a limb, the claimant here was provided with an actual living replacement organ. That replacement organ served to improve the physical condition of the claimant. It not only extended his life, but vastly improved the quality of his life. That is not to say that the claimant's transplanted heart relieved the claimant of all degree of disability." Id.

In *Hankard v. State Division of Criminal Justice/Office of the Chief State's Attorney*, 6226 CRB-8-17-10 (October 17, 2018), the respondent argued pursuant to *Safford v. Owens Brockway*, 262 Conn. 526 (2003), that when the trial commissioner awarded the claimant benefits for a 25% permanent partial disability based on the opinion of a doctor who originally opined that the claimant's disability was between 20% and 30%, it was error for the commissioner to choose a specific number within that range. The Board distinguished *Safford*, in which the trial commissioner was confronted with three ratings of impairment from three different doctors, with the present situation, in which a single medical witness opined on the issue of permanency. Moreover, the doctor stated in his deposition that he "would be comfortable with" a 25% PPD rating. The Board cited *Aylward v. Bristol/Board of Education*, 5756 CRB-6-12-5 (May 15, 2013), aff'd 153 Conn. App. 913 (2014) (per curiam), for the proposition that "we are not allowed to speculate on what evidence the trier of fact finds persuasive and reliable in the absence of the commissioner identifying such evidence," id., and *Lopez v. Lowe's Home Improvement Center*, 4922 CRB-6-05-3 (March 29, 2006), for the additional principle that "it is within the discretion of the trial commissioner to accept some, but not all, of a physician's opinion." Id. Given that the trial commissioner found the physician's 25% rating reliable, the CRB found itself "unable, as an appellate panel, to intercede in this determination." *Hankard*, at 14.

O. § 31-312 [Reimbursement of Out-of-Pocket Expenses]

In *Melillo v. City of Derby*, 6164 CRB-4-16-12 (September 13, 2018), the CRB affirmed the trial commissioner's ruling denying reimbursement for travel expense to Connecticut for a claimant who had relocated to Florida after sustaining a compensable back injury. The Board relied on the guiding principles set forth in *Evenson v. Stamford*, 5541 CRB-7-10-4 (March 31, 2011), "when

a trial commissioner is attempting to determine whether a claimant is owed compensation pursuant to § 31-312(a), the commissioner must examine whether: (1) the claimant actually received medical care is a result of the trip; (2) the medical care rendered was 'reasonable or necessary'; and (3) 'the manner in which the claimant traveled to the medical care was 'reasonable or necessary.'" *Melillo*, at 9, quoting *Evenson*. The trial commissioner denied reimbursement after finding that the Connecticut physician had already provided a disability rating, the claimant had permanently relocated to Florida, and the claimant had obtained Florida doctors to manage her medical needs. The trial commissioner was unpersuaded by the claimant's contention that she "had to" return to Connecticut. As a result, the CRB concluded, "Nevertheless, despite the nature of the claimant's testimony, it may be reasonably inferred that the trial commissioner was simply not persuaded, given the totality of the circumstances, that the [claimant's trip to Connecticut] constituted necessary or reasonable medical care. Such a determination as well within the discretion of the commissioner and cannot be reversed on appeal if there is evidence in the record to support it." Id., at 10.

P. § 31-315 [Modification of Award or Voluntary Agreement]

In *DeLoreto v. Union City Steel, Inc.*, 6120 CRB-8-16-7 (September 19, 2018), the CRB upheld the trial commissioner's denial of a pro se claimant's motion to open the stipulation pursuant to § 31-315. In ruling on the motion to open the stipulation, the trial commissioner noted that the claimant was fully canvassed and the stipulation documents included a denial of liability by the respondents for the injuries for which the claimant later sought benefits. The claimant, who had retained and dismissed three experienced workers compensation practitioners in the course of his litigation, contended that his attorneys "refused to present any commissioner with certain unidentified medical records" pertaining to his injury thereby causing the canvassing commissioner to undervalue the claim. The claimant further deemed the stipulation a "fraudulent contract," alleged that he had been "tricked" into signing it, and, although he admitted he knew he was settling his case when he was canvassed, contended that other workers in his trade with similar injuries had received settlements ten or twelve times larger. In his Memorandum of Decision the trial commissioner cited and applied the standard of *Marone v. Waterbury*, 244 Conn. 1 (1998), which limits a commissioner's power to open the stipulation to "cases of accident; … to mistakes of fact; … and to fraud; … but not mistakes of law." *Id.*, 17. After setting forth detailed findings of fact establishing that the claimant was thoroughly canvassed and fully apprised of the issues addressed by the stipulation and the rights he was giving up by signing it, together with additional findings that the respondents and the canvassing commissioner had committed none of the improper acts attributed to them, the trial commissioner denied the claimant's motion. The CRB endorsed the trial commissioner's reliance on *Marone* and found that he conducted a thorough hearing and fully considered the issues presented by the claimant, that he did not believe the evidence presented by the claimant met the *Marone* standard, and that as such, he could reasonably issue a finding and denial of the claimant's motion.

Q. § 31-349(a) [Specific Indemnity Credit for Prior Compensation Payable or Paid]

Section 31-349(a) includes the following provision:

> If an employee having a previous disability incurs a second disability from a second injury resulting in a permanent disability caused by both the previous disability and the second injury which is materially and substantially greater than the disability that would have resulted from the second injury alone, he shall receive compensation for (1) the entire amount of disability, including total disability, less any compensation payable or paid with respect to the previous disability, . . .

Id. The CRB determined that the trial commissioner correctly applied a § 31-349(a) credit in *Melillo v. City of Derby*, 6164 CRB-4-16-12 (September 13, 2018), wherein the claimant was assessed a 15% PPD for his compensable back injury after having previously settled the tort case from an earlier MVA for which he was compensated for an 8% permanent partial disability. The trial commissioner concluded that the respondents were entitled to an 8% credit and owed the claimant "new money" for the 7% difference. The claimant contended that the trial commissioner misapplied the credit because when the treating physician, Dr. Beiner, assigned his 15% disability rating, he stated that it was not in addition to the previous 8% rating because he did not consider the previous physician's rating as valid inasmuch as it appeared to have been "from a simple sprain which would carry a zero impairment." The CRB was not persuaded. Despite Dr. Beiner's and the RME physician Dr. Karnasiewicz's use of "language purporting to limit their respective disability ratings to the claimant's [work-related] injury, we note that Dr. Beiner also specifically stated that the claimant had not sustained a total disability rating of 23 per cent permanent partial disability. In fact, both doctors' opinions essentially discount the contribution of the claimant's prior disability to the claimant's current disability. Therefore, despite the fact that the medical evidence presented in this matter is somewhat ambiguous, we find no basis for reversing the trial commissioner's decision to apply the § 31-349(a) credit for [the] previous eight percent disability to the claimant's current disability award of 15 percent." Id., at 7.

R. § 31-355 [Second Injury Fund Liability for Uninsured Employers]

The respondents in *DeJesus v. R.P.M. Enterprises, Inc.*, 6201 CRB-1-17-7 (November 8, 2018), argued that the trial commissioner committed error by permitting the Second Injury Fund to appear and issues involving an uninsured employer, contending that §31-355(b) prohibits the Fund from appearing until after there has been a determination regarding liability, and award of benefits to the claimant, and nonpayment of that award. They further claimed that the Fund's remedies for an employer's failure to pay an award of benefits are limited to filing a civil collection action in Superior Court. The Fund argued that §31-355 empowers it to litigate the

merits of cases involving uninsured employers, citing *Muniz v. Allied Community Resources, Inc.*, 108 Conn. App. 581 (2008), cert. denied, 289 Conn. 927 (2008), as a case in which it intervened to contest jurisdiction prior to an award of benefits. The CRB found no error in the trial commissioner's decision to allow the Fund to participate in the formal hearing, finding that the Supreme Court's decision in *Dechio v. Raymark Industries, Inc.*, 299 Conn. 376 (2010), "stands for the proposition that the Fund should litigate the issues involved in the underlying claim whenever its interests are implicated." *DeJesus*, at 10.

VI. RELATED ISSUES

A. § 5-142 [Disability Compensation for Certain State Law Enforcement and Emergency Employees]

Section 5-142 provides that certain state law enforcement workers who are totally incapacitated as a result of injuries sustained while in active duty are entitled to receive "the full salary that such person was receiving at the time of injury subject to all salary benefits of active employees, including annual increments, and all salary adjustments, including salary deductions, required in the case of active employees," for a period of 260 weeks from the date of the beginning of such an incapacity. Id. The case of *Chadbourne v. State Department of Mental Health and Addiction Services*, 6243 CRB-5-18-1 (January 8, 2019), addressed a technical issue regarding application of the full pay provision of the statute to an eligible DMHAS worker whose earnings included "built-in standard overtime" that kicked in after she worked 28 hours in a week. Workers subject to this provision were also known as a "28 plus 4 employees" because they typically worked 32 hours per week for which they were paid 28 hours of base pay and four hours of overtime. The essential question the trial commissioner and the CRB faced was to determine what defines the term "full salary" for the claimant. Relying on case law that overtime earnings have generally been determined to be above and beyond the "full salary" that a claimant should receive as a benefit under § 5-142(a) and finding additional support in an arbitration decision that limited vacation and personal leave accruals for 28 plus 4 employees to those based on the 28-hour work week, the trial commissioner determined that for the purposes of § 5-142(a), the claimant should be based on a 28-hour work week. The CRB reversed, noting that while it might have credited the arbitration decision if it had been squarely on point, the decision did not discuss the terms "salary" or "overtime." Instead, the CRB looked to the hours the claimant actually worked in a "standard" work week and found that both the claimant and her supervisor testified that the claimant's *standard* work week was four eight-hour days per week for a total of 32 hours per week.

B. § 5-145a [Heart and Hypertension- State Employees]

Section 5-145a is a statute similar to § 7-433c that provides benefits to certain State personnel for impairment of health caused by hypertension or heart disease. The statute begins with a long list of eligible employees, including "a member of the security force or fire Department of The

University of Connecticut," and also "to any state employee designated as a hazardous duty employee pursuant to an applicable collective bargaining agreement…." Id. The claimant in *McGrath v. Western Connecticut State University*, 6231 CRB-7-17-11 (November 28, 2018), was a Western Connecticut State University (WCSU) campus police officer who sought § 5-145a benefits. The trial commissioner dismissed the claim after determining that although the statute provided benefits to UConn police, there was no equivalent provision for police officers for the Connecticut State College and University system, which included WCSU, the other state universities and the state's community colleges. The claimant appealed and also filed a posttrial Motion to Submit Additional Evidence, including evidence that the employer withheld funds from the claimant's paycheck because his job was listed as "hazardous duty" by the comptroller's office and his job title appeared on a list of occupations deemed "hazardous duty" by the comptroller's office, as well as a representation from the Assistant Attorney Gen. representing the state that the employer stipulated to the applicability of § 5-145a and "recognizes Police Officer Richard McGrath as a hazardous duty employee." The trial commissioner denied the Motion to Submit Additional Evidence on the basis that the motion constituted an improper effort to create jurisdiction by "agreement, waiver or conduct." While the appeal was pending, counsel for the state discovered the existence of a 1989 arbitration award that designated WCSU police officers as "hazardous duty" employees together with a letter from the State Employee's Retirement Commission stating that the 1989 arbitration award had been ratified by the General Assembly. The CRB observed, "It would obviously be of benefit to litigants to establish all necessary jurisdictional facts at the inception of a hearing, not after the record has closed. We confess to being somewhat perplexed as to why counsel for neither party was able to locate a copy of the actual 1989 award before the trial commissioner closed the record." Id., at 8. The CRB went on to state, "However, in previous instances when this board has discovered, after the completion of a formal hearing, that an error was made regarding jurisdiction, we have allowed the issue to be revisited. See, e.g., *Mankus v. Mankus*, 4958 CRB-1-05-6 (August 22, 2006), aff'd 107 Conn. App. 585 (2008), cert. denied, 288 Conn. 904 (2008). As we pointed out in *Mankus*, issues as to subject matter jurisdiction may be raised at any time. Id., citing Deltoro [v. Stamford, 270 Conn. 532 (2004)]." *McGrath*, at 8. Given that the additional documents were added to the record, the CRB vacated the finding and remanded the matter for further proceedings to give the trial commissioner the opportunity to consider the legal effect of the new evidence, noting "no case under this Act should be finally determined when the trial court, or this court, is of the opinion that, through inadvertence, or otherwise, the facts have not been sufficiently found to render a just judgment." *Cormican v. McMahon*, 102 Conn. 232, 238 (1925).

C. § 7-433c [Heart and Hypertension Act]

Brennan, Executrix v. City of Waterbury, 331 Conn. 672 (2019), addresses the question of whether § 7-433c heart and hypertension benefits are properly paid to a deceased claimant's estate if such benefits vested and were payable ("matured") during the claimant's lifetime but were not paid to the claimant before his death, or whether *Morgan v. East Haven*, 208 Conn. 576 (1988), and subsequent legislative changes require payment of such benefits to the claimant's

dependents or non-dependent children. The substitute claimant was the executrix of the estate of the deceased Fire Chief who years before had suffered a heart attack during the course of his employment and promptly filed a § 7-433c heart and hypertension claim, after which the district commissioner issued a finding and award ordering the City to pay the decedent claimant all of the benefits to which he "is or may become entitled." The parties could not agree on the amount due, however, and issues arose over the extent of the claimant's permanent partial disability that were the subject of further negotiations and litigation. The claimant collected various periods of TT and TP benefits and also elected to take a disability retirement, but at the time of the claimant's death, the PP issue remained unresolved.

Some ten years later the decedent's attorney renewed the PP issue and move to substitute the claimant's widow, in her capacity as executrix of his estate and in her individual capacity as a party claimant. The City objected on two grounds: first, that the claimant executrix was seeking to circumvent the City Charter's pension offset, which, the City contended, would negate any 7-433c benefits otherwise due to her as the decedent's sole heir and beneficiary of a spousal pension; and second, that pursuant to *Morgan v. East Haven*, supra, the estate was not a legally qualified recipient of 7-433c benefits. The decedent's counsel argued the substitution was proper because the benefits had vested and matured during the claimant's lifetime and, as such, would pass to his estate. The trial commissioner agreed and granted the Motion to Substitute. In subsequent proceedings, the trial commissioner awarded PP benefits based upon a postmortem PPD rating provided by the decedent's physician and concluded that the decedent's entitlement to PP benefits had vested prior to his death. In response to a subsequent Motion for Correction and Articulation, the trial commissioner ruled that the permanent partial disability benefits vested as of the date of maximum medical improvement and were payable to the widow as executrix of the estate of the decedent.

On appeal, the CRB concluded that the case was controlled by *Morgan*, which the board interpreted as holding that an estate is not a qualified recipient of vested but unpaid heart and hypertension benefits. In response to the executrix's ensuing appeal, the Supreme Court overruled the CRB in part and affirmed the CRB in part. The Supreme Court began with a detailed analysis of the *Morgan* decision, which arose from a situation in which the trial commissioner awarded 585 weeks of permanent partial disability benefits. The *Morgan* claimant received benefits until his death, and thereafter his surviving spouse received benefits until her death, at which .233 of the 585 weeks of benefits had been paid. At the time of the claimant's wife's death, there were two surviving adult children, but no dependents. The fiduciaries of the estates of the claimant and his wife then sought to collect and pass the balance of the benefits to the claimant's adult children. As summarized by the *Brennan* Court, "it was clear that these remaining benefits had not matured before the recipients' deaths because they were not yet due to be paid. Accordingly, the issue raised to this court was whether the original award made pursuant to § 7-433c, in its entirety, was an asset of the deceased recipients' estates." *Brennan*, 331 Conn. at 686, citing *Morgan*, 208 Conn. at 577-78. The *Morgan* court rejected that claim on the ground that "dependents" could not be construed to include the estate of the recipient. Id., at 582-83. In connection with that discussion, the court stated, "the clear and unambiguous

language of the statute requires a municipal employer to provide compensation only to police and fire personnel who suffer from hypertension and heart disease and their dependents, not to the estates of the deceased recipients." *Morgan*, at 583. The *Brennan* court explained, however, that this language was not as clear a pronouncement as it initially seemed, because the court in *Morgan* went on to explain that the reason the estates would not be entitled to the unpaid portion of the award was that it rejected the proposition that the unpaid § 7-433c benefits had vested. The court distinguished unpaid benefits that were payable on a weekly basis, from a liquidated lump sum benefit, such as a commutation, that was due in full before the decedent's death. Only the latter is a "matured" workers compensation benefit as contemplated by *Morgan*. *Brennan*, at 687-88. Thus, the *Brennan* court concluded, "The foregoing discussion makes clear that the holding in *Morgan* was limited to the distribution of unmatured § 7-433c benefits, which pass to 'dependents.'" Id, at 689. Explaining that the legislature responded to *Morgan* by enacting § 31-308(d), which establishes who can collect unpaid PP benefits in the event of the claimant's death, the *Brennan* court went on to observe, "We also see nothing in the legislature's response to *Morgan* that demonstrates an intent to overrule long settled precedent regarding matured but unpaid benefits. . . . In sum, we conclude that matured § 7-433c benefits – those that accrued during the claimant's lifetime – properly pass to the claimant's estate." Id., at 692-93.

The court then turned to the question of whether the benefits at issue had matured before the decedent's death. The executrix contended that the benefits matured because the decedent's right to those benefits vested when he reached maximum medical improvement and, had the City paid the benefits starting from that date, all compensation would have been paid during his lifetime. The City countered that any PP benefits it might have been obligated to pay had not matured because they were not payable to the claimant during his lifetime – noting that the decedent's disability award was based on a posthumous rating and further noting that rather than collect the benefits do him, he had elected to negotiate toward a lump sum settlement that was never consummated during his lifetime. The *Brennan* court acknowledged that permanent partial disability benefits vest, or become due, when the claimant reaches maximum medical improvement, but further noted that the claimant's entitlement to PP benefits and the employer's obligation to pay them both depend upon the establishment of a permanent partial disability and the extent of that disability, and benefits are not owed until the degree of permanent impairment has been established by award or agreement. Thus, the court was "compelled to conclude that permanent partial disability benefits mature only after the degree of permanency has been fixed by way of an award or an agreement between the parties sufficient to establish a binding meeting of the minds." Id. at 697. Based upon the foregoing analysis, the Supreme Court reversed the CRB, but only as to its determination that the trial commissioner improperly granted the motion to substitute the executrix as a party claimant. The case was remanded to the Board with directions to affirm the commissioner's decision granting that motion and remanding the case to the trial commissioner to determine the proper beneficiary and the amount of benefits due.

In *Costanzo v. City of Stamford*, 6274 CRB-7-18-5 (May 3, 2019), the CRB affirmed the trial commissioner's order after a *de novo* review denying with prejudice a Form 36 to terminate 31-306 death benefits she had previously granted on a prospective basis. The issue arose from an

accepted 7-433c claim filed by a Stamford police officer who was diagnosed with hypertension and established a compensable claim while he was an active member of the police force. He subsequently developed kidney problems as a consequence of his injury for which he underwent a kidney transplant in 2000 that was deemed compensable in a Finding & Award issued in 2004. The claimant retired from the Stamford Police Department in 2006 and eventually passed away in 2010, secondary to heart disease, hypertension and end-stage renal disease. He was not a uniformed member of the police department at the time of his death. The respondents commenced paying a survivorship benefit to the claimant's widow, but subsequently filed a Form 36 challenging coverage for the survivor benefit on the ground that § 7-433c does not cover a death that occurs while the decedent is not a uniformed member of the police department. The trial commissioner granted the Form 36 prospectively, and a formal hearing ensued at which after a review *de novo* she denied, with prejudice, the Form 36. As summarized by the CRB, "the respondent asserts that although widows' benefits have been included within the ambit of General Statutes § 7-433c since the legislation was adopted decades ago, our Supreme Court's decision in *Holston v. New Haven Police Department*, 323 Conn. 607 (2016), and our Appellate Court's decision in *Staurovsky v. Milford Police Department*, 164 Conn. App. 182 (2016), appeal dismissed, cert. improvidently granted, 324 Conn. 693 (2017), have banned this relief." The CRB rejected this argument, concluding "In the present matter, the commissioner found that the decedent had obtained an award for § 7-433c benefits while he was still an active member of the Stamford Police Department. Given that an award for survivor's benefits is derivative of the original claim, we therefore find that the respondent's reliance upon *Staurovsky*, supra, is misplaced, because in that matter, the initial claim for § 7-433c benefits was filed subsequent to the claimant's retirement from the police force. In the instant appeal, however, the claimant's right to survivorship benefits following her husband's death had vested pursuant to her husband's original claim." *Costanzo*, at 10-11. The respondent's argument based on *Holston* likewise failed, noting that the Board has "consistently rejected the argument that *Holston*… Bars claims predicated on a 'flow-through' theory of sequelae injuries." Id., at 77 n.7 (citations to supporting cases omitted).

The Board was faced with the same issue and reached the same result in *Gentle v. City of Stamford*, 6264 CRB-3-18-4 (May 30, 2019), "we note that the legal arguments presented in this matter are identical to the ones considered in [*Costanzo*], and because we cannot discern a material distinction between the factual bases of the two cases, *stare decisis* compels us to reach the same result. We affirmed the award of survivor benefits in *Costanzo*, supra, and we therefore affirm the finding in this matter." Id., at 2-3.

The CRB used a similar analysis of *Staurovsky* and *Holston* in *Coughlin v. City of Stamford Fire Department*, 6218 CRB-5-17-9 (February 15, 2019), reversing the trial commissioner's dismissal of a claim for coronary artery disease (CAD) for a worker who developed hypertension and filed a 7-433c claim while he was in active service that was found to be compensable, and then later, some three years after his retirement, was diagnosed with CAD. The trial commissioner specifically found that the claimant's excepted hypertension was "a significant causative three factor" in the development of his coronary artery disease and that the CAD "flows from the

hypertension," but concluded that because the CAD was "neither diagnosed nor claimed… Until after he had retired" the claim must be dismissed because *Holston and Staurovsky* mandate that the heart disease and disability resulting from such a condition must be suffered while the individual was on or off duty as a regular member of a police or fire department." Id., at 3. Moreover, *Gorman v. Waterbury*, 4 Conn. App. 226 (1985), held that both the condition of hypertension or heart disease *and* the death or disability resulting from such a condition must be suffered while the individual was on or off duty as a regular member of the police or fire department." Id., 231-32 (emphasis in original). The respondents argued and the CRB agreed that hypertension and heart disease are to be recognized as two separate diseases. "Nevertheless," the CRB observed, "the evidentiary record contained an unchallenged medical report from a qualified expert stating that the claimant's hypertension was a significant factor in the development of the claimant's coronary artery disease, thus providing the basis for the reasonable inference that the claimant's coronary artery disease was the sequela of an accepted workers' compensation claim. We further recognize that the factual circumstances in *Holston*, are inconsistent with those in the instant manner, and the *Holston* court was not persuaded that the claimant was barred from pursuing a § 7-433c claim for his heart disease because the evidence demonstrated, and the commissioner so found, that the claimant's ' hypertension was a significant factor in his heart disease and therefore, the two were causally connected.'" *Coughlin*, at 8, quoting *Holston*, 323 Conn. at 616.

The CRB reached the same result in *Dickerson v. City of Stamford*, 6215 CRB-7-17-8 (September 12, 2018), which presented a virtually identical factual scenario to *Coughlin*. Indeed, the CRB cited its decision in *Dickerson* in support of the conclusion it reached in *Coughlin*. *Dickerson* presented the additional wrinkle that there was a significant gap of time, some 14 years, between his initial diagnosis of hypertensive heart disease and the myocardial infarction (MI) for which he subsequently sought compensation. The record was clear, however, that the claimant's hypertension was a substantial contributing factor to the subsequent MI. The CRB found that the time gap did not mean that a new injury had occurred, citing *Marandino v. Prometheus Pharmacy*, 294 Conn. 564 (2010), *Hernandez v. Gerber Group*, 222 Conn. 78 (1992), and *McCullough v. Swan Engraving, Inc.*, 320 Conn. 299 (2016), among a number of examples of cases in which "flow from" or sequelae of compensable injuries had been deemed compensable consequences of accepted claims notwithstanding significant time gaps.

Similarly, in *Martinoli v. City of Stamford Police Department*, 6271 CRB-7-18-5 (April 24, 2019), the CRB affirmed the trial commissioner's award of benefits to a worker who filed a timely claim for hypertension, congestive heart failure and coronary artery disease that were found compensable after a formal hearing, subsequently retired, and later developed atrial fibrillation and had a stroke that the trial commissioner determined related back to the conditions previously found to be compensable. In the course of its decision, the Board noted that the present case was "squarely within the scope of this tribunal's analysis in *Dickerson*, supra.*"* Id., at 7.

McGinty v. City of Stamford, 6197 CRB-4-17-6 (July 17, 2018), addresses the question of what constitutes "heart disease" as contemplated by § 7-433c. This is a heavily fact intensive case in which the CRB summarized the claimant's medical history, treatment and conflicting expert opinions in considerable detail. The trial commissioner determined that claimant was initially diagnosed in 2007 with peripheral artery disease, but not heart disease, that he subsequently developed a compensable heart disease in 2009, that this condition was separate and distinct from the prior peripheral artery disease he had experienced in 2007. The respondents agreed that the claimant's peripheral artery disease was a heart disease, but contended that it was the proximate cause of the claimant's subsequent coronary ailments and argued that as a consequence, the claim should be dismissed pursuant to *Brooks v. West Hartford*, 4907 CRB-6-05-1 (January 24, 2006), in which the Board upheld the trial commissioner's dismissal of a claim for § 7-433c death benefits after affirming "a factual finding that the cardiac issues which led to the death of the decedent were clearly the sequelae of his sarcoidosis, and inflammatory ailments similar to cancer which was not specific or isolated to the heart." *McGinty*, at 11. The CRB distinguished *Brooks*, stating "In the case at bar, the trial commissioner cited evidence in the record suggesting that the claimant suffered from peripheral artery disease in 2007 but did not have heart disease. The record also reflects that the claimant's 2009 coronary artery disease was a separate incident for which the claimant filed a timely notice of claim for General Statutes § 7-433c benefits.… We believe that the record in this matter provided an adequate basis for the trial commissioner's findings that the claimant suffered from heart disease in 2009 and this heart disease was separate and distinct from the prior peripheral artery disease he had experienced in 2007." Id., at 11-12.

Mangione v. Town of West Hartford, 6268 CRB-6-18-4 (April 12, 1919), was another fact intensive claim, this time involving a claimant who was diagnosed with hypertension in 2004 but did not file a timely notice of claim or request a timely hearing, nor did any other notice exceptions apply. Some nine years later he was found to have dysfunctional mitral and aortic cardiac valves with a diagnosis of endocarditis secondary to a bacterial infection, as a result of which he sought § 7-433c benefits. The trial commissioner concluded that the claimant's heart condition was "not the type of heart disease contemplated within the meaning of Connecticut General Statutes § 7-433c" and dismissed the claim. The CRB reversed, relying on *Holston v. New Haven Police Department*, 323 Conn. 607 (2016), for the proposition that "an untimely claim for hypertension under General Statutes § 7-433c does not foreclose a timely claim for heart disease because they are separate conditions." *Mangione,* at 5. The Board further relied on *Brocuglio v. Thompsonville Fire District #2*, 6155 CRB-1-16-12 (December 21, 2017), *appeal pending*, A.C. 41237 (January 9, 2018), in which the board affirmed the trier's conclusion that pericarditis and mitral valve replacement and coronary artery disease are separate and distinct conditions. The Board found that the same reasoning applies to the present case, dysfunction in the valves of the claimant's heart represents another form of heart disease.

D. § 31-51bb [Right of employee covered by collective bargaining agreement to pursue cause of action]

In *Williams v. City of New Haven*, 329 Conn. 366 (2018), the Supreme Court held that § 31-55bb permits an aggrieved claimant to file a § 31-290a before the Workers' Compensation Commission, upholding a decision of the CRB permitting the claimant to file a claim alleging that the employer violated § 31-290a by wrongfully terminating his employment in retaliation for bringing a workers compensation claim notwithstanding that the State Board of Mediation and Arbitration previously ruled on a similar issue in an arbitration proceeding brought pursuant to a collective bargaining agreement between the parties. This case is discussed in greater detail above in § II.C.

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