File Number:
HR13-D-H

U.S. DEPARTMENT OF LABOR

OFFICE OF WORKERS' COMP PROGRAMS
PO BOX 8300 DISTRICT 50
LONDON, KY 40742-8300
Phone: (202) 693-0045

Date of Injury:
Employee:

Dear

This is in reference to your workers' compensation claim. Pursuant to your request for a hearing, the case file was transferred to the Branch of Hearings and Review.

A preliminary review was completed on the case. Based upon that review, it has been determined that the decision of the District Office should be reversed as outlined in the attached decision.

Your case file has been returned to the Jacksonville District Office. You may contact that office by writing to our Central Mail Room at the following address:

US DEPARTMENT OF LABOR
OFFICE OF WORKERS' COMP PROGRAMS
PO BOX 8300 DISTRICT 6 JAC
LONDON, KY 40742-8300

Sincerely,

Electronically signed

Hearing Representative

If you have a disability (a substantially limiting physical or mental impairment), please contact our office/claims examiner for information about the kinds of help available, such as communication assistance (alternate formats or sign language interpretation), accommodations and modifications.

Washington DC, March 31, 2017

U.S. DEPARTMENT OF LABOR
Office of Workers' Compensation Programs

DECISION OF THE HEARING REPRESENTATIVE

In the matter of the claim for compensation under Title 5, U.S. Code 8101 et. seq. of Claimant; Employed by the Case number

Merit consideration of the case file was completed on Based on the review, the decision of the district office dated is reversed for the reasons set forth below.

The issue for determination is whether the Office met its burden in terminating the claimant's entitlement to medical and wage loss benefits.

date of birth , is employed as a with the in She filed Form CA-1 for a timely notice of a Traumatic Injury that occurred on The claim is approved for a lumbar herniated disc, thoracic sprain/strain, trapezius sprain/strain (left, mild), and cervical herniated disc (C5-6 and C6-7).[1]

Following the injury, the claimant began treating at Concentra and Family Medical Clinic. She subsequently came under the care of , M.D. of Atlanta Knee & Shoulder, M.D .of Center Neurology, and M.D. of Atlanta Pain Clinic.

was also seen by , M.D. of University Orthopaedic Clinic as a new patient on . She was diagnosed with cervical radiculopathy, cervicalgia, lumbago, and lumbar radiculopathy. She denied any psychiatric problems at this visit. Dr. disabled her from work. At an appointment on Dr. reviewed MRIs of the lumbar and cervical spine and the claimant was diagnosed with cervical radiculopathy, cervicalgia, lumbago, lumbar radiculopathy, cervical internal disc disruption, cervical herniated disc, cervical stenosis, lumbar internal disc disruption, lumbar disc herniation, and lumbar spinal stenosis. Review of systems was significant for depression. Ms. Starr was instructed to remain out of work.

At an appointment on the claimant documented continued complaints related to the cervical and lumbar spine. She also noted that she was having worsening depression associated with the stress of work and no end in sight for her treatment. Given these

[1] The claimant has another claim for a Traumatic Injury. This was assigned file number . A left arm, left shoulder, neck and left leg condition were claimed however the case was formally denied.

complaints, it was recommended that be seen for a psychology consultation. At a follow-up appointment on Dr. released the claimant to modified duty and recommended surgical intervention related to the cervical spine.

At appointments on , and Dr. documented the claimant's continued complaints related to her cervical and lumbar spine. He also recommended that she continue ongoing therapy with a psychologist for her depression. She continued to be released to modified duty, although the claimant did not feel that she could return to work with her level of pain. At a follow-up on the claimant stated that she attempted to work light duty but had anxiety and panic attacks as well as increasing low back pain. Dr. recommended that she remain out of work until surgery had been completed since she was unable to tolerate light duty.

On the claimant underwent artificial disc displacement, C4-5 using LDR Mobi-C artificial disk at C4-5, application of PEEK cage at C5-6, application of PEEK cage at C6-7, partial corpectomy of C6 with decompression of spinal cord and nerve roots, anterior plate fixation (C5, C6, C7), anterior cervical discectomy with decompression of spinal cord and nerve roots at C5-6, and anterior interbody arthrodesis C6-7.

The Office began paying wage loss compensation for total disability effective was placed on the automatic 28 day periodic roll cycle, effective

On the claimant was seen for a two week post-operative visit. She complained of significant neck pain. She was anxious, depressed and tearful in the Office. At a follow-up on Dr. I stated that the claimant was 8 weeks post-op and should remain out of work. He also noted that she was plagued by anxiety and depression. She remained under the care of a psychologist for this. At an appointment on the claimant continued to complain of severe cervical and low back pain. Dr. noted that she was seeing Dr. for her depression and it was also recommended that she seek treatment for her right shoulder complaints.[2]

A CA-20/20a Attending Physician's Report dated was received from psychiatrist , M.D. He noted that the claimant had been under his care since She was initially injured on from repetitive lifting of mail while at work. He noted that she had a herniated disc and lumbar pain which resulted in anxiety and depression. She was unable to work. Dr. diagnosed acute stress disorder and post-traumatic stress disorder. He checked the box "yes" when asked whether these conditions were caused or aggravated by an employment activity.[3]

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[2] The claimant was evaluated for her right shoulder on by ı, M.D. He noted that her exam findings seemed cervical in nature. She was instructed to continue treatment with Dr.

[3] The Employees' Compensation Appeals Board has held that merely checking a box on an Office form, by a physician, is insufficient to establish causal relationship (Debra S. King, 44 ECAB (Docket No. 92-414, issued November 4, 1992); Robert J. Krstyen, 44 ECAB (Docket No. 92-666, issued November 16, 1992)).

At an appointment on Dr. noted that the claimant was still recovering from cervical surgery and she was also recovering from bilateral hammer toe surgery. He recommended that she hold off on anterior lumbar interbody fusion L5-S1 until she had recovered from her other issues. At an appointment on Dr. stated that the claimant wished to proceed with lumbar surgery. He stated, "If her depression is because of her low back pain then I will recommend that she proceed with the anterior lumbar interbody fusion L5-S1. If her depression is not because of her low back pain then I will recommend holding off the lumbar spine surgery until her depression is under control." was instructed to remain out of work.

The claim was forwarded to the District Medical Advisor (DMA) for an opinion regarding the proposed lumbar surgery. In a response of the DMA stated that the procedure should not be approved.

On the Office received a Report of Investigation from the Office of Inspector General (OIG) for the Postal Service. According to this report, the claimant had misled her physician regarding her physical and mental condition. Instead, she was leading what was described as an active lifestyle. The report also noted that in 1998 and 2011 the claimant had been involved in automobile accidents for which she claimed injuries to her neck and back. The investigative report contained additional information regarding these incidents.

Additionally, the investigation documented a number of things related to the claimant's behavior which seemed inconsistent with her claimed condition. Specifically, on posted a photo to her Facebook page showing her smiling and standing unevenly with her head slightly tilted to the right. Another picture showed the claimant in what appeared to be a bathroom with her head turned and looking towards the camera. However, the claimant was seen by her doctor on and complained of low back and neck pain that was described as 10 out of 10. Then, on the claimant posted several pictures to her Facebook page and she was holding a child (about 3 to 4 years old) with her right arm. She was also seen twisting at the waist with her neck turned, kissing the child. She was also observed leaning in with her face pressed together with the child. She was standing with her hands on her hips.

According to the investigative report, the claimant was seen by Dr. on He continued to state that her low neck and back pain was a 10 out of 10. He also said that she was exhibiting signs of depression due to her injury. The investigator noted that underwent spinal surgery in . At a follow-up appointment on she continued to complain of severe neck pain. She continued to exhibit signs of anxiety and depression, attributable to her injury. Then on posted a photograph on Facebook which appeared to be of her attending church. She was wearing high heels that were about 5 inches high. She was posed with her body slightly twisted and her head turned towards the camera. Her toenails were painted, she was wearing makeup and her hair was done.

On the claimant posted two photographs to Facebook. In one picture, she was turned as she hugged another individual. In the other photo, she was leaning on what appeared to be the front seat of a car. Another photo was posted to Facebook on and the caption noted that she was enjoying grandparents day at Child Time Learning Center with her granddaughter. The claimant was smiling and leaning her body with her head tilted. The claimant returned to Dr. on with neck and back pain described as 9 out of 10. He further stated that she exhibited signs of depression due to her injury. She complained of right shoulder pain as well.

On the claimant posted a photo of herself and several other women outside of Moe's restaurant. She posed with her arms around two of the women. Then, on the claimant was seen by Dr. at the Center for Neuropsychiatry. She was diagnosed with acute stress and post-traumatic stress due to her injury. The claimant returned to Dr. on with continued complaints of neck and back pain. He also documented depression and right shoulder pain.

The claimant posted additional photos on Facebook on and which showed her with her body turned at the waist and her head turned towards the camera. She also had her arm around an individual and she was smiling in the photo. The claimant returned to Dr. on and he documented her continued complaints. He stated that her pain was intolerable and she wished to proceed with surgery. He continued to document her depression as well.

Additional photographs were posted to Facebook on The claimant was neatly dressed sitting in a chair with her legs crossed. Another photo showed her standing off balance and bending at the waist. Another photo showed her with her hands on her head. The claimant returned to Dr. on . The findings were unchanged. Another Facebook photo was posted on of the claimant sitting in the driver's seat of a car holding a phone to take a picture as she twisted at the waist.
was seen again on by Dr. with the same complaints. He noted that she felt poorly. On the claimant posted a picture to Facebook of herself sitting in a beautician's chair with the following caption, "With at Dominican Hair Salon." On the claimant posted another photo on Facebook with the caption "Lunch with Daughter & Granddaughter...Love them Both!!!!" The claimant was holding her head at an angle and appeared to be holding the camera with her right arm extended. Her body was slightly twisted. On the claimant posted two photos to Facebook. She was leaning on a couch with several children and was smiling. She returned to Dr. on He stated that the claimant had neck and back pain as well as depression due to her injury. She also had sleep disruption and right shoulder pain. She returned to Dr. on with the same complaints.

The memorandum also noted that on the claimant sailed on a Carnival Cruise Line from Miami, FL to Nassau, Bahamas which was about 631 miles one way. The cruise was from to the . She traveled with her two youngest daughters, her mother and step-father. She traveled using the name of one of her older daughters (

. She had originally booked herself as the traveler but then changed the name to her daughter. Exhibits were provided to support this. On pictures were posted of the claimant and her daughter on the cruise ship. There was also a video posted by the claimant's mother of dancing with the waiter on the ship. She stood up and twirled around as she danced. Then, on the claimant posted the following message on Facebook, "Today is a very special person birthday. I call her my Ace!!! So I decided to take my beloved mother to Bahama...As the young people say Turnup...We are having a blast so help us celebrate....Turndown for what!!!! Lol happy Birthday Mom!!! I thank God for you young lady Pictures later..." A photo was posted on of the claimant and her family sitting at a dining table on the cruise ship. She also posted a picture of her and her daughters on a beach. On the claimant posted a video of her and one of her daughters at an unknown location. A beach and large body of water could be seen in the background. This trip was different from the Bahamas cruise because the claimant's hair was different.

According to the investigative report, the claimant's physician Dr. was interviewed by reporting agent on . He noted that he had been treating the claimant since for a work injury. She had undergone surgery in and the recovery period was usually 4 to 6 months. However, he noted that the claimant's recovery time was unusually long. He stated that he had done all he could do, outside of surgery for her back. He also stated that her pain complaints could be related to her psychological conditions. He noted that she had seen a psychiatrist for depression. Dr. proceeded to document the trouble the claimant would have relative to her condition. The reporting agent then presented him with photographs and video of the claimant that had been taken from 2013 to 2015. After reviewing this documentation, he stated that claims of pain and depression had strong credibility issues. He had a tough time juxtaposing her complaints of neck and back pain with her going on a cruise in He stated that the claimant presented herself in his office like "someone shot her dog" which did not coincide with the information contained in the photographs and video footage. He felt that there should be a second opinion ordered for the claimant.

In order to further assess the claimant's condition, she was referred for a second opinion evaluation which took place on with M.D., a board certified orthopedic surgeon. He acknowledged reviewing extensive medical records as well as the Statement of Accepted Facts. He performed a physical examination and noted that the claimant presented with slight paresthesias in her left hand and left leg. She had a well healed surgical scar over the cervical spine and there was excellent range of motion. Her grip strength was normal, manual dexterity was normal, deep tendon reflexes were normal and there were no signs of muscular atrophy. Dr. reviewed x-rays which showed "excellent disc replacement at C4-5. There was also excellent fusion at C5 to C7 with anterior plate fixation. He noted that nerve conduction studies of the median nerve and ulnar nerve were performed of the left upper extremity which was indicative for mild carpal tunnel syndrome.

In conclusion, Dr. stated that there was no objective evidence to support an ongoing diagnosis of a herniated cervical disc at C5-C7. He stated that this condition had resolved

long ago and had reached maximum medical improvement (MMI). He stated that she reached MMI one year following her surgery. Dr. further stated that the thoracic sprain and trapezius strain had resolved long ago. He opined that was capable of returning to her regular job as a and no further medical treatment was indicated or necessary. An OWCP-5c form was completed which released the claimant to work without limitations.

On the claimant contacted the District Office and asked about having her case expanded to including an emotional condition.

The Office created a memorandum to the file on regarding a Report of Investigation that had been received from the General's office. The Office acknowledged reviewing a video, photographs and a timeline of events. The content of the investigation was discussed in this memorandum.

By letter dated the Office expanded the accepted conditions on the claim to include a lumbar disc herniation. An addendum to the SOAF was written on this date to include this information. The Office also documented the fact that there had been an investigation conducted by the OIG for the postal service and they provided a DVD and photographic stills of the claimant's activities from to

By letter dated the Office asked Dr. to review surveillance video and photographic stills of the claimant's activities. He was then asked to respond to additional questions regarding the claimant's work capabilities.

An addendum report dated was received from Dr. He acknowledged reviewing the Statement of Accepted Facts dated He also reviewed photographs, surveillance video and medical records. However, he maintained that there was no objective findings to support a diagnosis of a disc herniation. This had fully resolved and the claimant had reached maximum medical improvement as of She was fully capable of performing her job duties as a

On the claimant contacted the Office with several questions, one of which had to do with having a psychological condition added to her claim.

On the Office released a Proposal to Terminate Medical and Compensation Benefits for the claimant's condition, affording thirty days for submission of evidence to stay the pending termination. The Office pointed to the second opinion report and addendum from Dr. in support of this decision.

By decision dated the Office terminated the claimant's entitlement to medical and wage loss benefits. The weight of medical evidence was afforded to Dr.

Following the denial, a letter dated was received from the claimant's attorney, Paul Felser, Esq. He requested copies of the surveillance video that had been provided to the second opinion examiner and treating physician. He argued that the claimant had never received a copy of this evidence. Mr. Felser stated that the Office had the responsibility to make the claimant aware that it was providing videotape evidence to a medical expert. Additionally, if the claimant requested a copy of the videotape, it should be made available and the claimant should be given the opportunity to comment on it. Mr. Felser stated that submission of this evidence to the doctor without making any effort to first obtain the claimant's comments was in violation of Board precedent and violated the claimant's due process rights.

The Office responded to Mr. Felser's correspondence by letter dated
They indicated that a copy of the OIG investigation and CD-ROM was enclosed.

A report dated was received from Dr. . He diagnosed cervicalgia, cervical radiculopathy, cervical stenosis, lumbago, lumbar herniated disc, internal disc disruption (lumbar), lumbar spinal stenosis, and major depressive disorder (recurrent). He recommended an updated lumbar MRI and if the findings were unchanged, he continued to recommend surgery. There was an addendum to this report dated Dr. states,

> "I have met with special agent concerning possible workers compensation fraud. I reviewed photos posted on social media of and a video of her dancing on a cruise in November 2015. I recommend suspending any further spinal treatment until she undergoes an independent medical evaluation."

A report dated was also received from Dr. He recommended that the claimant obtain an IME to assess her ongoing pain. She was instructed to remain off of work until the IME was completed.

The claimant disagreed with the decision and an oral hearing was requested. In accordance with this request, I have conducted an initial review of the file and find that the case is not in posture for a hearing at this time.

The decision of the District Office dated should be *REVERSED* for the reasons set forth below.

Once the Office accepts a claim, it has the burden of proving that the disability has ceased or lessened in order to justify termination or modification of compensation benefits.[4] After it has determined that an employee has disability causally related to his or her federal employment, the Office may not terminate compensation without establishing that the disability has ceased or that it is no longer related to the employment.[5] Furthermore, the right to medical benefits for an accepted condition is not limited to the period of entitlement for disability. To terminate authorization for medical treatment, the Office must establish that

[4] Lawrence D. Price, 47 ECAB 120 (1995).
[5] Id; Patricia A. Keller, 45 ECAB 278 (1993).

appellant no longer has residuals of an employment-related condition which require further medical treatment.[6]

In assessing medical evidence, the weight of such evidence is determined by its reliability, its probative value and its convincing quality. The opportunity for and thoroughness of examination, the accuracy and completeness of the physician's knowledge of the facts and medical history, the care of the analysis manifested, and the medical rationale expressed in support of the physician's opinion are facts which determine the weight to be given each individual report.[7] The Board has held that a medical opinion that is not fortified by rationale is of diminished probative value.[8] In situations where there are opposing medical reports of virtually equal weight and rationale and the case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based on a proper factual background, must be given special weight.[9]

The instant case was filed for a Traumatic Injury which occurred on The case was originally approved for a thoracic sprain/strain, trapezius sprain/strain (left, mild), and cervical herniated disc (C5-6 and C6-7). It was later expanded to include a lumbar disc herniation. The claimant was evaluated by several physicians but began regularly treating with Dr. Spinal surgery was performed on was ultimately referred for a second opinion exam which took place on with board certified orthopedist Dr. . Based upon his original report and addendum, the Office proposed to terminate medical and wage loss benefits. This decision was finalized on

On review, I find that the decision of the District Office must be reversed. As explained in detail above, an investigation had been conducted by the OIG for the A report of investigation dated was received into the case file on . According to this report, still photographs and surveillance video were presented to the claimant's attending physician Dr. on However, there was no indication that the claimant was made aware of this. Additionally, upon receipt of the investigative memorandum, the Office forwarded the photographs and video footage to second opinion examiner Dr. on He was asked to review this information and respond to the questions posed in the referral letter. The Office ultimately terminated the claimant's benefits and the weight of medical evidence was afforded to Dr. This was based upon his original report as well as the addendum (which was in response to the investigative findings). However, I find that this was improper. The claimant should have been made aware of the fact that video surveillance and still photographs were being provided to a medical expert. Failure to do this deprived Ms. Starr of her right to request a copy of this evidence and provide comments/explanation regarding the accuracy of the information contained therein.

[6] Furman G. Peake, 41 ECAB 361, 364 (1990).
[7] Connie Johns, 44 ECAB 560 (1993).
[8] Cecilia M. Corley, 56 ECAB 662 (2005).
[9] Gloria J. Godfrey, 52 ECAB 486 (2001).

Once a surveillance video is provided to the OWCP with a request that it be used in the management of the case, it becomes part of the official case record and a copy will be released to the claimant, if he or she requests it, just like any other portion of the case record. The ECAB held in J.M., 58 ECAB 478 (2007), that the OWCP has the responsibility to make the claimant aware that it is providing surveillance video evidence to a medical expert. If the claimant requests a copy of the surveillance video, one should be made available, and the claimant given a reasonable opportunity to offer any comment or explanation regarding the accuracy of the recording.

In a similar claim, *A.P.*, Docket No. 13-0030, issued the Board disfavors investigative evidence that is presented for the purpose of obtaining an adverse medical opinion, but is not disclosed to the injured worker.[10] Although video footage may be of some value to a physician asked to render a medical opinion, it may also be misleading if material facts are omitted. Thus, OWCP is obliged to notify claimant when such footage is given to a physician and, upon request, provide a copy of the recording and a reasonable opportunity to respond to its accuracy.[11]

Sending physical evidence to a physician with specific questions relating to the inconsistencies is ideal; however, if a videotape (i.e. surveillance of the claimant's activities) is provided to an OWCP- directed medical examiner, then the claimant must be notified.[12]

In addition to the abovementioned issue, I find that there are additional deficiencies that must be addressed. First, the claimant was seen for a second opinion on and in that report Dr. opined that her cervical disc herniation, trapezius sprain and thoracic sprain had resolved. However, by decision dated the Office formally expanded the claim to include a *lumbar* disc herniation. This was included in the amended SOAF of the same date. In Dr. addendum report, he stated that there were no objective findings to support a diagnosis of a disc herniation and that this condition had fully resolved. He stated that had reached maximum medical improvement 12 months following her surgery. This is noted however Dr. appears to be referencing the claimant's *cervical* disc herniation for which she underwent surgery. However, by decision dated the case was formally expanded to include a *lumbar* disc herniation and this was not addressed in Dr. report. Before the Office can terminate entitlement to benefits, they must ensure that the evidence supports that *all* of the accepted conditions on the claim have ceased/resolved. However, benefits were terminated without sufficient evidence to support that the effects of the lumbar disc herniation had ceased.

Lastly, there are a number of medical reports in the case file which note that the claimant was suffering from an emotional condition. This was first referenced in an report from Dr. and he continued to diagnose the claimant with anxiety and depression from that point forward. Additionally, a CA-20/20a Attending Physician's Report dated was received from psychiatrist Dr. He stated that

[10] F.S., Docket No. 11-863 (issued September 26, 2012).
[11] See Frederick Nightingale, 6 ECAB 268 (1953).
[12] See J.M., ECAB Docket No. 206-0661.

had a herniated disc and lumbar pain which resulted in anxiety and depression as she was unable to work. He diagnosed acute stress disorder and post-traumatic stress disorder. He checked the box "yes" when asked whether these conditions were caused or aggravated by an employment activity. It is also important to note that the claimant had contacted the District Office on more than one occasion asking about how to have her claim expanded to include a psychological condition. However, it does not appear that any further development was undertaken in this regard which I find to be in error. Before terminating entitlement to benefits, the Office has the burden of establishing that the effects of the work injury have ceased. However, it was premature for the Office to terminate benefits when they had not yet properly addressed whether the case should be expanded to include additional diagnoses.

Chapter 2-1400(11) of the FECA Procedure Manual addresses additional diagnoses and states that after an initial claim is accepted, the claimant or the medical provider may request that an additional diagnosis be accepted as work-related, or claim that weakness or impairment caused by a work-related injury led to a consequential injury. This may affect the same part of the body as the original injury/illness or a different area altogether, and could be for a physical or psychological condition. See PM 2-0805 for a discussion of causal relationship and consequential injuries. If the medical evidence establishes that the additional diagnosis or consequential injury is not a result of the original injury/illness, a formal disallowance is needed, and usually a Letter Decision is sufficient.

It is the responsibility of the Office, upon receipt of a request to amend the claim to include an additional diagnosis or consequential injury, to review the evidence of record and determine if sufficient documentation exists to support acceptance. If, after any necessary development, the weight of medical evidence does not support the additional diagnosis or consequential injury, the Office is responsible for issuing a formal decision with appeal rights.

Upon return of the case file, the District Office should immediately reinstate the claimant's medical and wage loss benefits retroactive to the date of termination.[13] Additionally, it is noted that a copy of the case file, including the investigative OIG report, was sent to the claimant's attorney Paul Felser, Esq. on However, it is unclear whether the Office supplied him with a copy of the physical evidence including video surveillance and still photographs. Therefore, the Office should ensure that copies of all materials are provided to Mr. Felser. He should be notified that will be scheduled for a new second opinion examination and that the investigative material, including video footage and photographs, will be supplied to the examiner. The Office should afford 30 days for Mr. Felser to submit a response relative to this investigation. At the end of this period, the Office should take any further action deemed necessary and refer for an Office directed second opinion examination with a board certified specialist to address her accepted orthopedic conditions. Specifically, the examiner should be asked to address whether she continues to suffer residuals of these conditions, thus requiring continued medical treatment and/or disability from work. The examiner should provide a well-reasoned medical opinion in support of his/her conclusions, including a discussion of the objective

[13] The Office should undertake appropriate development to determine whether there were any prohibited dual benefits received or any earnings for which a reduction in compensation would be necessary.

evidence of record. With regard to the claimant's emotional condition, the Office is instructed to initiate appropriate development in this regard and issue a formal decision as to whether the evidence supports a causal relationship between her diagnosed conditions and the work injury or effects thereof. Upon completion of the aforementioned actions, the Office should undertake further action as deemed appropriate.

Accordingly, the decision is hereby ***reversed*** and the case file is returned for further action as described above.

ISSUED:

WASHINGTON, D.C.

Electronically signed

Hearing Representative
for
Director, Office of Workers' Compensation Programs

Washington DC, March 31, 2017