

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. E804086

LOUIS CRYER, EMPLOYEE	CLAIMANT
SERENITY PARK, INC., EMPLOYER	RESPONDENT #1
HARTFORD INS. CO., CARRIER	RESPONDENT #1
SECOND INJURY FUND	RESPONDENT #2
DEATH & PERMANENT TOTAL TRUST FUND	RESPONDENT #3

OPINION FILED DECEMBER 29, 2004

Hearing before ADMINISTRATIVE LAW JUDGE ANDREW L. BLOOD, on September 29, 2004, at Little Rock, Arkansas.

Claimant represented by the HONORABLE STEVEN McNEELY, Attorney at Law, Little Rock, Arkansas.

Respondents #1 represented by the HONORABLE GENE WILLIAMS, Attorney at Law, Little Rock, Arkansas.

Respondent #2 represented by the HONORABLE DAVID L. PAKE, Attorney at Law, Little Rock, Arkansas.

Respondent #3 represented by the HONORABLE JUDY W. RUDD, Attorney at Law, Little Rock, Arkansas.

STATEMENT OF THE CASE

A hearing was conducted in the above-referenced claim to determine the claimant's entitlement to additional workers' compensation benefits.

Several pre-hearing conferences were conducted in this claim, the last of which on July

20, 2004, from which a Pre-hearing Order of the same date was filed. The Pre-hearing Order reflects stipulations entered by the parties, the issues to be addressed during the course of the hearing, and the parties' respective positions relative to the issues. The Pre-hearing Order is herein designated a part of the record as Commission Exhibit #1.

The testimony of Louis Cryer, the claimant, Jeanette Zig-Hill, coupled with medical reports, and other documents comprise the record in this claim. The parties also submitted briefs on the issue of the application of Act 796 of 1993 on a scheduled injury relative to permanent total disability. The briefs are retained in the commission's file.

DISCUSSION

Louis K. Cryer, the claimant, with a date of birth of August 22, 1964, is a high school graduate with one and one-half years of post-secondary education. Claimant's work history reflects that he performed manual labor type jobs at Sam's Club and Harp's Grocery Store, both in Fayetteville, Arkansas. Claimant worked at Affiliated Foods in the warehouse and at one time as a automobile salesman with Little Rock Dodge. Claimant has also worked at Wal-Mart. Claimant noted that while attending college he made up his mind that he wanted to be hired as a police cadet with the Little Rock Police Department.

Claimant became a reserve deputy sheriff for the Pulaski County Sheriff's Department in 1985/86. In 1991 claimant was hired as a full time deputy and left the Department in May 1994. Claimant's testimony reflects, with respect to his employment training:

Other than the law enforcement and the, my time that I worked in narcotics and the training that I received in law enforcement - - I went through many different law enforcement type schools while I was employed there. I'm a certified radar operator. I went to the Arkansas Police Training Academy;

Arkansas Law Enforcement Training Academy. I went to the Drug Enforcement Administration two-week basic drug education school they put on. . . .(T. 18).

The testimony of the claimant reflects that in 1989, as a reserve deputy he was involved in a motor vehicle, when the patrol car he was driving was hit broadside resulting in injuries to his head and neck. Claimant received epidural injections in his neck for radiating pain, numbness and tingling. The testimony of the claimant reflects that he began to experience problems in his low back in the 1990/91 time frame, however didn't seek medical treatment, attributing the symptoms to a pulled muscle. Prior to the point of surgery he was having significant problems with back pain and right leg pain. Claimant also acknowledged that five milligrams of Vicodin, one or two every four to six hours. Claimant's testimony reflects that on July 7, 1994, he underwent surgery for a herniated disc at L4-5. In April 1995, claimant was in a pain management regimen due to the right leg and low back pain.

On June 30, 1995, claimant underwent surgery on his right shoulder for complaints of pain down his arm. Claimant acknowledges that part of the bone was taken out of the shoulder in the surgery. In 1995 claimant suffered a fracture to his left ankle which was treated with the placement of a cast for six to eight weeks.

On May 1, 1996, claimant injured his back while lifting milk crates. Claimant was employed by Circle K Stores at the time of the milk crate lifting incident. Claimant was ultimately seen by Dr. Anthony E. Russell, a North Little Rock neurosurgeon. Dr. Russell assessed the claimant with a 10% permanent physical impairment relative to the 1994, lumbar disc surgery. (R#1,Ex#1, p. 39). In September 1996, claimant suffered a gun shot wound to his left calf. Claimant explained that while practicing on top of Chenal Mountain he was struck in the calf

by the bullet. Claimant is uncertain of the source of the bullet.

In December 1996 claimant injured his right knee while duck hunting. On December 23, 1996, claimant underwent an arthroscopy on the right knee under the care of Dr. Hefley.

Claimant's testimony reflect that on January 17, 1997, he slipped and fell on his right knee and wrist. Claimant attributes the afore to walking down some stairs following an ice storm.

Claimant's testimony reflect that in April 1997, he was in another automobile accident when his vehicle was rear ended. Claimant maintains that the accident made his back worse. In May 1997, claimant treated with Dr. Annette Meador for complaints of neck pain and tingling in his hands and fingers. Dr. Meador's treatment included epidural injections in the neck.

Claimant's narcotic use problems came to a head between his doctors resulting in the claimant enrolling in a program at Serenity Park in October 1997. In September 2000, claimant went to Bridgeway for a detox program. Claimant denies that he had ever been diagnosed with RSD prior to 1998.

Claimant's testimony reflects that he first learned about Serenity House following the March 13, 1996, death of his first wife in a motor vehicle accident. The testimony of the claimant reflects:

. . . I knew form my prior back surgery what killed pain and I started abusing prescription pain killers and muscle relaxers.

* * *

Okay. Basically, my parents confronted me with the problem and I agreed that I did have a problem. And I agreed to go check in and I went and checked in to Serenity House and stayed there for the 30 day program and completed the program and got out of the program and started going to at

lease one, sometimes as many as 3 AA meetings a day. (T. 20-21)

Claimant testified that in late December 1997 or early January 1998 he was asked by the Director of Serenity House to take the clients to a noon meeting on Wolf Street. Later claimant was offered a full time day position, Monday through Friday, working for Serenity House, respondent #1, as a house manager and doing other duties. Claimant asserts that at the time he accepted the position he had his own drug problem under control, and was not drinking or taking any narcotics.

Jeanette Zig-Hill, the claimant's mother, who resides in Roland, Arkansas, testified that while the claimant currently reside in an apartment of "C" street, and has done so for approximately one year, for a six year period prior to same he resided with her. Ms. Hill and her husband own a gun shop. Ms. Hill denies that claimant has worked in gun shop or to her knowledge any place else since his March 31, 1998, compensable injury. Ms. Hill acknowledged that three (3) checks were written to Dr. Merritt on the business account of the gun shop on behalf of the claimant for medical treatment.

The compensability of the claimant's March 31, 1998, right knee injury is not disputed.

Claimant's testimony reflects, with respect to the injury:

. . . I was working for Serenity Park and on March 31, 1998 we had a new client that was rather standoffish and would not get involved with the other clients. And the Director instructed me to take him down and get him involved with some of the other guys and to play, you know, basketball to see if we could get him interactive with the other individuals. And while playing basketball, being recreational therapy with the client, I went up and came down and my right lower leg went our at a 70 degree angle to my knee outward with me over it. And the condyle of the femur crushed the tibial plateau, broke it into my, I believe the doctor told me 30 large pieces and over 250 bone fragments. And I had compartment

syndrome set in immediately and then I had several different infections (T. 19-20).

Claimant noted that since the March 31, 1998, compensable accident he has undergone a total of twenty-three (23) surgeries including his leg, back and wrist. On May 23, 2000, claimant underwent a total knee replacement relative to the right knee injury.

Claimant asserts that in September 2003, he suffered an injury to his left wrist attributable to the March 31, 1998, compensable right knee injury. Claimant maintains that at the time of the injury he had gone to visit his parents at the gun shop. Claimant testified:

. . . . I had walked out back and was talking on my cell phone and my right knee , I wear this brace all the time because I don't have any stability in my right knee, and sometimes my right knee will buckle even in the brace and give out and when it gave out I grabbed a ladder that was leaning up against the wall and when I grabbed it, my knee had given out, I fell backwards, the ladder slid with me into a gate and when I fell backwards I put my hand down straight out, like that, palm down, to break my fall - -

. . . . And it immediately began to swell and began to hurt. My mother took me to Baptist Medical Center ER and they x-rayed my wrist and I believe the Doctor's name was Kershner - -(T.22).

Following the emergency medical treatment, claimant treated with Dr. Bryan, an associate of Dr. William Hefley, his primary treating physician relative to the March 31, 1998, compensable right knee injury.

Claimant's testimony reflects that in January 2004, he suffered another fall attributable to the March 31, 1998, compensable injury. Claimant explained that as he was getting out of the shower, having stepped out onto the bath mat with his left leg, his right foot hung on the bathtub and he fell. Claimant asserts that he ultimately fell on his wrist injuring same. Regarding the

role that his injured right knee played in the January 2004 fall, claimant testified:

. . . . - my knee will only bend to about 85 degrees and in bending my knee to get out of the tub my foot hung on the side of the tub and I fell - - I was starting to fall, I got my right leg out and then I didn't get good footing with it and fell. (T. 24)

Claimant asserts that he went to the doctor on Monday for the left wrist complaint growing out of the January 2004 fall, and was referred by Dr. James W. Bryan, IV, to Dr. David Rhodes, who later performed surgery.

Claimant asserts entitlement to reimbursement for out of pocket medical expenses. Specifically, the testimony of the claimant reflects that medication prescribed by Dr. Merritt and relative to his compensable injury was denied by respondents #1. Claimant noted that until December 2003, respondents #1 had paid for the medicine, to include Endocet, [for breakthrough pain], Diazepam [for muscle spasm], Lodeine XL, Neurontin, Kepra, and Trazodone. Claimant was also prescribed band aids by Dr. Bryan for a lesion on his leg.

Claimant testified that he had been seen Dr. Charles Watson, and that after he closed his office, he initiated treatment under the care of Dr. Valentine pursuant to a recommendation of his attorney. Claimant commenced treatment with Dr. Merritt pursuant to a referral by Dr. Valentine. Claimant explained that Dr. Valentine closed his practice and moved to Florida. Claimant also acknowledged that he had abused Methodone and was referred to Dr. Merritt, a Fellow in the Society of Addiction Medicine, who does pain control for people who have addictive problems.

Claimant testified that he is unaware of any job that he can perform in light of his current physical limitations and restrictions. With respect to his current daily activities, claimant's

testimony reflects that he gets up in the morning at 8:00, go through a ritual of waking up, taking his dog to the park to let him exercise. Thereafter he goes by the business of his parents and visits. Claimant goes to AA meeting at 5:30 P.M. Sometimes claimant attend the 8:00 P.M. AA meeting. Claimant notes that in sitting and watching television he elevates his right leg.

Claimant asserts that he can stand comfortably for 10 to 15 minutes, however thereafter the right leg becomes uncomfortable, begins to swell, and the pain level increases. Claimant encounters difficulty squatting due to residuals in the right leg. Claimant noted that he can walk up to eight blocks, however the longer he walks or is up on the leg, the more pain and swelling he experiences in it.

Claimant maintains that before he was placed in a brace for the right leg he fell up to twelve (12) times a month, with his right knee giving way. Since having the brace claimant testified that he still falls occasionally, four to six times a month. Claimant asserts that the brace is protecting his knee.

Claimant's testimony reflects that on a scale of one to 10, his average pain level is between 4 to 5, and the greater activity he engage in the greater the pain. When the pain level increases claimant noted that he has to stop whatever he is doing. Claimant wears a Duragesic pain patch. Claimant maintains that the pain has adversely affected his predisposition toward chemical abuse:

It's - - the worse that the pain gets, if I have the pain medication right there in my control, you know, I am subject to taking more of the medication than prescribed and if I take the medication and I'm not hurting then I'm subject to trying to do too much as far as walking or something like that and I start hurting more and I would take more than I should. So, that's why I don't want to take - -

I didn't have any pain medication and my pain was really bad and I was in between getting in and seeing Dr. Watson, if I remember correctly, and I forged a prescription for Percocet I think it was three prescriptions for Percocet. (T. 30-31).

Claimant acknowledged that he eventually plead guilty to a felony relative to the forged prescriptions. The afore occurred in May 2002, with the plea being entered on May 9, 2003.

Claimant's first back surgery was performed by Dr. James B. Blankenship on July 7, 1994. In November 2002, claimant was seen by Dr. F. Richard Jordan, an North Little Rock neurosurgeon, for complaints of right leg and low back pain. On April 7, 2003, claimant underwent a lumbar laminectomy at L4-5 and L5-S1 with diskectomy at L4-5 under the care of Dr. Jordan.

On June 6, 2003, claimant was involved in a motor vehicle accident on Highway 10, in Little Rock. The medical records reflect that on July 3, 2003, claimant was seen in the emergency room of Washington Regional Medical Center, in Fayetteville. Claimant relayed a history to emergency medical personnel to having injured his back when he fell getting out of the shower. On July 4, 2003, the medical records reflect that claimant was seen in the emergency room of Northwest Medical Center in Springdale, and relayed a history of injuring his back when he slipped in water getting out of the shower. Claimant acknowledged getting pain medicine prescribed during both emergency room visits. Claimant was seen by Dr. Merritt on July 8, 2003. The records of the July 8, 2003, visit does not reflect histories from the claimant relative to the northwest Arkansas emergency room visits.

The medical records reflect that claimant was seen at the emergency room of Northwest Medical Center in Springdale on September 1, 2003, and provided a history of having slipped in

the shower the previous night and twisted his back. Claimant was prescribed Percocet and Valium during the visit. Claimant was also scheduled to see Dr. Jordan on September 8, 2003. The medical records reflect that claimant was seen in the emergency room of Baptist Medical Center on September 2, 2003, with a long history of cervical radiculopathy. Claimant also relayed during the visit that for the past two months he had been having a flare up on and off. The September 2, 2003, emergency room report reflects that claimant was scheduled to see Dr. Jordan on September 17, 2003. The medical reflects that claimant was seen at the emergency room of Baptist Medical Center on September 15, 2003, with a history of having pain in the left wrist following a fall.

Claimant denies that has worked anyplace since his March 31, 1998, compensable injury. Claimant acknowledged working at his parent's gun store prior to March 31, 1998, however specifically denies doing so since. Claimant's testimony reflects that in 1999 his former case manager, Deb Allen, mentioned vocational rehabilitation, however that was the last that he heard of it. Claimant denied that he has been offered job placement assistance in getting back into the work force. Claimant notes that his right knee and lower leg swells every day, with the amount corresponding with his activity level.

Claimant's testimony reflects that he visits friends who have a houseboat at the lake in Garland County during the spring/summer/fall three to 10 times a month. Claimant visits friends and family members of his late wife Washington County three to four times a year. Claimant testified that he visits friends in Redfield, and Bebee, as well as friends at their hunting club in Woodruff County. The duration of the visits range from one day to a weekend. Claimant is not currently married. Claimant's testimony reflects that he did most of the driving, although

sometimes he rode with somebody. Claimant asserts that prior to losing his driving license due to forgery conviction there were physical restrictions on his driver's license.

Claimant has had a hunting license for each year subsequent to his 1998 compensable injury. While claimant denies going duck hunting during the 2003 season, he acknowledge doing so in 2002. Claimant's testimony reflects, with respect to his hunting:

Yes, sir, if it was somewhere where I could go that we could boat into or they could take me in on a four-wheeler.

* * *

I may get out and stand to hunt, when I hunt. If they, as far as me putting out decoys whenever I am dropped off I may toss them out and let whoever is hunting with me place the decoys out or some areas they may be placed out by boat, from the boat. (T. 66).

With respect to the nature of the work he performed at the gun shop before his March 31, 1998, compensable injury, claimant testified:

Oh, things like answer the telephone, assist customers, you know, sales, a lot of stuff. I would keep up the records that we were required to keep up by the FFL, help my stepfather clean guns and repairing them and things of that nature.(T. 67).

Claimant acknowledged that he can perform some of the former activities that he performed at the gun shop in his present physical condition, to include answer the phone, assist customer, and working on the books. However, claimant maintains that in order to do the afore he would have to be able to get somewhere where he could get comfortable, and was not standing or sitting for prolonged periods of time. (T. 67-68). Claimant concluded that given his current physical limitations and restrictions he does not believe that he would be able to do enough to significantly help out the job effort at the business.

Claimant asserts that the majority of the medical treatment he has received since 1998, to include surgeries and physical therapy has been related to his compensable injury. Claimant acknowledged last having back surgery in April 2004, under the care of Dr. Jordan. Claimant denies claiming as a part of his compensable 1998 injury, the April 2004 back surgery. Further, claimant concedes that since he has not been released by Dr. Jordan relative to the back surgery he could not work regardless of the compensable knee injury.

Claimant's source of income is social security disability benefits, \$657.00 monthly. Claimant applied for social security disability in 2002, and was approved without having to attend a hearing. At the time of his March 31, 1998, compensable injury claimant's weekly gross earnings were between \$250.00 and \$280.00.

Ms. Hill testified that claimant developed a chemical dependency following the death of his first wife in March 1996. As a consequence of the afore, Ms. Hill's testimony reflects, claimant completed a program at Serenity House, and later secured employment there. Ms. Hill testified that based on her observations claimant get a handle on the chemical dependency problem in the completion of the program at Serenity House. Ms. Hill added that after the March 31, 1998, right knee injury of the claimant, the chemical dependency problem returned. Ms. Hill's testimony reflects, with respect to her observation of the claimant and of his physical limitations:

Well, definitely his knee is impaired. He will fall sometimes. And he cannot work. Basically he's just in a period of either recuping or having surgery. (T. 13).

Ms. Hill noted that she sees the claimant almost on a daily basis.

There is not a dispute regarding the medical treatment rendered to the claimant relative to

his March 31, 1998, compensable injury through the September 13, 2002, evaluation by Dr. J.K. Smelz. A review of the exhaustive report of Dr. Smelz reflects that she had access to the claimant as well as to his prior pertinent medical records. Claimant's treating pain management physician at the time of the September 13, 2002, evaluation was Dr. Robert Valentine. Claimant continued to treat with Dr. Valentine for complaints attributed to the March 31, 1998, compensable injury subsequent to the evaluation by Dr. Smelz.

The September 13, 2002, report of Dr. Smelz reflects, in pertinent part:

5. Problems with drug abuse, drug seeking behavior with inpatient detoxification times two. There is a history of questionable behavior concerning narcotic pain behavior. . . . His past history certainly gives the impression of drug seeking behavior. Given the problem with narcotic addiction, there are serious question as to why he did not inform his physicians of this problem when receiving narcotic prescriptions, or why he waited to inform the case manager, in Dr. Watson's case.

6. There is no evidence of reflex sympathetic dystrophy at this time. It is certainly unclear whether he ever had reflex sympathetic dystrophy. He has had over twenty sympathetic blocks, and these appear to have done little for resolution of his complaints. There should have been no blocks done after the 4th block. There is no indication at this time for blocks, STS or any other treatment for ostensible reflex sympathetic dystrophy since he does not have the signs or symptoms associated with this diagnosis.

7. Mr. Cryer has reached maximum medical improvement. His situation cannot be improved further. It is likely however, that his present status will deteriorate over time. Mr. Cryer does indeed have a serious problem with his right knee. He has a knee arthroplasty at a very young age, persists in being quite active, and has steadily gained weight over the last several years and is a smoker. He will at the very least, require replacement of the arthroplasty. He has the additional problem of patellar tendon ruptures, with three repairs, and will not be able to continue with such surgeries should that problem repeat itself. He will most likely eventually come to fusion of the knee.

Questions:

Sympathetics Blocks: Dr. Ackerman appeared to feel that his physical examination tended toward reflex sympathetic dystrophy and his findings documented are consistent with RSD. . . . Dr. Watson’s physical examination did not suggest a diagnosis of reflex sympathetic dystrophyDr. Valentine stated that his diagnosis of reflex sympathetic dystrophy was based on a bone scan. . . .

* * *

Pain medication. Mr. Cryer has received narcotics, and antiepileptics. Furthermore, there has been no coordination between physicians, including Dr. Watson and Dr. Hefley, all the ER visits, and now Dr. Valentine, and the psychiatrist at Bridgeway, Dr. Harber who detoxes Mr. Cryer, who then receives more pain medications elsewhere. Based on the inconsistencies of today’s examination, it is unclear whether Mr. Cryer requires any pain medication; he did not appear to be in any pain and was taking only the antiepileptics when observed.

* * *

5. Additional treatment:

Mr. Cryer will likely require later in his life, as noted above, one additional, and definitive surgery for his knee, which most probably would be fusion. I would recommend that evaluation and recommendation for this surgery be done outside this area, by a knee specialist. I would recommend about 6 sessions of physical therapy to teach him a back stretching and strengthening home program, so that he has the tools to re-condition himself, should he wish to do so.

I would recommend 4-6 sessions with Behavioral Medicine to teach his psychological coping skills for any perceived pain, and would recommend Dr. Allen Sherman at the Behavioral Medicine Program at UAMS for this.

I would recommend that he continuously wear the knee brace, both in home and outside, and that he carry a cane or preferably a forearm crutch as he states that he feels afraid of falling. . . .

I would recommend strenuously against any treatment of pain with narcotic analgesics. Today Mr. Cryer stated that he had taken no narcotic analgesics, and there was no complaint of pain or pain behavior when distracted or during spontaneous behavior. This type of fluctuation in pain behavior contraindicates the risk of further addiction detoxification cycles, as well as the risk of aggressive intervention with spine stimulators or morphine pumps.

6. Ability to work:

Mr. Cryer is able to work at sedentary activities, which would allow him to stand and sit at will without necessity for heavy lifting, kneeling, crawling or stooping, and without prolonged walking or standing. At present, as mentioned above, he may be working at his gun store, which should prove ideal. He mentioned that he is interested in owning a shooting range/gallery, which would also be within his physical capabilities. It is in fact, highly recommended that Mr. Cryer work, since distraction appears to cause complete pain resolution. (CX. #1, p11-12)

Dr. Smelz assessed the extent of the claimant's permanent physical impairment at 52 % to the right lower extremity.

Claimant continued to treat with Dr. Valentine subsequent to the September 13, 2002, evaluation by Dr. Smelz. Claimant was referred by Dr. Valentine to Dr. F. Richard Jordan, a North Little Rock neurosurgeon, for treatment of a diagnosed complex regional pain syndrome of right lower extremity.

Claimant was initially seen by Dr. Jordan on November 13, 2002, pursuant to the above-mentioned referral of Dr. Valentine. The November 13, 2002, report of Dr. Jordan, relative to the visit reflects, in part:

He does have a past history of back problems and had a lumbar discectomy for an HNP in 1994 and had no residual. He reports that the current complaints started about five to six months ago. He has fallen several times since these symptoms started. The pain extend down the leg and out into the right great toe. As you know, there is a suggestion that he is developing RSD in the right lower extremity.

He had an MRI in April of 2002 which suggested some recurrence at L4/5 and a bulge at L5/S1. You will remember he has fallen since then.

. . . Pertinent exam findings include the noticeable multiple incisions and scarring in the right lower extremity. He does not have hypersensitivity over the areas that have been skin grafted but over the areas that have not he is sensitive to touch, even with light touch. He has

weakness in the extensor hallucis longus on the right and he is tender in the lumbar paraspinal muscles, more on the right than the left. He wears a right knee brace.

I certainly feel that Mr. Cryer is a good candidate for a trial with epidural stimulation. We have discussed at length the procedure and expected outcome and he is interested in proceeding. . . In the interim, we will plan for him to have psychological screening with Dr. Ken Counts to insure there is no contraindication to using implantable therapy. . .(R#1, Ex.#1, p. 85)

On December 17, 2002, claimant was admitted to Baptist Memorial Medical Center, where Dr. Jordan performed an implantation of an epidural electrode via thoracic laminotomy.

The December 17, 2002, operative report of Dr. Jordan reflects, in terms of history:

THIS IS A 38-YEAR-OLD MAN WHO WAS REFERRED FROM BOB VALENTINE WITH A VERY SEVERE RIGHT LEG PAIN PROBLEM. HE ALSO HAS BACK PAIN. HE HAS AN EXTENSIVE HISTORY WITH A RIGHT KNEE INJURY IN 1998. THIS FRACTURE REQUIRED SURGERY. HE DEVELOPED A COMPARTMENT SYNDROME AFTER THAT. HE HAS SINCE THEN HAD 15 SURGERIES FOR REOPERATION . . . HE ALSO HAD A PAST HISTORY BACK PROBLEMS AND HAD A LUMBAR DISCECTOMY FOR AN HERNIATED NUCLEUS PULPOSUS IN 1994. HE HAS FALLEN SEVERAL TIMES AND HAS MORE BACK PAIN RECENTLY. THE PAIN IN THE RIGHT LEG RESEMBLING A REFLEX SYMPATHETIC DYSTROPHY HAS DEVELOPED OVER THE PAST YEAR.(CX. #1, p.45)

On December 19, 2002, claimant was again admitted to Baptist Memorial Medical Center, under the care of Dr. Jordan where the trial epidural stimulator was removed, having achieved the desired pain relief in the right leg, and implantation of epidural stimulator with implanted pulse generator performed. (CX. #1, p. 47-49).

Prior to being seen in follow-up by Dr. Jordan relative to the December 19, 2002, procedure, claimant was seen in the emergency room of Washington Regional Medical Center, in

Fayetteville, Arkansas, on February 9, 2003, in which he relayed a history of having fallen on "2/8 @1730" landing on his right knee on the side of tub. (R#1, Ex. #1, p. 98-103). Claimant had also been seen by Dr. James Merritt, in January, February, and March 2003.

The claimant was seen in follow-up by Dr. Jordan on April 2, 2003. The clinic note relative to the visit reflects, in pertinent part:

Louis returned to the office today for reevaluation. He had a spinal cord stimulator implanted for chronic regional pain syndrome in the right lower extremity on December 19, 2002. He reports that the stimulator has helped some with the leg symptoms; however, he has had a marked increase in back pain over the last month. He reports that he is not able to get any relief unless he is lying down. When he does stand he gets a shooting pain down the left leg which was not present previously.

Studies were obtained which show recurrent disc herniations at L4/5 and L5/S1 with spinal stenosis.

* * *

After a lengthy discussion we have decided to proceed with decompression and posterior lumbar interbody fusion at L4/5 and L5/S1 with instrumentation. We scheduled surgery at Baptist Health on April 07, 2003. (R#1, Ex.#1. p.106).

On April 7, 2003, claimant underwent a lumbar laminectomy at L4-5 and L5-S1 with diskectomy at L4-5 under the care of Dr. Jordan.(R#1, Ex. #1, p. 107-108;110-111).

The medical in the record reflects that on April 14, 2003, claimant was seen by Dr. Merritt with complains of pain. (R#1, Ex. #1, p.109). Thereafter claimant presented at the emergency room of Baptist Medical Center on May 13, 2003, with a chief complaint of back pain attributable to the April 7, 2003, surgery and a need for pain medicine. The emergency room report noted that a check of the hospital's computer disclosed that claimant had been seen at

Baptist Health Medical Center-North Little Rock on May 1, 2003, after a fall. (R#1, Ex. #1, p. 113-114).

On May 14, 2003, claimant was seen by Dr. Merritt. The office note reflects that the reason for the visit was a follow up for pain meds. (R#1, Ex. #1, p. 112). The medical records reflect that claimant executed a Pain Management Agreement during the May 14, 2003, visit to Dr. Merritt. (R#1, Ex. #1, p. 115-116).

On June 10, 2003, claimant was seen in follow-up by Dr. Jordan relative to the April 7, 2003, lumbar laminectomy. The office note reflects that claimant had been involved in a motor vehicle accident of June 6, 2003, however no major injury. The June 10, 2003, clinic note recited improvements realized by claimant as a result of the surgery, and claimant's plans to be seen by Dr. Merritt in a pain management facility for chronic medication. Accordingly, a return appoint was not scheduled with Dr. Jordan. (R#1, Ex #1, p. 117). The medical reflects that claimant returned to Dr. Jordan on June 17, 2003, requesting instructions on using his stimulator. Claimant was furnished Percocet, and Valium during the visit. (R#1,Ex.#1, p. 118).

The medical in the record reflects that following the June 17, 2003, visit to Dr. Jordan with complaints of pain, claimant was seen at two (2) different medical facilities in Northwest Arkansas during between July 3-4, 2003, where he obtained prescription pain medication.(R#1, Ex.#1, p. 119-127) Claimant was also seen by Dr. Merritt on July 8, 2003, for complaints attributable to a flare up of his RSD, and a refill of prescription pain medication. (R#1, Ex. #1, p. 128). The medical in the record reflects that on August 3, 2003, claimant was seen in the emergency room of St. Vincent Infirmiry Medical Center, where he relayed a history of "recently re-injured knee". (R#1,Ex.#1, p. 129).

On September 1, 2003, claimant again presented to the emergency room of Northwest Medical Center of Washington County, in Springdale, and relayed a history of having slipped getting out of the shower and twisted his back the prior night. Claimant complained of severe low back pain. Claimant obtained prescription pain medication during the visit. (R#1, Ex.#1, p.130-133). The following day, September 2, 2003, claimant presented to the emergency room of Baptist Medical Center in Little Rock with a chief complaint of neck pain. Claimant was provided a prescription for pain medication and directed to keep his scheduled September 17, 2003, appointment with Dr. Jordan, which he had relayed to emergency medical personnel. (R#1, Ex.#1,p. 134-135).

The medical reflects that claimant was seen in the emergency room of Baptist Medical Center on September 15, 2003, for treatment relative to his left wrist falling a fall. The emergency room report noted the presence of “marked swelling” and decreased range of motion in the claimant’s left wrist. Treatment rendered to the claimant during the visit included Webril and plaster navicular splint applied, directed to use ice, elevation and a sling. Claimant was also directed to followup with Dr. Hefley and the pain resolved. (R#1,Ex. #1, p. 136-138).

Claimant was seen by Dr. Bryan, at the clinic of Dr. Hefley on September 16, 2003, for follow-up care of the left wrist complaint. The report authored by Dr. Bryan relative to the claimant’s visit reflect, in pertinent part:

This 39-year-old man is disabled from right knee arthropathy and posttraumatic RSD. The problematic right knee gave out on his yesterday when he struck a glancing blow to a ladder he was walking past. He fell backward and caught himself with his left hand, experiencing immediate severe wrist pain. He was seen at the Baptist Emergency Department where he was found to have a nondisplaced fracture of the distal pole of the scaphoid.

He was fitted in a thumb spica splint and referred here for follow-up.

* * *

IMPRESSION:

1. Distal pole sacphoid fracture.
2. This was a direct result of his right knee giving was with incidental contact.(R#1,Ex.#1, p139-140)

Claimant was furnished a prescription for additional Percocet by Dr. Bryan and directed to return in three(3) weeks for removal of the cast and repeat x-rays.

On September 29, 2003, within two weeks of the visit to Dr. Bryan, claimant again presented at the Baptist Medical Center emergency room with complaints of pain and muscle spasms in the left shoulder and up into his neck relative to the sling around his neck for the cast due to the fractured left wrist. Claimant relayed that he had taken two instead of one pill for pain, and, as a consequence, was out of his medication, Percocet. Following his examination , claimant was assessed with muscle spasm in the left upper extremity along with the wrist fracture. Claimant was provided three each Percocet and Soma pills, and directed to contact he primary care physician. (R#1, Ex. #1, p.141-142)

Claimant was seen by Dr. Bryan on December 1, 2003, in follow-up to his left wrist injury. Following his examination of the claimant, Dr. Bryan's impressions were "left wrist sprain with injuries to the distal radioulnar joint and the triangular fibrocartilage complex and degenerative arthritis in the scaphoid-trapezium articulation, aggravated by" the claimant's fall and sprain". (CX.#3,p.1).

The medical in the record reflects that claimant presented to the emergency room of Washington Regional Medical Center in Fayetteville, Arkansas on Friday, December 26, 2003,

and Saturday, December 27, 2003, with complaints of back pain and in an effort to secure prescription pain medication. The claimant reported to emergency medical personnel during the December 27, 2003, visit, that “his Percocet and Valium were stolen last PM.”(R#1,Ex.#1, p.149-151).

On December 29, 2003, claimant was again seen by Dr. Bryan. Dr. Bryan’s impression to the claimant’s complaint was that of left wrist sprain and degenerative arthritis. The report reflects that the claimant was to be seen by Dr. Rhodes for further evaluation.(R#1,Ex. #1, p. 152). On January 4, 2004, claimant presented to the emergency room of Baptist Health Medical Center-Little Rock with complaints relative to his left wrist when he fell and re-injured same. Examination of the claimant’s left hand during the visit yielded findings of “bruising and swelling around the thumb.” Claimant was provided a 6-Pak Lortab. (R#1,Ex.#1,p.153-156).

The medical reflects that claimant was seen by Dr. Bryan following the January 4, 2004, emergency room visit. A January 5, 2004, report of the visit reflects, in pertinent part:

He fell once again. He injured his left wrist and right elbow as he was unable to lift his leg over the edge of the tub, falling, striking the dorsum of the wrist on the edge of the tub. He is in considerable pain and has exhausted his current Percocet and Lortab.

Inspection: The wrist is visibly swollen from the hand to the mid forearm.

IMPRESSION:

1. Nondisplaced distal radius fracture from fall injury on 01/03/04.
2. Right [left] wrist sprain with triangular fibrocartilage tear (date of injury, 09/15/03).(CX #3, p.3)

Claimant was provided Percocet by Dr. Bryan during the January 5, 2004, visit.

On January 8, 2004, claimant was evaluated by Dr. David M. Rhodes pursuant to the

referral of Bryan relative to his left wrist. Dr Rhodes's impression of the claimant's injury was that of lect distal radius fracture. (CX. #3, p.4). On January 9, 2004, Dr. Rhodes performed an open reduction with internal fixation of the claimant's left distal radius fracture. (CX. #3, p.5). Claimant was seen in follow-up relative to the left wrist surgery by Dr. Rhodes on several occasions with the last being March 15, 2004. During the March 15, 2004, visit, claimant was released to return to work with a 10 pound weight restriction, directed to continued with his therapy, and was scheduled to be seen in follow-up in three weeks. (CX. #3, p. 9).

On March 31, 2004, the deposition of Dr. Bryan was obtained by the parties. Dr. Bryan has a double medical speciality of family practice, in which he is board certified, and sports medicine, in which he has a certificate of added qualification. Dr. Bryan's testimony reflects that he first treat the claimant on September 16, 2003, relative to an injury to the left wrist growing out of a fall. Claimant had been referred by the emergency department of Baptist Health Medical Center-Little Rock. Claimant was found to have a fracture of his scaphoid - - a small bone in the wrist.. Following the initial visit of September 16, 2003, Dr. Bryan's testimony reflect that claimant was seen on September 29, 2003, when a cast was changed, and on October 14, 2003, when the long-arm cast changed to a short-arm, spica cast. The cast was removed on November 10, 2003. X-rays were obtained of the claimant's left wrist at the time the cast was removed.

Dr. Bryan noted that a CT scan was obtained during a December 1, 2003, visit with the claimant, and that the radiologist specifically mentioned that the claimant's ulna was slightly out of place, which suggested that there was some instability, or looseness, of the ligaments of the wrist. During a December 29, 2003, follow-up visit Dr. Bryan noted the improvement in the claimant's wrist. In terms of the duration of his treatment relative to the claimant's left wrist, Dr.

Bryan testified:

At no point in his treatment did I have any diagnostic certainty how long I would need to see him because of the nature of his pain and the uncertainty over his chief underlying diagnosis in the wrist. So it was ongoing follow-up at that point. In fact, the record shows that he was still requiring a very strong narcotic analgesic for occasional pain relief at that visit. (R#1, Ex. #3, p. 10).

Claimant was next seen by Dr. Bryan on January 4, 2004, regarding a new injury of January 3, 2004, involving the left wrist and right elbow. X-rays disclosed a fracture of the distal radius in the left arm. Claimant's care was then transferred by Dr. Bryan to Dr. Rhodes. Dr. Bryan testified that claimant relayed, with respect to the mechanism of the January 3, 2004, that he was unable to lift his right leg sufficiently to clear the bathtub, due to the prior injury, thereby resulting in the fall. (R#1, Ex. #3, p.12).

After a thorough consideration of all the evidence in this record, to include the testimony of the witnesses, review of the medial evidence, and application of the appropriate statutory provisions and case law, I make the following:

FINDINGS

1. The Arkansas Workers' Compensation Commission has jurisdiction of this claim.
2. On March 31, 1998, the employment relationship existed between the claimant and Respondent #1.
3. On March 31, 1998, the claimant earned wages sufficient to entitle his to weekly compensation benefits of \$172.00/154.00, for total/permanent partial disability.
4. On March 31, 1998, the claimant sustained an injury arising out of and in the course of his employment.

5. The claimant was temporarily totally disabled relative to the March 31, 1998, compensable right knee injury for the period beginning April 1, 1998, and continuing through September 13, 2002.

6. Prior to March 31, 1998, claimant had a pre-existing tendency toward chemical dependency. The evidence preponderates that the March 31, 1998, compensable right knee injury of the claimant aggravated claimant pre-existing chemical dependency, and treatment relative to same is a compensable consequence of the compensable injury.

7. Claimant developed Reflex Sympathetic Dystrophy (RSD) in his right lower extremity as a compensable consequence of the March 31, 1998, compensable right knee injury.

8. On September 15, 2003, and January 4, 2004, claimant suffered falls growing out of residuals of his March 31, 1998, compensable right knee injury, resulting in injuries to his left wrist and right elbow. The evidence preponderates the left wrist injuries and right elbow injury are compensable consequences of the March 31, 1998, compensable right knee injury.

9 Respondents #1 shall pay all reasonably necessary and related hospital and medical expenses arising out of the injury of March 31, 1998, to include treatment relative to the claimant's RSD, compensable consequences of chemical dependency, and September 15, 2003, and January 4, 2004, left wrist and right elbow injuries.

10. In July 1994, claimant under lumbar disc surgery which resulted in a permanent physical impairment of 10 % to the body as a whole.

11. The claimant reached the end of his healing period relative to the March 31, 1998, compensable right knee injury, on September 13, 2002, and has sustained a permanent physical impairment as a result of same in the amount of 52 % to the right lower extremity.

12. Claimant, having sustained compensable scheduled injuries growing out of the March 31, 1998, accident, to included the compensable consequences to his left wrist, right elbow, and RSD relative to the right lower extremity, has failed to sustain his burden of proof by a preponderance of the evidence that he has been rendered permanently and totally disabled, when is age, education, permanent restrictions and physical limitations are considered.

13. Respondent #2, the Second Injury Fund, has no liability in this claim, the claimant having failed to sustain his burden of proof by a preponderance of the evidence that he is permanently totally disabled and thereby entitled to wage loss or permanent partial disability in excess of the anatomical impairment of 52 % to the right lower extremity. Respondent #2 is dismissed from this claim.

14. Respondent #3, the Death & Permanent Total Disability Trust Fund, has no liability in this claim, the claimant having failed to sustain his burden of proof that he has been rendered permanently totally disabled. Respondent #3 is dismissed from this claim.

15. Respondents #1 have controverted the payment of medical benefits relative to claimant's compensable consequences of the aggravation of claimant's pre-existing chemical dependency, medical treatment relative to the September 15, 2003, and January 4, 2004, left wrist and right elbow injuries, and claimant entitlement to benefits relative to the RSD.and continued medical treatment relative to the March 31, 1998, compensable right knee injury.

CONCLUSIONS

The compensability of the claimant's March 31, 1998, right knee injury is not disputed. Claimant has been assessed with a permanent physical impairment in the amount of 52% as a result of the injury and surgery, which has been accepted and paid by Respondents #1. Prior to

the March 31, 1998, compensable injury claimant had suffer injuries requiring surgery to his low back, left knee, right knee, as well as narcotic drug addiction. Claimant had in place a rating of 10% to the body as a whole as a result of the prior lumbar disc surgery. Claimant asserts that he has been rendered permanently and totally disable and is entitled to corresponding indemnity benefits. Further, claimant asserts entitlement to medical and indemnity benefits as a result of injuries suffered to his left wrist and right elbow as a consequent of falls growing out of the March 31, 1998, compensable injury. Likewise, claimant asserts entitlement to workers' compensation benefits as a result of RSD and an aggravation of his pre-existing chemical dependency tendency, which he attributes to the March 31, 1998, compensable injury.

Respondents #1 deny that the claimant has been rendered permanently totally disabled as a result of the compensable March 31, 1998, injury. Respondents #1 assert that if claimant is indeed permanently totally disable, the Second Injury Fund, Respondent #2, is liable for the payment of said benefits. Respondents #1 deny the compensability of the claimant's left wrist and right elbow injuries, as well as any treatment relative to chemical dependency. Respondents #1 further deny that claimant suffers from RSD.

Respondent #2 deny that the claimant is permanently totally disabled. Further, Respondent #2 contend that because the claimant suffered a compensable injury, pursuant to recent ruling of the Full Commission, the claimant cannot establish entitlement to permanent total disability benefits, pursuant to Ark. Code Ann. §11-9-521; 519 (b); and 525 (a) (1), (c)(3).

In addition the arguments of Respondents #1 and Respondent #2, with respect to claimant's assertion of permanent total disability, Respondent #3 asserts that if a finding of permanent total disability is had, Respondents #1 are not entitle to credit for the payment of

indemnity benefits paid toward the anatomical impairment against the requirement of paying the first \$75,000.00, in permanent disability benefits.

The present claim is governed by the provisions of Act 796 of 1993, in that claimant asserts entitlement to workers' compensation benefits as a result of an injury having been sustained subsequent to the effective date of the afore provision.

In workers' compensation law, the employer takes the employee as he finds him, and employment circumstances that aggravate pre-existing conditions are compensable. *Heritage Baptist Temple v. Robison*, 82 Ark. App. 460, 120 S.W.3d 150 (2003). An aggravation of a pre-existing non-compensable condition by a compensable injury is, itself, compensable.

In the instant claim, prior to his employment with respondents #1 claimant suffered from chemical dependency. Indeed, the evidence disclosed that claimant had completed a thirty-day program for drug dependency at respondent-employer #1, prior to his employment by same.

Claimant's testimony reflects regarding his chemical dependency tendency:

After Becky died when the doctor had give me, you know, like Xanax. I was having anxiety attacks and stuff, and I unfortunately have got the addictive genes. My grandfather on both sides and my grandmother and my father were all either alcoholics or drug addicts. And so I knew what killed pain, and I did it then. And then I got sober and was going to AA meetings and everything and unfortunately broke my knee. (R#1, Ex. #4, p.31).

Evidence of claimant's drug seeking behavior is replete through the medical records subsequent to the compensable March 31, 1998, compensable injury. The aggravation of a pre-existing condition by a specific work-related incident need not be the major cause of a claimant's disability in order to be compensable. *Farmland Ins. Co. v. Dubois*, 54 Ark. App. 141, 923 S.W. 2d 883 (1996). The claimant has sustained his burden of proof by a preponderance of the

evidence that the compensable March 31, 1998, right knee injury aggravated his pre-existing chemical dependency tendency. Respondents #1 have controverted claimant's entitlement to medical treatment relative to the compensable aggravation of the pre-existing condition.

The evidence in the record reflects that subsequent to the claimant March 31, 1998, compensable injury and treatment he experienced instances of instability and giving away in the right leg, which resulted in numerous falls. Claimant ultimately underwent a total knee replacement relative to the compensable right knee injury in 2000. The residuals relative to the claimant's right knee are not disputed. In her September 13, 2002, evaluation, Dr. Smelz noted the importance of claimant wearing the brace on his right knee and also stressed the usefulness of a cane or other device to assist in walking and preventing fall.

Claimant presented consistent histories relative to the falls he suffered on September 15, 2003, and January 4, 2004, both of which resulted in treatment at the emergency room, objective evidence of injury, and the need for medical treatment. Claimant ultimately underwent surgery on January 9, 2004, relative to the January 4, 2004, left wrist injury. Ark. Code Ann. § 11-9-508 (a) requires that the employer provide such medical services as may be reasonably necessary in connection with the employee's injury. *Cox v. Klipsch & Associates*, 71 Ark. App. 433, 30 S.W. 3d 764 (2000). Claimant has sustained his burden of proof by a preponderance of the credible evidence that falls suffered on September 15, 2003, and January 4, 2004, resulting in injuries to his left wrist and right elbow, were compensable consequences of the March 31, 1998, compensable knee injury. Respondents #1 have controverted the compensability of the afore compensable consequence injuries in their entirety.

The diagnosis of the claimant's Reflex Sympathetic Dystrophy (RSD), has been

established by objective findings by several of his treating physicians, to include Dr. Robert Valentine, Dr. Charles Watson, Dr. Richard Jordan, Dr. James Merritt. Claimant has undergone bone scans, and under diagnostic studies, as reflected in the medical records, establishing the RSD. Medical treatment rendered to the claimant relative to the RSD, is reasonable, necessary and related to the compensable injury of March 31, 1998. Only Dr. Smelz in her evaluation of September 13, 2002, opined that claimant did not suffer from RSD. It is noteworthy that claimant underwent further treatment relative to the RSD subsequent to September 13, 2002. Respondents #1 have controverted the claimant's entitlement to medical treatment relative to the RSD.

While it is undisputed that claimant suffered prior injuries relative to his low back, had undergone surgery relative to same on one occasion and had been assessed with a permanent physical impairment of 10 % to the body as a whole prior to his employment with Respondents #1, the credible evidence in the record reflect that subsequent to his compensable injury of March 31, 1998, claimant experienced numerous falls attributable to the compensable injury. Further, the medical in the record reflects that the falls increased claimant's symptoms relative to his low back. Claimant was ultimately diagnosed with a recurrent of the herniated disc at L4-5 and L5-S1, for which he has undergone two (2) surgical procedures under the care of Dr. Jordan since the compensable March 31, 1998 injury. As a consequence of the afore, claimant has sustained an increase in his anatomical impairment relative to the lumbar spine of 2% to the body as a whole at a minimum. Claimant has not claimed the additional medical treatment relative to his back as a consequence of his compensable injury. Accordingly, there is no basis for an award of benefits to body as a whole growing out of the March 31, 1998, compensable injury, on which

claimant asserts entitlement to permanent total disability benefits.

In the instant claim, claimant is a highschool graduate with approximately two years of post secondary education. Additionally, claimant has extensive training in law enforcement. Claimant's work history reflects experience in law enforcement, as an assistant manager of a convenience store, an automobile salesman, a gunsmith, and as a counselor.

Claimant suffered a scheduled injury to his right knee in his March 31, 1998, compensable accident. The afore resulted in a permanent physical impairment in the amount of 52 % to the right lower extremity. While claimant suffered compensable consequence injuries to his left wrist and right elbow, there is no evidence to reflect that the same has or will result in additional anatomical impairment. Claimant had surgery relative to the left wrist under the care of Dr. David M. Rhodes. While pins were placed in the left upper extremity and a cast on the site, every indication from the medical in the record is that the has fully recovered without permanent physical impairment relative to same. When last seen by Dr. Rhodes on March 15, 2004, the pins had been removed during the prior visit; x-rays showed good alignment of the left distal radius, claimant had good range of motion; and he was non-tender to palpation. (CX.#2, p.9).

When the claimant's age, education, work experience, permanent restrictions and limitations are considered, I find that he has failed to sustain his burden of proof by a preponderance of the evidence that he has been rendered permanently and totally disabled within the preview of the Arkansas Workers' Compensation Act, as a result of the March 31, 1998, compensable injury. Accordingly his claim for said benefits is respectfully denied.

AWARD

Respondents #1 are herein directed to pay to the claimant weekly temporary total disability benefits in the amount of \$172.00, for the period April 1, 1998 and continuing through September 13, 2002, as a result of the March 31, 1998, compensable injury. Said sums accrued shall be paid in lump without discount. Respondents #1 may claim credit for sum heretofore paid toward the afore obligation.

Respondents #1 are further ordered and directed to pay to the claimant permanent partial disability benefits to correspond with the 52% permanent physical impairment to the right lower extremity at a weekly compensation benefit rate of \$154.00, as a result of the March 31, 1998, compensable injury. Said sum accrued shall be paid in lump without discount. Respondents #1 may claim credit for sums heretofore paid toward to afore obligation.

Respondents #1 are further ordered and directed to pay appropriate temporary total disability to the claimant relative to his compensable consequence injuries of September 15, 2003, and January 4, 2004, relative to his left wrist and right elbow, growing out of the compensable injury of March 31, 1998. Said sums accrued shall be paid in lump without discount.

Respondents #1 are further ordered and directed to pay all reasonable related medical, nursing and other apparatus expenses, to include medical relate travel, relative to the claimant's compensable injury of March 31, 1998, compensable consequences of September 15, 2003, January 4, 2004, and aggravation of claimant's pre-existing chemical dependency tendency, as well as treatment for claimant's RSD relative to the March 31, 1998, compensable right knee injury.

This award shall bear interest at the legal rate pursuant to Ark. Code. Ann. § 11-9-809,

until paid.

Maximum attorney fees are herein awarded to the claimant's attorney, the Honorable Steven McNeely, on the controverted portion of this Award pursuant to Ark. Code. Ann. § 11-9-715, § 11-9-801, WCC Rule 10, and *Holiday Inn-West v. Coleman*, 31 Ark. App. 224 (1990).

Respondent #2 and Respondent #3 are herein dismissed from this claim.

Matters not addressed herein are expressly reserved.

IT IS SO ORDERED.

Andrew L. Blood, Administrative Law Judge