

**BEFORE THE ARKANSAS WORKERS' COMPENSATION
COMMISSION**

CLAIM NO. F404769

RILEY CARPENTER, EMPLOYEE **CLAIMANT**

**INTERNATIONAL PAPER COMPANY,
EMPLOYER
SELF-INSURED** **RESPONDENT**

**SEDGWICK CLAIMS MANAGEMENT SERVICES
(TPA), INSURANCE CARRIER** **RESPONDENT**

OPINION FILED JANUARY 26, 2005

Hearing before Administrative Law Judge Cynthia Estes Rogers on October 29, 2004, in Pine Bluff, Jefferson County, Arkansas.

Claimant represented by Mr. Kenneth A. Harper, Attorney at Law, Monticello, Arkansas.

Respondents represented by Mr. Michael J. Dennis, Attorney at Law, Pine Bluff, Arkansas.

A hearing was held on October 29, 2004, to determine the compensability of the claim filed herein.

The parties stipulated to the existence of the employee-employer relationship on March 12, 2004. The parties did not have adequate records at the hearing to produce a compensation rate, but stipulated that they would work together to agree to a stipulated compensation rate following the hearing. That rate has not, as of this date, been provided to the Commission.

Claimant contends that he sustained an inhalation injury on March 12, 2004, and that he is entitled to past and future medical treatment at respondents' expense. Claimant further contends that he is entitled to temporary total disability indemnity benefits from the date of injury to April 4, 2004.

Respondents controvert the claim entirely, contending that the claimant did not sustain a compensable injury during the course and scope of his employment. Specifically, respondents contend there is no causal connection between any exposure at work and claimant's current condition, which is asthma, and that there is no scientific basis to link the two incidents together.

STATEMENT OF THE CASE

_____ Claimant is forty-two years old and has been employed with respondent-employer for twelve years. Claimant testified that he has had several different types of jobs with respondent-employer but at the time of alleged injury, he was working the poly system, which pertains to the coating that is put on the paper. The poly-coated paper is used to make milk cartons. Claimant testified that he had been working in that capacity for about three months at the time of his alleged injury.

Claimant testified that part of his job was to shake dust collector screens, or filters, twice per shift, in order to get the poly dust off of the paper. Claimant testified that the poly dust is a light dust that has plastic coating on it that is used to coat the paper; therefore, it is a mixture between poly and paper dust. Claimant testified that

on Friday, March 12, 2004, he had to shake four different screens two times each, during his shift. Claimant testified that during his second time shaking the screens, dust just “went everywhere” and got into his mouth.

Claimant admitted that he was not wearing a mask; and, although he later testified that he normally holds his breath when shaking the screens and that this “usually” keeps it from getting in his mouth, he apparently did not do that on March 12, 2004, at the time he claims he inhaled a large quantity of the poly dust. Although claimant admitted that he may have previously gotten poly dust in his *nose* while shaking the screens, he denies ever having gotten it in his *mouth* prior to March 12, 2004.

Claimant testified that he did not pay much attention to the fact that he had gotten the dust into his mouth until later on that day, when he began experiencing a cough and scratchy throat. He testified that later that evening, at home, he noticed he had a fever, and he felt very bad. Claimant testified that he was sick the whole weekend and eventually went to the emergency room at Jefferson Regional Medical Center.

Medical records indicate that claimant was seen at Jefferson Regional on March 16, 2004, for cough and fever. The records make no mention whatsoever of any alleged work-related injury or any type of inhalation injury. The records state that claimant complained of cough and fever since March 12, 2004, and in the space

provided for “where accident occurred,” the word “HOME” is designated. It was determined that claimant suffered “acute bronchitis.” Claimant received an updraft treatment at the hospital, as well as antibiotics and a steroid injection.

Claimant testified that he called Ms. Jane Elliott at respondent-employer the day he was supposed to return to work the following week and told her that he was having respiratory problems, that he had gone to the hospital, that they had given him an updraft treatment and medication. Claimant maintains that he explained to Ms. Elliott what he thought had caused his problem and that he believed it was work-related; however, he testified that, despite this, she did not ask him to fill out any paperwork or offer to send him to a doctor.

Claimant testified that he went to Jefferson Regional on two different occasions and then went to see Dr. Jerry Harvey, his family physician, on March 24, 2004, presenting to the doctor with complaints of breathing problems, chest tightness, wheezing, and fever. Dr. Harvey’s notes of that date indicate that claimant mentioned his exposure to dust at work on March 12, 2004; however, Dr. Harvey’s notes further state, “but he is usually exposed to this anyway.” Dr. Harvey’s notes further state that claimant has a “history of exposure to asbestos in the past.” Dr. Harvey ordered a battery of tests, including heart, allergy, and acid reflux tests; claimant admitted in testimony that he had had prior acid reflux problems. Dr. Harvey diagnosed claimant as having “bronchitis/reactive airway disease.” Dr. Harvey opined:

I will see him back in one week. It seems that he has some chronic reactive airway disease after his probable infectious bronchitis. He will call us if his symptoms worsen in the meantime.

Claimant testified that he was off work from March 12, 2004, the date of alleged injury, until April 4, 2004. Claimant testified that he had begun feeling better before returning to work on April 4th. Claimant continued his follow-up examinations with Dr. Harvey, however; and, on April 28, 2004, Dr. Harvey diagnosed claimant as having asthma and GERD. Dr. Harvey's notes of that date further state:

Presents for follow up. He is doing better. Less wheezing and cough. Echocardiogram was normal with normal left ventricle size estimated EF of 50%. He is on the Advair and this has helped. Chest discomfort is resolved with Aciphex, as well.

Claimant saw Dr. Harvey again on June 15, 2004, for a follow-up in regard to his asthma. Again, Dr. Harvey notes that claimant "is doing fairly well with Advair," although claimant presented on that date with allergy symptoms of cough and congestion. Dr. Harvey diagnosed him on that date as having "sinusitis; asthma; GERD." Claimant testified that he has continued to see Dr. Harvey, although the last medical record in evidence from Dr. Harvey is that of June 15, 2004. None of Dr. Harvey's records or reports indicate any causal connection between claimant's respiratory problems and his alleged work-related injury, other than Dr. Harvey's mere mention on claimant's first visit with him that he had been exposed to dust at work on March 12, 2004, but that he is "usually exposed to this anyway."

Respondents offered the expert testimony of Jay Gandy, Ph.D. Dr. Gandy is a professor and chairman of the Department of Environmental Health in the College of Public Health at the University of Arkansas for Medical Sciences (UAMS). Dr. Gandy also holds a secondary appointment in the Department of Pharmacology and Toxicology at UAMS; and, he is a senior toxicologist and partner in a private firm, the Center for Toxicology and Environmental Health, in Little Rock. Dr. Gandy testified that one of the main areas with which he has dealings is occupational exposures to chemicals and things of that nature and that his primary focus is in human health consequences of chemical exposures.

Dr. Gandy defined his job as a toxicologist as follows:

The role of the toxicologist in any sort of situation where there is a question about whether a chemical exposure or a dust exposure from either a chemical or particulate was involved as a causative agent in an illness is to look at that and look at the scientific evidence and do what we call a causation analysis and draw a conclusion about whether or not the potential offending agent really was causally-related to the disease state in question.

Dr. Gandy testified that as part of his involvement in this case, he was asked to assess certain information to try to determine the exposure and causation in claimant's case. To do this, he reviewed a variety of materials, including medical records of claimant, claimant's deposition, some MSDSs for poly materials, and an industrial hygiene dust sampling report. He further consulted scientific and medical literature as part of his investigation; and, finally, he personally visited the site where

the dust screens are located to get an understanding of the workplace situation and conditions, as well as to witness the screen-cleaning process.

Dr. Gandy testified that at the time he witnessed the screens being shaken out, he conducted monitoring or sampling tests with what is called a “dust track,” which measures the total level of particulates in the air. As far as the standards allowable under OSHA for an eight-hour work day, based upon a five-day work week, for a twenty-year period of employment, Dr. Gandy testified that there is no permissible exposure limit for the category of *poly* dust, per se. There is, however, a permissible exposure limit for a general category of dust, and he testified that poly dust would fit under that category of nuisance dust or total particulates.

Dr. Gandy stated that the permissible exposure limit (PEL) for total particulates is fifteen (15) milligrams per cubic meter; that is the number of particles in the volume of air for total particulates. He further testified as follows:

But particulates are a broad range in size, and there's a second standard for respirable particulates. Those are the smaller particles within the right range that can actually be inhaled into the lungs, and that would be five (5) milligrams per cubic meter.

And I might point out that my instrument as I had it set up was to measure total particulates.

Q And your instrument, what did it show in comparison to the PEL for those particulates?

A I have those data here with me. In the overall PE reclean area in the first level, which is before we went up for the screens to be cleaned, shaken, it was .164 milligrams per cubic meter, so .2 we'll

say, and then at the first landing and the second landing began around the same level, .15, .17, so that's 0.15 and 0.17.

Up on the third landing just before they actually shook the screens it was 0.21, and then when they cleaned, during the cleaning of the north boiler screen, that was actually during the process, it was 0.43. And during the cleaning of the south boiler screen, during that cleaning process it was 0.52, and that's for total particulates, with the standard being fifteen (15).

Q What about the air sampling that you received that was done – I can't recall the specific name for it – that was done by others?

A Yes, sir. There were some industrial hygienists [who] came into the plant at some date prior to my visit and took a different approach, they measured dust exposure for some designated workers for a full day shift. And remember, and in fact, that's a very interesting point that needs to be made here is that these standards are not instantaneous numbers or standards, they are a standard that the worker is allowed to be exposed to for an eight hour shift, five days a week, for a working career, and a working career is generally assumed to be twenty years.

So fifteen (15) milligrams per cubic meter is the standard that's allowable under OSHA all day long, five days a week, for the lifetime career of the individual.

Q So it can remain constant at fifteen (15)?

A That's correct. And my numbers were what we call excursion measurements.

Q Right. But it could remain constant at fifteen (15) all day long and that would be within the OSHA limitations?

A That's correct. So another way to assess dust, I did the more instantaneous excursion assessment that would be relevant for the time with the activity that's in question here.

The alternate approach is to hang personal pumps on workers during their daily activity for an eight-hour work shift or whatever their work shift is and convert that to an eight-hour exposure number and express that as a time-weighted average over that eight-hour period, and that's what was done by this other group that came in and assessed some specific workers.

And they got a time-weighted average of .063, or less than, in fact, it was less than their ability to measure on one of the other workers, less than .016, which are in line with my numbers that I got as background numbers when I walked into that work area.

Q This is, again, as compared to a standard of fifteen (15)?

A That's correct.

When asked if, based upon his scientific analysis, knowledge, and a review of the evidence in this case, he had been able to reach a conclusion of whether the exposure claimant was likely to have received shaking out the screens would cause asthma, Dr. Gandy testified as follows:

A Yes, sir, that was part of the assessment that I did. There's several lines of evidence that contribute to coming to that conclusion.

Q Okay.

A The first is that poly dust – and let's back up and describe what poly dust is. Poly dust is polymerized polyethylene, so they're plastic pellets, essentially. When they arrive onsite, then that plastic is melted and coated on paper to give this a plastic-coated paper so it would hold liquid. These plastics in their polymerized form are *inert* materials, so they really *do not induce asthma*. *They don't cause asthma*. Now certainly *high levels* of dust *could aggravate an existing*

asthmatic condition, but they don't *cause* asthma. So we have that as a first line of evidence.

Secondly, the levels of these dusts are not at a level that would be significant for a respiratory concern to begin with, they're well below any workplace standards.

Thirdly, just because we have a correlation between work activity and at some subsequent time an illness, that's not sufficient to conclude a *causation* relationship. In fact, the medical evidence, Doctor Harvey diagnosed Mr. Carpenter with infectious bronchitis, and "infectious" here would indicate either a bacteria or a virus. Poly materials or dust in general don't *cause* infections, infections are caused by bacteria and viruses.

Thirdly, Doctor Harvey noted that the patient *got better with antibiotic treatment*, again indicating an *infectious* disease, as opposed to a dust-load asthmatic initiation.

And third, we have an alternative component here, an alternative explanation as well, that Mr. Carpenter was diagnosed with GERD, that's the gastric esophageal reflux, and there's a lot of evidence in the scientific literature linking GERD with asthma.

So putting all this scientific evidence together, there's just insufficient evidence to conclude that the dust exposure contributed or caused asthma in this case.

[Emphasis added.]

Dr. Gandy further testified that he is not aware of any testing that has established a link between poly dust and asthma; in fact he is unaware of poly dust ever being *tested* as a causative agent for asthma.

Dr. Gandy admitted on cross-examination that he was not present for testing the particulates at respondent-employer on the alleged date of injury and that he does not measure there every day. Dr. Gandy further admitted that a very large dust load could aggravate an existing asthmatic condition; however, he further opined that there was such a low dust load potentially available at respondent-employer to even aggravate an existing asthmatic condition that he would be surprised if one was aggravated by it.

Dr. Gandy testified further that a distinction should be made between “ingestion” and “inhalation.” In this case, claimant testified that he had taken the dust in through his mouth on the date of alleged injury. Dr. Gandy opined that this would be “ingestion” and not “inhalation,” and that that would, therefore, not contribute to bronchitis or asthma, as the dust would have been swallowed and cleared through the GI tract. He did agree, however, that if the dust flew into claimant’s face, he may have gotten some in his nose, as well as his mouth.

Claimant insists that he continues to have problems. Claimant testified that he has constant wheezing, shortness of breath, and when pollen is heavy, he has asthma attacks. Claimant testified that he never had these problems before March 12, 2004. Claimant averred that prior to the alleged inhalation injury he was a “top athlete” and “top body builder,” but since the incident, he has lost twenty pounds. He claimed he had never had asthma before in his life or any respiratory problem whatsoever. He

testified that this has changed his life. Claimant seeks payment of past and future medical expenses, as well as temporary total disability indemnity benefits from the date of injury to April 4, 2004, and attorney's fees.

FINDING OF FACT

Claimant has failed to meet his burden of proving that he sustained a compensable injury. Specifically, he has failed to establish a causal connection between his occupation or employment and his asthma/respiratory condition by a preponderance of the evidence.

DISCUSSION

Arkansas Code Annotated §11-9-601(g)(1)(A) provides in part:

An employer shall not be liable for any compensation for an occupational disease unless:

(A) the disease is due to the nature of an employment in which the hazards of the disease actually exist and are characteristic thereof and peculiar to the trade, occupation, process, or employment and is actually incurred in his or her employment.

Where the condition involved is a disease (as opposed to an accidental injury), the claim is compensable only if the disease is an "occupational" one as defined in the Workers' Compensation Act, and the claimant proves by a preponderance of the evidence a causal connection between the employment and the disease. *See* Ark. Code Ann. § 11-9-601(e)(1)(A),(B); *Howell v. Scroll Technologies*, 343 Ark. 297, 35 S.W.3d 800 (2001). An "occupational disease" is defined as follows:

[A]ny disease that results in disability or death that arises out of or in the course of the occupation or employment of the employee or naturally follows or unavoidably results from an injury as that term is defined in this chapter.

Id.

The fact that the general public may contract a disease is not controlling; the test of compensability is whether the nature of the employment exposes the worker to a greater risk of the disease than the risk experienced by the general public or workers in other employments. *Osmose Wood Preserving v. Jones*, 40 Ark. App. 190, 843 S.W.2d 875 (1992); *Sanyo Mfg. Corp. v. Leisure*, 12 Ark. App. 274, 675 S.W.2d 841 (1984).

An occupational disease is characteristic of an occupation, process or employment where there is a recognizable link between the nature of the job performed and an increased risk in contracting the occupational disease in question. *Sanyo Mfg. Corp. v. Leisure, supra*. In this case, the credible evidence is overwhelming that there is no recognizable link between the nature of claimant's job and an increased risk in contracting asthma, bronchitis, or any respiratory disease. Dr. Gandy's testimony was clear that there are no known tests that have established a link between poly dust and asthma.

Claimant testified that he *believed* his problems exist as a result of his exposure to the dust from the screens on March 12, 2004; however, as his own doctor, Dr.

Harvey, pointed out, his exposure on that date was not unusual. Further, Dr. Harvey diagnosed him first with infectious bronchitis. As Dr. Gandy testified, an “infection” would be caused by bacteria or virus, not by an inert material, such as poly dust.

In short, when looking at Dr. Gandy’s expert testimony with regard to the low levels of dust to which claimant was most likely exposed, based upon Dr. Gandy’s scientific research, testing, and knowledge of the field, coupled with the problems claimant has been diagnosed as having, the evidence is simply insufficient to conclude that the dust exposure in this case contributed to or caused asthma.

There was some testimony that claimant may have in fact suffered from GERD or other problems prior to March 12, 2004; and, GERD and asthma have, indeed, been medically linked. However, claimant has failed to establish by a preponderance of the credible evidence that any condition from which he may have suffered previous to March 12, 2004, was aggravated by the dust from shaking the screens at work, thereby *causing* him to have asthma. While it is certainly the law that the employer takes the employee as he finds him, *see Jim Walter Homes Travelers Ins. v. Beard*, 82 Ark. App. 607, 120 S.W.3d 160 (2003), the claimant still must prove a causal connection between his employment and his alleged injury. In this examiner’s opinion, claimant has failed to do so.

Claimant undoubtedly suffers from asthma, which prior to his diagnosis of bronchitis in March of 2004, he had obviously never been diagnosed as having.

However, claimant has simply failed to establish a causal connection between his occupation or employment and his asthma/respiratory condition by a preponderance of the credible evidence.

For the above-stated reasons, the claim herein is respectfully denied and dismissed.

IT IS SO ORDERED.

CYNTHIA ESTES ROGERS
Administrative Law Judge