

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F508000

MARLENE SERATT	CLAIMANT
PHARMERICA, INC.	RESPONDENT
HARTFORD INS. CO. OF THE MIDWEST INSURANCE CARRIER	RESPONDENT

OPINION FILED DECEMBER 29, 2006

Hearing before ADMINISTRATIVE LAW JUDGE ELIZABETH DANIELSON in Springdale, Washington County, Arkansas.

Claimant represented by EVELYN BROOKS, Attorney, Fayetteville, Arkansas.

Respondents represented by MICHAEL RYBURN, Attorney, Little Rock, Arkansas.

STATEMENT OF THE CASE

A hearing was held on September 11, 2006, in Springdale, Arkansas.

A pre-hearing conference was held in this claim, and as a result a pre-hearing order was entered in the claim on October 31, 2005. This pre-hearing order set forth the stipulations offered by the parties, the issues to litigate and the contentions thereto.

The following stipulations were submitted by the parties and are hereby accepted:

1. The Arkansas workers' Compensation Commission has jurisdiction of this claim.

2. On all pertinent dates, the relationship of employee-employer-carrier existed between the parties.

By agreement of the parties the issues to litigate are limited to the following:

1. Compensability of the claimant's injuries due to carbon monoxide poisoning and mold.

2. Related medical.

In regard to the foregoing issues the claimant contends that she was injured on June 8, 2005. She has had injuries to her eyes, nose, throat, lungs and brain due to exposure to carbon monoxide and nitrogen dioxide. Prior to testimony the claimant responded to the respondents' attorney's restatement of his contentions. See transcript received October 17, 2006.

In regard to the foregoing issues the respondents contend that the claimant did not miss enough time from work to qualify for TTD. She was not injured in the course and scope of her employment. There are no objective medical findings. There is no medical opinion with any degree of certainty regarding causation. Since the claimant did not sustain a compensable injury, she is not entitled to a change of physician. The claimant has to prove a compensable injury to get any benefit. Before testimony, the respondents' attorney restated their contentions. See the transcript received October 17, 2006.

The documentary evidence submitted in this matter consists of the Commission's pre-hearing order marked Commission's Exhibit No. 1. The claimant submitted documentary evidence marked Claimant's Exhibit No. 1, Claimant's Exhibit No. 2 and Claimant's Exhibit No. 3. All these exhibits were admitted without objection.

DISCUSSION

Amanda Johnson testified that she had been employed with the respondent and began working with them on September 27, 2004, and ended her employment with them on February 28, 2006. Ms. Johnson testified that she is a pharmacist. Ms. Johnson testified that the respondent's business did not sell drugs to walk-in clients but furnished medications to the various nursing homes. Ms. Johnson testified that their building did not look like a pharmacy and when you would enter the building, there was a thirty-foot hallway and at the end of the hallway was where the pharmacist sat. Ms. Johnson testified that in the pharmacist's area was where they input information by the different pharmacists. Ms. Johnson testified that there was a door which was kept locked which went into a separate facility where the technicians worked. Ms. Johnson explained that in this separate facility which was approximately a thousand square feet there was a divided section which contained their narcotics, a separate room for their IVs and then in the very back was where the technicians worked. Ms. Johnson testified that off of the technicians area there was another door that was kept locked which went into a storage area that housed the water heater and the air-conditioning units. Ms. Johnson testified that there was a wall with a door that separated the main room from the storage area. Ms. Johnson testified that she was into the larger room every day in order to make IVs as well as to do her narcotics and to check on the technician's work. Ms. Johnson testified that on June 8, 2005, she was the pharmacist in charge of the facility. This witness stated that when she got to work the first thing she

said when she got in the building was "it stinks in here." Ms. Johnson testified that there was a very very bad odor in the building. Ms. Johnson testified that all the employees were there and a few minutes later they began coming to her telling her that they did not feel good and that their head hurt. Ms. Johnson testified that she noticed that she had begun coughing and her eyes had started watering but they all stayed because there was an order which needed to go out by 10:00 to a nursing home. Ms. Johnson testified that about an hour later she became very concerned because the relief pharmacist, who is rarely there, began bleeding from the nose. This witness testified that she then called her boss, Chuck McCauley, to report what was going on. Ms. Johnson testified that she told Mr. McCauley that something was not right that all the employees were complaining including the relief pharmacist and that she herself did not feel right. This witness testified that Mr. McCauley said that he would call her back but he never did. Ms. Johnson testified that after about an hour everyone was worse, some were shaking and that her pupils had dilated so much you could not see any of the color in her eyes. Ms. Johnson testified that she called Brian Smith who was the other pharmacist who was on vacation to see if he could get Mr. McCauley to respond. Ms. Johnson testified that Mr. McCauley did call back and instructed her to call the fire department which she did. Ms. Johnson testified that it took the fire department approximately twenty minutes to get there and during this period of time she opened the doors to get a little ventilation and that the different

employees would step outside for fresh air at different times because they were still in need of getting the medications out to the nursing home. Ms. Johnson testified that their boss instructed them to get the orders out so they all went back in and worked for another thirty to forty-five minutes until the fire department arrived then everyone was instructed to get out of the building except for her. Ms. Johnson explained that by law she cannot leave the building with other people in the building who are not pharmacists.

Ms. Johnson testified that she observed the other employees reporting that they were light headed, they were coughing, their eyes were watering and they were shaking even though they were not cold because it was in the summer. Ms. Johnson recalls that a couple of the employees' noses started bleeding, their voices were raspy and they were short of breath. Ms. Johnson testified that, "It was like someone was taking your breath away."

Ms. Johnson testified that they have had ongoing problems with the hot water heater in that it was not draining properly. Ms. Johnson testified that the water would pile up on the floor and the carpet got soaked several times. Ms. Johnson testified that this was reported to the respondent and that they were instructed to call the building supervisor which they did. Ms. Johnson testified that she remembers the last time that this problem was called in and that an air-conditioning man was sent out. Ms. Johnson testified that the service man looked around for a little bit, did not fix anything and said he would be back in a week but he never

showed back up. Ms. Johnson testified that the problems with the hot water heater had been in existence since the day she went to work for the respondent.

Ms. Johnson testified that she did go to the emergency room at St. Mary's Hospital and after waiting two hours she was never seen so she went home. Ms. Johnson testified that after this incident she felt nauseous and dizzy with a slight numb headache. This witness testified that about twenty-four hours later she still had her numb headache, she had begun to have headaches so severe she was unable to get off her couch. Ms. Johnson testified that these headaches went on for months and that she got where she could not remember things. Ms. Johnson testified that after the first two weeks they would not let any of the employees back in the building so there was not an option as to whether she should go to work or not. This witness testified that when she was called back to work they were in a different building and that she did work every day. Ms. Johnson explained that they had closed the facility where they had been located and placed a mobile unit about five feet from the back door of their old building. Ms. Johnson testified that she still has migraines every day and she still has memory loss. Ms. Johnson testified that she was a very quick worker and very efficient but she found herself not as efficient. This witness testified that she could not multitask like she used to and became frustrated much easier.

Ms. Johnson testified that she was sent to see Dr. Moffitt who treated her for normal migraine headaches but none of the treatment

worked. Ms. Johnson testified that then the respondents sent her to a neurologist in Little Rock. Ms. Johnson testified that besides her migraine headaches she also experienced a weight loss of ten pounds within the first month following this incident. Ms. Johnson testified that she saw a carbon monoxide report in Dr. Moffitt's office and he went over this report with her. Ms. Johnson testified that she was in the adjoining trailer when the mechanical engineer came out and it was discovered that there was a broken seam in the back of the hot water tank. Ms. Johnson testified that she was not in the building when the levels were taken and remembered that these tests were taken approximately three weeks after June 8.

On cross examination, Ms. Johnson testified that she worked for approximately one year in the building that had that particular hot water heater. Ms. Johnson testified that her work station was further away from the hot water heater than the work stations of the technicians. Ms. Johnson testified that there is only one small wall separating the technicians from the mechanical room. Ms. Johnson agreed that this was the same hot water heater that was there when she began working for the respondent and that nothing had been done to repair it while she was there. Ms. Johnson was asked what her opinion was as to why there was such a difference on June 8 than there had been all the other days that she had been working. Ms. Johnson responded that it was her opinion that the water tank had exploded in the back and that was the reason for the problem. Ms. Johnson testified that the whole back of the hot

water heater was ripped open and there was about a foot of water underneath the water heater when the fire fighters got there. Ms. Johnson testified that she does not know whether the level of carbon monoxide in the room was higher on June 8, 2005, than it was on June 8, 2004. Ms. Johnson testified that on June 8, 2005, they all began work at 8:30 and that by 10:30 they were beginning to rotate in and out of the building. Ms. Johnson testified that they did have the front door open for ventilation. Ms. Johnson testified that the odor she noticed when she first came into work on June 8 was an odor that she had never noticed before but would describe it as smelling like an old gym bag that had been in a very hot car for a month. Ms. Johnson agreed that carbon monoxide is odorless. Ms. Johnson testified that six months after this incident her headaches went away. Ms. Johnson testified that even though she was in the building perhaps more than some of the other employees on June 8, 2005, her office was up front and not as close to the hot water heater. Ms. Johnson testified that in her opinion she did not have any more exposure than any of the other employees.

Brian Keith Smith testified that he was a pharmacist and was the manager at the Rogers location. Mr. Smith testified that he began working for the respondent in October 2004 and worked for them until December 26, 2005. Mr. Smith testified that he was aware that there were problems with a leak in the hot water heater after he had been there two to three months. Mr. Smith testified that he came in one day and there was water on the floor so the building manager was called and supposedly this leak was fixed.

Mr. Smith testified that he was unaware of any leak after it was fixed. This witness testified that he was not at the site on June 8, 2005, because he was on vacation. Mr. Smith testified that he was called and told that some of the employees had gone to the emergency room and when he got there it was his memory that Amanda Johnson was still there as well as the relief pharmacist. Mr. Smith testified that when he arrived Amanda Johnson handed him a folder of orders as to what they had been doing and after they left he went in to make sure that everything was taken care of. Mr. Smith testified that he was in the building approximately one hour to make sure that everything was taken care of on June 8, 2005. This witness testified that he continued to work in this building every day for the next two weeks noting that none of the other employees ever went back into the building. Mr. Smith testified that the respondent brought in people specifically remembering a man named Ray from St. Louis from Global Labs who did testing. Mr. Smith remembers that then EGIS was brought in to do clean up of the bottles and that he, Mr. Smith, was in labeling and keeping track because a pharmacist has to be on site with the medicines when anyone else is on site. Mr. Smith testified that after June 8 he did see the hot water heater and noticed that the seam at the back had blown out in the middle. Mr. Smith testified that after they moved into the trailer, the three techs, Seratt, McMillion and Cortez eventually returned to work over a period of time. Mr. Smith testified that he noticed a difference in their performance in that their error rate went up tremendously and that he found

himself having to double check their work more often. Mr. Smith testified that all three of these employees missed work for doctor's appointments and that there were times when he had to send them home because they were so fatigued or disoriented. Mr. Smith testified that these three employees error rate went up noticeably and things they would do on a routine basis without error now mistakes were found such as sending medications to the wrong pharmacy or inputting the medications to the wrong patient. Mr. Smith testified that in order to address the fatigue problem he bought a hammock and put up in one of the rooms so that each of these employees could lay down for a while and then go back to work. Mr. Smith testified that during this period of time they were only inputting orders not actually filling prescriptions because their inventory had been locked down for fear of mold. Mr. Smith explained that the actual prescriptions were being filled out of the Little Rock office and, that at one point, the respondent wanted the technicians, Marlene Seratt, Daniel McMillion and Aurora Cortez, to come to Little Rock and work filling prescriptions. Mr. Smith stated that he did not think that these three employees could function in the Little Rock atmosphere. Mr. Smith stated that, "Getting into work and having them healthy even long enough to work a day was difficult."

On cross examination, Mr. Smith testified that when he came to the respondent's facility on June 8, 2005, most of the people were gone. The claimant testified that he was told that there was a water spot on the floor and he witnessed a ten foot long and

approximately three to four feet wide spot on the carpet. This witness remembers that everything was unfinished explaining that it looked like people had just stopped working. Mr. Smith testified that it was speculated by everyone that there was a mold problem and there was a moldy odor. Mr. Smith testified that before this date he had not witnessed a water spot on the floor where the techs work but was aware of a water problem in the mechanical room where the water heater sat up on a two-foot platform that was enclosed. Mr. Smith testified that he was not aware of the split in the hot water heater prior to June 8 but was aware that there was a drip from the plumbing or the pipes that connected to the hot water heater. Mr. Smith testified that there was a plastic tub that was underneath the drip and once new pipping was put in that leak stopped. Mr. Smith testified that he was sicker when he worked in that building than he has ever been in his life. This witness testified that he had never had any health problems and that after he began work for the respondent in that building he was constantly having breathing and sinus problems and feeling under the weather. Mr. Smith testified that for the two weeks that he was in the building when the testing was going on after June 8 there was a period of about thirty to forty-five days that he coughed every single day and that he even went to see a doctor for this cough. Mr. Smith testified that prior to June 8, 2005, there was no pattern from the other employees of missing work due to illness. Mr. Smith testified that once he was out of the environment where he had been working for the respondent, he did get better over time

and his breathing got better. Mr. Smith testified that he has been told that he has some allergies but nothing that he takes medication for. This witness testified that the only problem that he can relate back to his exposure from June 8 forward is that his memory is not the same as it was before. Mr. Smith testified that he worked with Ms. Seratt, Mr. McMillion and Ms. Cortez from June 8, 2005, until December 26, 2005. Mr. Smith testified that they were dealing with the problem every day such as going to the doctor and sharing information as far as symptoms were concerned.

On redirect examination, Mr. Smith testified that prior to June 8, 2005, he spent most of his time in the input room not in the room with the technicians. Mr. Smith stated that around 3:30 or 4:00 in the afternoon he would go into the room with the technicians and start checking orders. Mr. Smith testified that he was in the room with the technicians a couple of hours a day, noting that most of his time was either in his office or in the input area.

On recross examination, Mr. Smith testified that, to the best of his memory, the respondent's building had three separate air-conditioning units. Mr. Smith remembered that one unit serviced the input area and his office as well as the conference room, another one was specifically for the IV room and the other one was for the large back room and the pharmacy area.

The claimant testified that she was forty-two years old and began working for the respondent on August 17, 1998. The claimant testified that she initially worked as a delivery driver for the

respondent and then became a technician. The claimant testified that she became a tech in 1999 and has worked her entire time for the respondent in the same building in the back room where the techs work. The claimant testified that she was familiar with the hot water heater in that building and was aware that it had a problem with leaking prior to June 8, 2005. The claimant testified that the various technicians took turns emptying out a little plastic water catcher and that this problem had been going on ever since she began working for the respondent. The claimant testified that her hours were from 8:00 a.m. to 5:00 p.m. and that she worked Monday through Friday and every other Saturday for the respondent. The claimant testified that prior to going to work for the respondent in 1998, she was not aware of having any health problems. The claimant testified that prior to June 8, 2005, and after she went to work for the respondent, she ended up having sinus trouble. This witness also remembers that she did miss work between June and October 2004, noting that she had a lot of pain in her body, in her joints and muscles so she was taken off work to undergo tests. The claimant testified that when she arrived at work on June 8, 2005, at 8:00 in the morning there was a huge water spot in the area close to where she worked. The claimant testified that the night before she left she had noticed a little water spot on the carpet. This witness testified that there had been an additional piece of carpet laying on the floor for the techs to work and walk on and that she and Amanda drug this piece of carpet outside. The claimant testified that there was just a huge big old

puddle of water and it smelled horrible. The claimant testified that this problem had happened before and that they had never cleaned the carpets, noting further that it stank. The claimant testified that she has complained to management prior to June 8 about the leaking water problem. The claimant testified that she began working and started getting a headache the same as she always did and she just assumed it was from her computer. The claimant remembers that as the day went on her problems kept getting worse and then her nose and throat started burning and she ended up putting on a mask to try and keep whatever was going on from getting worse. The claimant testified that all the techs put on masks to try to prevent whatever was going on from getting into their nose, throat and eyes. The claimant testified that this was reported to Amanda Johnson. The claimant testified that Ms. Johnson opened the doors and started having the techs take turns going outside for thirty minutes at a time. The claimant opined that it was around 9:00 or 10:00 when they started rotating in and out of the building. The claimant testified that she was having a hard time concentrating and her hands got to shaking so bad she was having a hard time holding onto the bottles. The claimant testified that all three of the techs including herself were shaking. The claimant testified that she drove herself to the emergency room and on the way she stopped right in the middle of the highway and she did not even realize what she had done. The claimant testified that it was like her mind was not working. The claimant stated that things were in there, people were asking her

questions and she would be trying to answer but it just would not come out right. The claimant testified that in the emergency room the doctor told her to take Claritin, drink lots of water and go home. This witness testified that no tests were run at the ER. The claimant testified that at the ER she was shaking, her eyes, nose and throat were burning and that her voice had changed in that it was real raspy.

The claimant agreed that she was seen by Dr. David Brown, a neurologist who ultimately referred her to a neuro-toxicologist. The claimant testified that she was not able to see the neuro-toxicologist but was seen by a Dr. Johnson in Little Rock who she thought was a neuro-psychiatrist. The claimant testified that Dr. Johnson's office was smelly and dirty and in her office she had crystal balls, wicked looking dolls as well as normal dolls and that she noticed a certificate of sorcery hanging on her wall. The claimant testified that she quit working for the respondent at the end of January of 2006. The claimant testified that between June 8 and when she stopped working for the respondent, she continued to have memory problems as well as having problems concentrating while working. The claimant testified that she no longer can multitask like she used to and she can only concentrate on one thing at a time. The claimant testified that during the period of time she was working for the respondent after June 8 she did have to miss work as well as take unscheduled breaks. The claimant testified that she also had severe headaches and that she would wear a migraine patch on her forehead. The claimant testified that she

also used a chap stick looking product called Head On to try and stop her pain. The claimant remembered that her vision was different in that it was a little blurry, noting that she had gotten glasses a couple of months before June 8 and they did not seem to be working much anymore. The claimant testified that she currently is not working and one of the main reasons she is not employed is because she has constant fatigue. The claimant was asked if she had other problems other than the fatigue which she attributed to the June 8 incident and the claimant replied that she had memory problems, stating that she has a hard time hanging onto things. The claimant testified that she currently is being seen by Dr. Petty.

On cross examination, the claimant agreed that she had lots of medical conditions before June 8, 2005. The claimant testified that she did not know that she had allergies and hystoplasmosis until after June 8, 2005. The claimant testified that her sinusitis started after she started to work for the respondent. The claimant testified that about a month before June 8, 2005, she began having coughing spells so hard that she would throw up. The claimant testified that she was prescribed medication to address this problem as well as she took an anti-inflammatory and a sleeping pill. The claimant agreed that she had worked in the same building for the respondent for seven and a half years. The claimant testified that during this seven and a half year period she was treated by Dr. Hull for a sinus problem. The claimant testified that currently and as a result of her exposure on June 8

she is very fatigued and also has memory problems. The claimant remembered that she suffered from fatigue prior to June 8, 2005. The claimant agreed that the respondent paid for her to have an MRI of her brain, a neuropsychological evaluation, blood work and lung tests. The claimant testified that she also was given a test that measured the amount of carbon monoxide in her blood. The claimant testified that she is a cigarette smoker, smoking about a pack of cigarettes a day but agreed that in the past she has smoke up to three packs a day. The claimant testified that she understood that cigarette smoking is a cause for elevated carbon monoxide in the blood. The claimant testified that currently she is having lung problems and is on inhalers which she never was before and she is having muscle problems for which she would like to receive medical treatment. The claimant testified that she started having asthma and allergy problems about a month before June 8, 2005, agreeing that her symptoms began to manifest themselves before anyone else experienced similar symptoms but, in her opinion, her symptoms were elevated on June 8, 2005. The claimant testified that she was being treated for fibromyalgia prior to June 8, 2005, noting that she was having pain in her muscles which the doctor diagnosed as fibromyalgia. The claimant testified that she was last seen by Dr. Petty a couple of weeks before this hearing and to her knowledge Aurora Cortez and Daniel McMillion are also being treated by Dr. Petty. The claimant agreed that she saw a doctor a couple of weeks before June 8, 2005, for several of her medical problems. The claimant testified that she needed to get refills so she had to be

examined or checked over by a doctor in order to get refills on her medications. The claimant testified that she still has these medical problems and in addition she now has problems with her lungs and her sinuses and memory are really bad. The claimant testified that she had been to the doctor a month before June 8 and had been given Singular because of a suspected allergy and that after June 8, 2005, and after she had been seen by Dr. Moffitt she went to her doctor and that was when she got her first breathing treatment, noting that there was nothing wrong with her lungs before that. The claimant was asked how long she had smoked cigarettes and she responded, "Twenty years." The claimant testified that she did undergo a functional capacity evaluation but is unaware of the results of that evaluation.

On redirect examination, the claimant testified that she began to experience fatigue several years ago because they used to work a lot without lunch. The claimant testified that she experienced fatigue before she went to work for the respondent but it got worse after she began working for the respondent and now it is really bad. The claimant testified that even after they moved into the new building, they would lay down on the carpet to rest. The claimant was asked who would lay down and she testified, "Aurora, Dan, Amanda and Brian." The claimant testified that she never did lay down at work prior to June 8.

Daniel McMillion testified that he was twenty-nine years old and went to work for the respondent around March or April 2005. Mr. McMillion testified that he was hired as a pharmacy technician

and it was his responsibility to fill prescriptions after they were input in the computer and he did inputting as well. This witness testified that he did small things with the IV room, made contact with the various nursing homes and took refills. Mr. McMillion testified that most of his working day for the respondent was spent at the press, explaining that the nursing home's medications were sealed in plastic so that they could be punched out for convenience. Mr. McMillion testified that his station was in the back of the building right in the middle of the other girls and toward the wall where the utility room is. Mr. McMillion testified that before he went to work for the respondent, he had allergies as well as some tension headaches from time to time. Mr. McMillion testified that before he went to work for the respondent he might have headaches biyearly and particularly around the holidays attributing it to stress or something in the air. Mr. McMillion testified that he worked on an average of forty-five hours a week for the respondent. Mr. McMillion testified that there was a compressor that operated their hydraulic presses and that he was told by his supervisor, Brian Smith, to go drain the compressor because it collected condensation. Mr. McMillion testified that he went into the utility room a few days before June 8, 2005, and took the compressor outside and drained it of its water and took it apart. Mr. McMillion testified that he noticed that there was a wooden box that the compressor sat on and that it looked all wet and moldy. Mr. McMillion testified that he did not touch it because he really did not want to because it was kind of yucky.

Mr. McMillion testified that the floor looked like it had a calcium stain on it as if it had been wet at one time but had dried up. Mr. McMillion testified that after he began working for the respondent but before June 8 he did experience fatigue as well as having more headaches which he attributed to working so much. Mr. McMillion testified that his headaches would go away when he would leave the respondent's business. Mr. McMillion testified that on June 8, 2005, he got to work about 8:00 and went to his station. This witness testified that after about twenty or thirty minutes his eyes started burning. Mr. McMillion testified that he thought that perhaps he had touched something that set off an allergic type reaction and he went to Amanda and asked if he could get some eye drops. Mr. McMillion testified that after another fifteen or twenty minutes he began to make mistakes which he was not accustomed to making and at one point could not remember how to do his job. Mr. McMillion remembers that he could not remember what sequence to do things in, he started filling empty bottles, mislabeling and just feeling very scramble brained. Mr. McMillion testified that he complained to Amanda Johnson and told her that he was going to take an early lunch because he was not feeling well and something was not right and he wanted to go home. Mr. McMillion testified that Amanda told him that they were calling the fire department right then and he went ahead and took his early lunch. Mr. McMillion testified that besides his eyes being irritated and experiencing confusion, he was shaking, he had an onset of headache and he experienced a nose bleed. Mr. McMillion

testified that he left the respondent's office to go directly to see Dr. Robert Hull but when he got to Dr. Hull's office he was met at the door and immediately told to go the emergency room so he left and went to St. Mary's Hospital. This witness testified that at the ER he was given a shot for his headache, his blood sugar was checked, his oxygen level was checked and they had him do some breathing exercises as well as describe his pain because they were concerned about his heart rate. Mr. McMillion testified that he had to call someone to come get him since he could not drive. This witness testified that he continued to work for the respondent although he did not work at all for the next week to a week and a half and eventually he was transferred to work in Little Rock for the respondent. This witness explained that they would drive down on Sunday evening and would work from 7:00 until 7:00 or later and then go back to their hotel. Mr. McMillion testified that there were three or four days when he had to go back to the hotel early because he was not feeling well, vomiting as well as having headaches and shaking very bad. Mr. McMillion testified that he worked for the respondent until around New Years Eve of 2005. Mr. McMillion estimated that he missed approximately 30 percent of his working days due to his problems and these were over and above the days which he missed for doctor's visits. Mr. McMillion testified that after the incident in June 2005, he had problems focusing on things, noting that he made errors which he had never made before. This witness testified that after he left the employment of the respondent he began working for Harps in their pharmacy. Mr.

McMillion testified that he is currently working approximately thirty hours each week. Mr. McMillion testified that even with a reduced work week, he still is very tired and gets shaky at the end of the week as well as has headaches although not as often and severe as they were earlier. Mr. McMillion testified that he will start making more errors by the end of the week, therefore, he limits his time to forty hours. Mr. McMillion testified that he was seen by Dr. Johnson, a neuro-psychiatrist or psychologist, in Little Rock. Mr. McMillion stated that he was seen by Dr. Johnson seven hours the first day and four or five hours the second day. Ms. McMillion described Dr. Johnson's office as a home office that was full of stuffed animals and dollies sort of like a big antique store and kind of strange. Mr. McMillion testified that in the doctor's office, it was like a living area with all kinds of weird stuff. This witness testified that there were things like warlocks and little crystals as well as all kinds of different mid evil looking things like witches and a bunch of diplomas and stuff on her wall. Mr. McMillion testified that he recalls seeing a certificate certifying Dr. Johnson in sorcery.

On cross examination, Mr. McMillion testified that the only objective medical findings that he has are shaking and some headaches. This witness testified that he also still has memory problems which have not been determined as yet since he has not been seen by a memory specialist. Mr. McMillion testified that currently he is being treated by Dr. Petty. Mr. McMillion agreed that he has fairly severe allergies, noting that he was allergic to

grasses and trees and other things that might be happening in the spring and summer. Mr. McMillion testified that he had had a steroid shot probably a week before June 8, 2005, so he had his allergies under control on June the 8th. Mr. McMillion agreed that initially he thought he had been exposed to mold but later learned that was not the offending agent. Mr. McMillion testified that he is a cigarette smoker and was aware that cigarette smoking is the leading cause of carbon monoxide in his system. Mr. McMillion agreed that the test he took to determine the level of carbon monoxide in his blood as well as an MRI of his brain were both normal and that he has also gone through a neurological and a neuropsychological evaluation. Mr. McMillion testified that he started working for the respondent in April 2005. Mr. McMillion was asked what he considered attributed to the onset of his symptoms on June 8, 2005, and Mr. McMillion responded, "I think that something happened to the hot water heater that night before we came in---something drastic, not subtle." Mr. McMillion testified that on June 8, 2005, he was exposed to something three to four hours.

On redirect examination, Mr. McMillion testified that he smokes approximately a pack of cigarettes a week and that is approximately what he was smoking prior to June 8, 2005. Mr. McMillion was asked if he had ever gone into the mechanical room June 8, 2005, and experienced problems? Mr. McMillion indicated that yes he had had occasion to go into the mechanical room and when he did it just did not feel right. Mr. McMillion testified

that he would feel kind of light headed and kind of dizzy when he would go back in the mechanical room and he just did not feel good.

Aurora Cortez testified that she was 41 years old and had been working for the respondent since July 19, 2004. Ms. Cortez testified that when she began work Marlene Seratt, the claimant herein, was also working. Ms. Cortez testified that she was hired to pack pills and that her station was in the middle where she could see the pharmacist coming in and the door to the narcotics room. Ms. Cortez testified that she worked in the big main room where all the technicians worked. Ms. Cortez testified that when she was first hired she was told that one of her jobs would be to empty the bin under the hot water heater. Ms. Cortez testified that she emptied this bin every morning and every evening. Ms. Cortez testified that this was not a part of the hot water heater but something someone had put there to catch the water. Ms. Cortez testified that she did this job until Brian Smith came to work because she remembers telling him that it made her nervous to go back into that room for fear of getting closed up in the mechanical room. Ms. Cortez testified that prior to working for the respondent she did not have any health problems nor was she taking any medications. Ms. Cortez testified that she did not have any health problems from the time she began working for the respondent until June 8, 2005. Ms. Cortez testified that she is deaf in one ear but this was not as a result of her work nor does she require medication or treatment for her ear. Ms. Cortez testified that after Brian Smith got there he had the water heater fixed and they

no longer had to empty the bin. This witness testified that on June 8, 2005, she got to work at 8:00 and they saw a large puddle of water. Ms. Cortez testified that Amanda was taking care of this water problem. Ms. Cortez testified that they began to work filling orders and started feeling sick. Ms. Cortez testified that she started trembling and sweating so she moved to another work area thinking that maybe she was just a little on edge and a change would improve her situation. Ms. Cortez testified that after about twenty minutes she was walking toward Mignon and remembers looking at Dan McMillion and he looked terrible. Ms. Cortez testified that she said to Mignon that she did not feel good and that Mignon told her that she did not look good at all and then they looked at Dan McMillion and he did not look good either. Ms. Cortez testified that Mr. McMillion was trembling and his eyes were red. Ms. McMillion testified that she was trying to get a hold of Mr. McMillion's hand so she could tell him to come on and go but she could not get a hold of him. Ms. Cortez testified that she did not know where he was, she could see him but she could not get to him. Ms. Cortez agreed that she was having problems with confusion. Ms. Cortez testified that they did not complain to Amanda during the morning but that she did look up and see Amanda coming in and that her face was very red. Ms. Cortez remembers that Amanda told them to come on they needed to get out. Ms. Cortez testified that the respondents initially told her to go to see Dr. Hull but then she received word that Dr. Hull did not want to see anyone that was

sick in his office so she went to St. Mary's Hospital to the emergency room.

At this point in the testimony, Ms. Cortez appeared to have a medical emergency for which the paramedics were called. The hearing was stopped at this point and arrangements were made to take Ms. Cortez's testimony by deposition.

Ms. Cortez testified by way of deposition and still on direct examination. Ms. Cortez testified that she is being treated by Dr. Corwin Petty for headaches and her back burning. Ms. Cortez testified that everything is wrong with her and she just wants to sleep all day, she cannot do anything. Ms. Cortez testified that the first symptom that she noticed after June 8, 2005, were her headaches. Ms. Cortez testified that the respondents gave her paid time off for two weeks following June 8, 2005, and then called her back to work in a trailer. Ms. Cortez testified that she is still working for the respondent but when she had a seizure in April she was told that she would have to get a medical leave and is currently on short term disability. Ms. Cortez testified that she has not worked since April. Ms. Cortez testified that since her first seizure in April 2006 she has seizures every day and that she did not have any seizures before June 8, 2005. Ms. Cortez was asked about the burning in her back and this witness described it as a horrific pain that goes all over her back. Ms. Cortez testified that it is like if you touch her back it just starts hurting real bad. Ms. Cortez testified that this happens once in a while but did not happen before June 8. Ms. Cortez testified

that when she returned to work after being off two weeks after June 8, 2005, she could not concentrate and she was forgetting quite a bit. This witness testified that she could not multitask very well. Ms. Cortez testified that she was making lots of mistakes which worried her greatly and she was having headaches. Ms. Cortez testified that Dr. Petty has given her medications for her headaches. Ms. Cortez testified that when she returned to work, Brian brought a cot and he would let her take breaks and lay down when he knew that she just could not do the work. Ms. Cortez testified that sometimes she would sleep for an hour. Ms. Cortez testified that she was under extra pressure and stress due to her grandmother being in a nursing home and she was afraid that her mistakes with the medications might kill someone else's grandmother who was in a nursing home. Ms. Cortez testified that currently she is taking medication called Topamax which is for her headaches and seizures. Ms. Cortez testified that she is also taking Phenobarb and Nadolol which are for seizures and she also takes an anti-depressant.

On cross examination, Ms. Cortez was asked questions concerning a car wreck she was involved in which she thinks was just prior to June 8, 2005. Ms. Cortez testified that one of her supervisors, Bettie, told her that the problems which she was having were problems as a result of her car wreck. Ms. Cortez testified that she did not have any problems after her car wreck. Ms. Cortez testified that she smokes about a pack of cigarettes a month. This witness testified that she did not have a history of

headaches prior to June 8, 2005. Ms. Cortez testified that the first she ever heard that she might have been exposed to mold at work was from the fire department. Ms. Cortez agreed that the only thing different on June 8, 2005, when she got to work that morning was that there was water on the floor and that she was totally confused. Ms. Cortez testified that she had worked in this building for approximately a year and a half. Ms. Cortez testified that she attributes her symptoms to carbon monoxide once she learned that there was no mold exposure. This witness testified that the company doctor did release her to return to work which she did but in a different facility. Ms. Cortez agreed that her only exposure was June 8, 2005, and that she was only in the building till the fire department got there. This witness agreed that the new building where she went back to work did not have any problems with mold or carbon monoxide. Ms. Cortez testified that after she went back to work and worked for a period of time, she was transferred to Little Rock but cannot remember how long she worked in Little Rock. This witness testified that she had her first seizure sometime in April 2006 and that she was at work when this seizure occurred. Ms. Cortez testified that there was nothing unusual that day to make her have a seizure and that she has not been checked out by a doctor due to her seizures. Ms. Cortez testified that since June 8, 2005, besides having headaches and back pain she has lots wrong with her. This witness testified that she is very slow, cannot read and cannot write but has not been checked by a doctor because she cannot afford one. Ms. Cortez

agreed that the respondent paid for her to undergo several tests, one of them being a carboxyhemoglobin test which is a test to measure carbon monoxide in the blood. Ms. Cortez testified that she understands that this blood test as well as the MRI of her brain were both normal. Ms. Cortez testified that everything is wrong with her but that she has no proof because how can she prove it. This witness stated that, "I can only tell you that I am sick, and I wasn't sick before." Ms. Cortez agreed that her diagnosis by Dr. Petty of her having anxiety syndrome was brought on by her having to leave her children at home when she went to work in Little Rock. Ms. Cortez agreed that she worked part time in Rogers and part time in Little Rock. Ms. Cortez testified that she has not worked since her seizure because the respondent will not allow her to and she has tried to apply for short term disability, long term disability and social security disability. Ms. Cortez agreed that she is not able to work at this time because she cannot find a doctor who can find a medication to correct her seizures. Ms. Cortez again testified that she has seizures just about every day but has not physically hurt herself as a result of these seizures.

The medical records set forth that the claimant was being treated by Dr. Corwin Petty. At least as early as June 2, 2005. On that date, the claimant had called in to have a number of prescriptions refilled. Those prescriptions included Estratest, Synthroid, Norflex, Zetia and Klonopin. It is noted that the claimant reports that she has increased irritability, stress and is curious if she should have her Estratest increased. On June 7,

2005, Dr. Petty refilled the claimant's prescription for Clinoril. The claimant was seen by Max Beasley, a physician's assistant with the Arkansas Occupational Health Clinic on June 9, 2005. Nurse Beasley writes that he has seen the claimant for an evaluation due to mold exposure which occurred on June 8, 2005. The claimant reported to Nurse Beasley that they were instructed by their employer to continue their work and after a period of time she began to experience a headache, burning in her nose, throat and chest and feeling disoriented. The claimant reported that she had been to the emergency room the night before and was instructed to take Claritin and Benadryl. Nurse Beasley writes that the claimant currently is complaining of headache, photophobia as well as burning of her throat, nose and has a cough. The nurse writes that the claimant reports that she has a history of having H.pylori and at times takes Nexium. The claimant also reported that she takes Singulair which she relates to a respiratory component of some reflux problem and she also takes Hydrocodone, Orphenadrine and Sulindac for some myalgias and arthralgias which she developed a year ago. The claimant reports that she also is on Estratest due to post hysterectomy and takes Synthroid for thyroid insufficiency as well as Clonazepam for sleep. After a thorough physical examination, a chest x-ray was taken which showed lymphadenopathy present which is probably due to histoplasmosis exposure. Nurse Beasley notes that the claimant's spirometry was within normal limits. The claimant was instructed to return on Monday to see Dr. Moffitt and she was instructed to increase her fluids. Dr. Gary

Moffitt writes on June 13, 2005, that the claimant is continuing to complain of complete body pain and significant fatigue, noting that she has been seen by her personal physician, Dr. Cohagen for quite some time due to fatigue, body pain and that she has been diagnosed with fibromyalgia. Dr. Moffitt writes that the claimant has a non productive dry type of cough which is not that severe for which the claimant has been prescribed Singulair in the past. Dr. Moffitt writes that the claimant reports a history of asthma, noting that her family has no history of asthma and that her appetite has decreased, noting that her weight was down one pound from four days ago stating that she currently weighs 188. The claimant reports that she has a sore throat which started about a year ago and she has had some nasal congestion as well as some sneezing fits at work. The claimant reports to Dr. Moffitt that her mother is a hypochondriac and suffers from psychiatric problems which consist of anxiety and depression, that her father died at 46 due to esophageal cancer, her brother is being treated for depression, her sister has back problems, her twenty-four-year-old daughter has polycystic ovarian disease and is over weight and her son who is 22 was born with a hemifacial microsomia who has had a number of surgeries. After a thorough examination, Dr. Moffitt reviewed her chest x-ray, noting that there are some calcified nodules that appear to be consistent with histoplasmosis but he did not see any evidence of any active infiltrates. Dr. Moffitt returned the claimant to work but to avoid returning to the building which might contain mold exposure. The claimant was seen at Dr. Petty's office

on June 20, 2005, by Kristy Walker, a physician's assistant, where it is noted that the claimant has had a headache since June 8 noting a chemical exposure at work. The claimant reports that since June 8, 2005, she has had more fatigue, her joints are achy, shortness of breath and difficulty clearing her chest of mucus, more nasal congestion and drainage in the mornings. Ms. Walker notes that the claimant did have allergy symptoms before this exposure but they have gotten worse. The claimant reports that she has been having a headache that she cannot get rid of and her sinuses feel inflamed. Dr. Gary Moffitt writes on June 23, 2005, that the claimant's major complaint today's is fatigue and generalized body aching, noting that she also has a cough. Dr. Moffitt notes that the claimant reports that she is still having headaches in the front part of her head but that it does travel to other places. CBC were obtained which were completely normal, her blood sugar was within normal range and her urinalysis had a trace of blood. Dr. Moffitt notes that the claimant reports that over the past year she has been evaluated by her doctor extensively for fatigue, generalized body aching and headaches. Dr. Moffitt's report then talks about an insecticide which had been sprayed in the claimant's building, noting that this ingredient is derived from Chrysanthemum flowers and is thought to be quite safe although it can cause asthma, allergic rhinitis, contact dermatitis, however, these reactions are short lived. Dr. Moffitt notes that he is highly skeptical that the claimant's symptoms are as a result of an exposure of this insecticide. Dr. Moffitt also notes that

many of the claimant's symptoms are similar to those which she was experiencing prior to her exposure and noted that there is no objective medical evidence of any disorder. Dr. Moffitt noted that the claimant is scheduled to be seen by a dermatologist and he considers it reasonable for her to be evaluated by a pulmonologist. Dr. Moffitt returned the claimant to work. The claimant underwent a complete metabolic panel on June 27, 2005. The claimant was seen at Dr. Petty's office by the physician's assistant, Kristy Walker, where it is reported that she continues to have headaches and fatigue. The claimant reports that she has been told that she was exposed to carbon monoxide but it is unsure how long this exposure was. The claimant reports that this past Sunday she was nauseated and vomited all day long and complains of ear pain, nasal congestion and sore throat. The claimant also states that she is continuing to have memory loss and forgets what she is doing, noting that this has been occurring for at least the last year and she had attributed this to her hysterectomy. The assistant notes that the claimant is to be seen by a pulmonologist and an allergist, noting that her exposure was three weeks ago. The claimant's physical examination was normal and she was sent to the hospital to have another complete blood count and arterial blood gases assessment for carboxyhemoglobin by cooximetry. It is noted that the claimant's repeat labs showed an elevated hgb rbc and hematocrit and that her white blood cells have returned to normal. No medications were given to this claimant at this time.

The claimant was seen by Dr. David Brown with the Neurological Associates on July 1, 2005. Dr. Brown sets forth a history given by the claimant of her exposure to carbon monoxide in early June. The claimant reports to Dr. Brown that initially it was thought to have been an exposure to mold and that several coworkers were affected. The claimant reports the following day after her exposure that she began to experience tightness in her chest as well as burning in her eyes and throat and was sent to Dr. Moffitt. Dr. Brown notes that the claimant feels as though she has been chronically poisoned to cause all of her symptoms and described a long history of headaches as well as defused aches and pains of her muscles which were diagnosed and treated as fibromyalgia. The claimant reports that she has had a lot of fatigue issues as well as memory problems, she is not as strong as she once was and her sinuses always bother her. The claimant reports that she has been treated with steroids for her muscle aches and pains which has caused her to swell dramatically. Dr. Brown writes that the claimant is somewhat diffusely positive and did not fill out his questionnaire, noting that she does have all the symptoms mentioned above. In addition, Dr. Brown notes that the claimant described shooting pains out her arms, noting that it can start in one arm and go across her chest into the other and that other times she just has shooting pains in her chest. It is also noted that the claimant reports palpitations at times, shortness of breath, a sore throat and that her sinuses feel congested. Dr. Brown, after examination, notes that the claimant is obviously very angry and

feels as though she has been poisoned over a long period of time and is fearful that she may be chronically stuck with her bad headaches, memory loss and all her other symptoms. Dr. Brown notes that the claimant feels as though the respondent is not being earnest in trying to get her proper care. After examination, Dr. Brown writes that the claimant has a large constitution of symptoms that include headache, photophobia, sore throat, weakness and muscle aches and pains, noting that many of these symptoms predate her acute intoxication of carbon monoxide. Dr. Brown ordered an MRI to see if there was any evidence of basal ganglia injury due to the claimant's reports of being uncoordinated and always dropping things. The doctor notes that he found no objective findings of basal ganglia abnormalities. Dr. Brown did not initiate any therapy and suggested that she be seen in Little Rock by a specialist. Dr. Brown writes that many of the claimant's symptoms would not be related to carbon monoxide poisoning, noting that he was unaware of any kind of chronic symptoms of muscle aches and pain that would be related to carbon monoxide poisoning. Dr. Brown again mentions that the claimant is very significantly angry and upset about her situation and notes that he will see her back after her MRI.

Dr. Gary Moffitt writes on July 11, 2005, that the claimant reports that she is not doing any better and is still experiencing fatigue, forgetfulness and headaches. Dr. Moffitt notes that the claimant reports that she saw Dr. Whiteside and has been diagnosed with being allergic to numerous trees, grasses, dust as well as

cats and dogs. The doctor notes that the claimant reports that Dr. Whiteside is treating her for thrush and has also given her medication for asthma as well as for her allergies. Dr. Moffitt writes that the claimant reports that she may have had a carbon monoxide exposure and presented to him a blood gases test which indicated that her carboxyhemoglobin level of blood gases was found to be 7.3. Dr. Moffitt notes that normal is up to 1.5, however, the claimant is a smoker and it is not uncommon for a smoker to have levels of up to 10. Dr. Moffitt recommended that she be seen by a neurologist and blood samples were drawn for a carboxyhemoglobin level. Dr. Moffitt recommended that the claimant continue to work with the same restrictions. Dr. David Brown writes on July 11, 2005, that he has reviewed the claimant's MRI and that he sees no basal ganglia infarcts which can occur with acute poisoning. Dr. Brown indicates that he has been reading up on poisoning and notes that there is a poorly understood more chronic CO₂ intoxication syndrome which has more cognitive type symptoms. Dr. Brown writes that he does not elect to treat the claimant at the present time due to her anger with the respondent and notes that they will wait to see if Dr. Rutherford has any recommendations. The claimant was seen at Dr. Petty's office by Ms. Walker who writes that the claimant reports having respiratory difficulties and expresses concern that her smoking and the exposure is making it worse. The claimant reports that she has problems breathing at night and reports that she has been diagnosed with having allergies as well as asthma. The claimant is also

complaining of neck pain and fatigue. After examination, the claimant was diagnosed with panic disorder, asthma, carbon monoxide poisoning, fatigue, allergies and neck pain. Medications were prescribed. Dr. Edwin Whiteside writes on July 13, 2005, that he has evaluated six employees of the respondent to determine if they have significant allergies. Dr. Whiteside writes that it appears that with the available research that there is no way a patient could inhale enough mold spores to cause a toxic reaction to mold that might be found in a home or a work place. Dr. Whiteside administered a spirometer test and the claimant's was normal. Dr. Whiteside opines that the difficulties which the claimant and the other employees are having with headaches and other symptoms would have to be due to another etiology other than an allergy to mold. Dr. Whiteside opined that perhaps they were experiencing problems due to exposure to carbon monoxide and or nitrogen dioxide. The claimant was seen by Dr. Reginald Rutherford on July 20, 2005, for a neurological consultation. Dr. Rutherford notes that the claimant's medical records indicate numerous complaints and sets forth the current medications which the claimant is taking which total up to fifteen. Dr. Rutherford notes that the claimant reports a twenty-year history of smoking a half a pack of cigarettes a day but the medical records indicates that she smokes up to one and a half packs of cigarettes a day. Dr. Rutherford sets forth that the claimant was tested for carbon monoxide exposure and that her carboxyhemoglobin level was elevated but normal in light of her smoking history. Dr. Rutherford writes that

the claimant reports multiple somatic complaints including muscle pain, agitation, confusion, irritation of mucus membranes, weakness, fatigue, nausea, vomiting, diarrhea alternating with constipation, insomnia, memory problems, blurred vision, moodiness, depression and persistent headaches. Dr. Rutherford notes that the claimant reports that what is different now as before the carbon monoxide exposure was that currently she has difficulty driving a car and doing her house work. Dr. Rutherford examined the claimant and she was found to be normal in all phases. The doctor then conducted a neurological examination which also proved to be normal. Dr. Rutherford writes that there is no evidence from clinical examination to suggest neurological injury. Dr. Petty's records are difficult to follow as to time of appointment but the claimant was seen by Dr. Petty or in his office around July 21, 2005, noting that the claimant was seen by a neuropsychiatrist and was offended that the doctor wanted to take her off all her medications. The nurse practitioner also notes that the personnel at rehab where the claimant has been attending also recommended that she get off her medications but the claimant does not feel that she can do so. After an examination, the claimant was diagnosed with headache, chronic pain, anxiety syndrome, depression and allergies. The claimant was prescribed Neurotin as well as her Zanex was refilled. The claimant was seen by Eric Walker with the Millennium Chiropractic and Rehab Center on August 10, 2005, with complaints of cervical and lumbar spine pain. The claimant reports that her cervical problems began in 2000 and that her lumbar pain

began in 2001. The therapist notes that he anticipates seeing the claimant at a rate of one to two times a week over a four-week period, noting that she is also receiving messages to reduce her myofascial restrictions in both her lumbar and cervical spine. Mr. Walker writes that the claimant was given home exercise instructions as well as a topical ointment to help relieve her pain. Cervical radiographs were obtained and revealed mild to moderate degenerative disc disease at C5/C6 and C6/C7 and she also had a moderate reversal of her cervical lordotic curve.

The claimant was seen by Dr. Judy White Johnson a clinical neuropsychologist on August 17, 2005. Dr. Johnson notes that the claimant reports her current symptoms as headache, confusion, vision, fatigue, sinus, asthma, allergies, memory and that one day last week she woke with her hands tingling and could not breathe and began crying. The claimant also reports to the doctor that she is taking thirteen medications on a daily basis and that she is just undergone allergy testing and is scheduled to begin injections, further noting that she is a smoker. The claimant reported to Dr. Johnson that she has Googled on the internet and found out that her symptoms do not fit carbon monoxide but has determined that her problem is nitrogen dioxide poisoning from the hot water heater leak. Dr. Johnson writes that the claimant does not like her job, believes that she is underpaid and gives a history of being discriminated against when she was passed over for a manager's job. Dr. Johnson administered the claimant numerous neuropsychological tests and sets out at length the various

findings for these different tests. Dr. Johnson writes that the claimant throughout the test would exhibit behaviors which would interfere with her performance and it is noted that without any prompting the claimant would begin talking about the events at work, various illnesses of co-workers and things she had read on the internet. Dr. Johnson assessed the claimant with having an intellectual functioning level of the upper limit of below average. Dr. Johnson notes that on memory testing the claimant's overall performance was consistent with her other cognitive abilities but due to her test behavior, her verbal learning/verbal memory were areas of great weakness, further noting that when the claimant was administered follow up testing to specifically assess this dimension no problems were found. On the claimant's Wahler's test it was noted by Dr. Johnson that the number and frequency of the complaints reported by the claimant were numerous each day. Dr. Johnson writes that the all over pattern of the claimant's reported symptoms are consistent with symptom magnification. Dr. Johnson concludes after going through the claimant's various tests that the claimant's overall pattern of neuropsychological test findings reflects an individual who is functioning in the low average range of cognitive abilities with no significant impairments or focal problems. Dr. Johnson writes that there is no indicator in the findings of brain damage or traumatic injury and further notes that the claimant's personality findings indicate that she is apt to have significant emotional problems and personality difficulties in her interpersonal relationships, behavior, attitudes and day to day

functioning. Dr. Johnson notes that the claimant's pattern of findings is consistent with a somatization disorder and borderline personality disorder. Dr. Rutherford writes on August 18, 2005, that he has reviewed the claimant's MRI of her brain which was normal as well as the report from Dr. Johnson. Dr. Rutherford writes that the claimant's FCE revealed inconsistent and unreliable effort on the part of the claimant, noting that she passed forty-one out of sixty-one consistency measures. Dr. Rutherford released the claimant to resume full unrestricted duties with no permanent partial impairment rating. The claimant continued to be seen by Dr. Petty for medication refills throughout September and on September 1, 2005, it is noted that the claimant reports that her nerves are getting the best of her and that she is quite upset with the neuropsychiatrist for the report she wrote. It is also noted that the claimant is quite upset due to her best friend committing suicide and reports that she, the claimant, has been yelling at her co-workers and her children. It is noted that the claimant reports having pain all over that is relieved by the pain medications and Norflex and that she would like to have something stronger for her nerves. The claimant was seen by Dr. Eric Stewart on October 24, 2005, for some skin disorders. On October 24, 2005, Kristy Walker with Dr. Petty's office writes that the claimant is taking Neurotin for headaches but feels it is not helping as much and was causing more sexual dysfunction. Ms. Walker writes that the claimant is concerned with her asthma diagnosis and states that she has increased her smoking up to three packs a day, noting that her

allergies are worse. Ms. Walker writes that she discussed with the claimant the fact that she is on multiple pain medications and the claimant indicated that she does not feel that this is her problem and that she needs her medications to function. Ms. Walker encouraged the claimant to decrease her smoking dramatically, noting that smoking is not helping anxiety her allergies and sinus infections or headaches. Ms. Walker recommended that the claimant begin chiropractic therapy and message therapy. On November 3, 2005, Dr. Petty writes that the claimant reports numbness on the right side of her face. Dr. Petty notes that the claimant's cranial nerves are intact except for decreased sensation in the right facial nerve distribution, noting further that the claimant has normal motor function, no facial droop, no slurring of words and the claimant has good movement of her eyes and is able to open and close them. Medications were prescribed and a CT scan was performed. An MRI of the claimant's brain made on November 7, 2005, was normal. A CT of the claimant's head done on November 4 was normal. Throughout November Dr. Petty continued to follow the claimant as to her face numbness and notes that the claimant overall is doing better. Dr. Petty continued to monitor and prescribe medications for the claimant throughout December 2005 and into January 2006.

The non-medical evidence sets forth that the Rogers Fire Department responded to a call from the respondent on June 8, 2005, at 11:43 a.m. The report sets forth that the manager, Amanda Johnson, reported that everyone in the office had been having

headaches and she showed them a wet spot on the floor in the northwest corner of the building. Upon inspection, it was discovered in the mechanical room there was water dripping down into the return platform. It is further reported that one inch of water was found under the platform and the problem appeared to be a stopped up condensation drain line. John Minden with Minden Engineering filed a report on June 29, 2005, concerning his inspection of the respondent's physical plant in Rogers, Arkansas. The results of Mr. Minden's test do set forth that the levels of carbon monoxide and carbon dioxide in the main pharmacy room did increase when the hot water heater was fired, noting that this was evidence that the hot water heater flue gases are being drawn into the mechanical air handler and distributed into the pharmacy space. Dr. Corwin Petty, a family practice physician, writes on August 31, 2006, to whom it may concern that the claimant, in his medical opinion, has suffered from delayed neurological sequelae due to prolonged carbon monoxide exposure and subsequent poisoning. Dr. Petty then refers to medical literature in support of his opinion which is attached to and made a part of his statement.

After a complete and thorough review of this entire matter, I find that the claimant has failed to prove by a preponderance of the evidence that she sustained a compensable injury while working for the respondent on June 8, 2005. It is not questioned that some event occurred and that the claimant may have been exposed to some chemical such as carbon monoxide on June 8, 2005, while working for the respondent. The engineering report does indicate that when the

hot water heater is fired up there is some level of carbon monoxide in the respondent's previous building. Arkansas law, however, requires that there be objective medical findings of injury in order to establish a compensable injury. The claimant has been given numerous tests and evaluations all of which are normal or do not indicate any type of injury to this claimant as a result of her working for the respondent. This claimant has a long history of numerous medical problems for which she was being treated and taken a variety of medications prior to June 8, 2005. The claimant also has a long history of heavy cigarette smoking which her various physicians have recommended that she stop due to the affect they are having on her multiple symptoms. This claimant may have medical problems which would require treatment but it is seriously doubted that any of these problems are a result of her working relationship with the respondent. Therefore, this claim should be denied in its entirety.

FINDINGS & CONCLUSIONS

1. The Arkansas workers' Compensation Commission has jurisdiction of this claim.
2. On all pertinent dates, the relationship of employee-employer-carrier existed between the parties.
3. The claimant has failed to prove by a preponderance of the evidence that she sustained a compensable injury while working for the respondent on June 8, 2005. See discussion above.

ORDER

The claimant has failed to prove by a preponderance of the evidence that she sustained a compensable injury on June 8, 2005, while working for the respondent. Therefore, this claim should be denied in its entirety.

IT IS SO ORDERED.

ELIZABETH DANIELSON
ADMINISTRATIVE LAW JUDGE