BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. G105493

MARIA PINEDA, EMPLOYEE	CLAIMANT
TYSON POULTRY, INC., EMPLOYER	RESPONDENT
TYNET CORPORATION, INSURANCE CARRIER/TPA	RESPONDENT

OPINION FILED SEPTEMBER 23, 2022

Upon review before the FULL COMMISSION in Little Rock, Pulaski County, Arkansas.

Claimant represented by the HONORABLE EVELYN E. BROOKS, Attorney at Law, Fayetteville, Arkansas.

Respondents represented by the HONORABLE R. SCOTT ZUERKER, Attorney at Law, Fort Smith, Arkansas.

Decision of Administrative Law Judge: Affirmed.

OPINION AND ORDER

The respondents appeal an administrative law judge's opinion filed April 25, 2022. The administrative law judge found that the claimant proved she sustained a compensable injury. After reviewing the entire record *de novo*, the Full Commission affirms the administrative law judge's opinion. The Full Commission finds that the claimant proved she sustained a compensable lung injury in accordance with Ark. Code Ann. §11-9-114 (Repl. 2002).

I. HISTORY

Maria Pineda, now age 48, testified that she became employed with the respondent, Tyson Poultry, in 2009. The parties stipulated that the employment relationship existed on June 27, 2011. The claimant testified on direct examination:

> Q. What job were you doing at that time?
> A. I was packaging. I was packaging boxes of chicken.
> Q. And what happened on June 27, 2011?
> A. There was a chemical spill. Where I was, all of the people were leaving. I didn't know why they were leaving. The door was small. The one that was closest to me was a small door. It stayed open so people could leave, but as I was waiting to leave, I started feeling like a burning sensation in my chest, on my face. My face felt like it was really big until someone told us to get out because there was a chemical spill….When we got out, there were several ambulances. After that, they took me in a bus. There was a lot of us. They took us to the Rogers clinic.
> Q. Okay. When you got to the clinic, what were your symptoms then?
> A. Well, I couldn't breathe and I felt like I was burning….

According to the record, the claimant treated at Northwest Medical Center - Bentonville on June 27, 2011:

> REASON FOR ADMISSION: Chlorine gas exposure with respiratory difficulty.
> HISTORY OF PRESENT ILLNESS: This is a 37-year-old Hispanic female who was among multiple workers at a Tyson's plant in Springdale when she was exposed to chlorine gas….In the emergency room, the patient was in respiratory distress, and was noted to have bilateral pulmonary infiltrates on chest x-ray. She was intubated using rapid sequence technique by the emergency room physician and I was then contacted. The patient is intubated and sedated and as a result, I have no past medical history….
> Chest x-ray shows bilateral pulmonary infiltrates with normal heart size.

Dr. G.B. Waldon's impression on June 27, 2011 was "Chlorine gas exposure with acute interstitial edema. PLAN: The patient will be admitted, kept on positive pressure and will be treated with bronchodilator therapy and steroids."

An x-ray of the claimant's chest was taken on June 28, 2011 with the impression, "Mild atelectasis right mid lung."

An x-ray of the claimant's chest was taken on June 29, 2011 with the following findings:

> Cardiac silhouette, pulmonary vasculature and mediastinum are within limits of normal. The lungs are clear. There are no pleural effusions. No pneumothorax identified. IMPRESSION: No acute pulmonary disease.

The claimant was discharged from Northwest Medical Center – Bentonville on June 30, 2011:

> This is a 37-year-old white Hispanic female, who was exposed to chlorine gas on June 27, 2011. She presented to the emergency room and the ER physician felt like her chest x-ray showed increased interstitial markings. She has some respiratory distress and was intubated by the emergency room physician and I was called to admit the patient. The patient was weaned off mechanical ventilation within 24 hours. Chest x-ray remained clear. She was treated with IV steroids, which resulted in a transient elevation of blood sugar. On the day of discharge, the patient was ambulatory with a normal room air pulse ox. Lungs are clear. CBC and basic metabolic panel are both normal. The patient still has multiple nonspecific complaints such as lightheadedness, headache, and chest discomfort on inspiration, although her physical exam is completely normal. At this time, she is discharged on above medications.

Dr. Waldon's Final Diagnoses were "1. Chlorine gas exposure. 2. Hyperglycemia secondary to steroids."

The claimant treated at Northwest Medical Center Springdale on June 30, 2011:

> Pt was [involved] 4 days ago [with] Tyson/Chlorine gas exposure….Pt was admitted to NWBV after event and developed Pneuomonia….Pt was released from hospital today 3 hrs ago….states that went to Tyson to have papers signed and began to become SOB again….states tightness in chest and pain….sharp….
> Onset of symptoms was 4 day(s) ago. Symptoms came on suddenly….
> **Respiratory:** Respiratory effort is mildly labored. Lung Sounds: Decreased breath sounds upper right chest, mid right chest, upper left chest, mid left chest. Remainder of lung exam normal.
> Chest X-Ray PA & Lateral View – No acute disease.

A physician's impression on June 30, 2011 was "1. Hyperventilation Syndrome. 2. Acute Anxiety."

An x-ray of the claimant's chest was taken on July 1, 2011 with the following findings: "The heart is normal in size. The lungs are clear. Bones are intact. IMPRESSION: Negative chest."

It was noted at Mercy Clinic Bentonville Highway 102 on February 22, 2012, "1 month PT is experiencing a cough, body aches, chest congestion, shortness of breath, fatigued, nasal congestion, headache, nasal drainage, and nausea."

Dr. Graeme Archer assessed the following on November 10, 2012: "1. Reactive airway disease. 2. Wheezing. 3. SOB (shortness of breath). 4. Allergic rhinitis, cause unspecified."

An x-ray of the claimant's chest was taken on July 26, 2013: "Suboptimal inspiratory effort, but diffuse interstitial opacity suggests there could be some mild pulmonary edema versus interstitial inflammation. No consolidation. IMPRESSION: Interstitial pulmonary opacity, as discussed."

Dr. Kyle G. Hardy reported on April 21, 2015:

> This patient is a 41-year-old Hispanic female whom we have been following for reactive airways dysfunction syndrome after a chemical exposure at her place of work….Patient reports that she has missed about 10 days of work over the past 6 months. Most of these [absences] were due to respiratory symptoms. She has a morning cough and notes wheezing which does not occur daily. She occasionally wakes at night with dyspnea. Currently using Advair twice a day. She uses 1 albuterol inhaler every 2 months. She continues to have rhinorrhea and is taking her Flonase. Patient reports 3 urgent care physician [visits] since her last visit….
> PFT: Spirometry is compatible with mild restrictive lung disease. There is a moderate reduction in mid flow rates and there is significant improvement in FEV1 and mid flow rates after bronchodilator therapy. Flow volume loop shows less than maximal effort. There has been a significant reduction in her pulmonary function as compared with a study performed one year ago. Patient complained of dyspnea and chest tightness during the study which may have led to less than maximal effort.

Dr. Hardy assessed "Reactive airways dysfunction syndrome. I find it difficult to assess her symptoms today." Dr. Hardy prescribed medication and planned a six-month follow-up visit.

Kristin A. Zaharopoulos, APN examined the claimant on May 19, 2015 and gave the following impression: "1. Reactive airways dysfunction syndrome, symptomatically improved with the addition of Singulair."

Dr. Hardy reported on April 21, 2016:

> Patient is a 42-year-old Hispanic female who I believe developed reactive airways dysfunction syndrome after a chemical exposure at work. Patient returns today for followup. Overall she feels good. Patient complains of exposure to Clorox at work causes chest tightness, nasal dryness, coughing and a dry throat. She also notes some hoarseness. Patient is going to be moved to a different area plan (sic) for several weeks. Currently using Advair twice a day, Flonase, Singulair and albuterol which she uses about once daily….
> Lungs: Clear to auscultation with no wheezes or crackles. There are no intercostal retractions. Patient is not using accessory muscles. Chest is symmetrical….
> PFT: This patient provided very poor effort negating the results of our pulmonary function testing.

Dr. Hardy assessed "Reactive airways dysfunction syndrome. It is very difficult to tell whether this patient remains symptomatic. She is not providing good effort on her pulmonary function testing so we are not able to adequately measure for evidence of obstruction. I did fill out FLMA paperwork today." Dr. Hardy refilled the claimant's prescriptions and planned, "I will schedule return appointment in one year with SBA, lung volumes and an exhaled nitrous oxide. I've asked her to provide her best effort when she performs these studies."

Dr. Hardy's assessment on April 5, 2018 was "Reactive airways dysfunction syndrome" and "Allergic rhinitis."

Marlys A. Bitner APRN noted on September 18, 2018, “Ms. Perez is a 45 year old patient of Dr. Hardy’s who is followed for asthma/reactive airways dysfunction syndrome after a chemical exposures (sic) in the workplace on 6/27/11. Has been seen multiple times in sick clinic.” The claimant continued to follow up with Ms. Bitner and other providers at MANA Medical Associates.

The respondents’ attorney examined Dr. Hardy at a deposition taken July 22, 2020:

> Q. What is your working diagnosis?
> A. We have been calling her asthma, you know, or reactive airways dysfunction from the chemical exposure. Her symptoms have just drug on for so long. You can develop asthma after a significant exposure like that that is permanent. We have really had no success in treating her or, you know, relieving her symptoms….
> Q. And just to be clear as we sit here, you can’t point me to any objective medical evidence that she has any condition caused by this exposure?
> A. Yeah, no, I cannot. That is such a difficult thing because somebody tells you they have pain and how do you prove that they do or don’t and it is kind of the same way with shortness of breath. So I have taken her at her word. We have done our best to try to prove it with our testing and we haven’t been able to. We have done our best to treat her symptoms and we have made no progress. She has had therapy for her asthma, which she doesn’t always take like she is supposed to and often takes intermittently. But even when we give her Prednisone, that really ought to make your asthma better and I am not sure that she really has had that much improvement….

The claimant’s attorney also examined Dr. Hardy:

> Q. Well, I don't believe that there is any dispute that there was an incident at the plant where there was a chemical exposure. In fact, I think people were taken by bus to a doctor on this date of June 27, 2011. And I don't have any prior medical records for Ms. Perez, but if we assume that she did not have these kinds of symptoms prior to this happening –
> A. Yes.
> Q. – I know you said you had not been able to have access to her Mercy Clinic records, but I went through probably hundreds of pages of records today from Mercy Clinic and she was there a lot and she was complaining of cough, wheezing. She had bronchitis quite a few times.
> A. When was this?
> Q. This was starting in, let's say, July – well, these aren't in order. February of 2012: Wheezing bilaterally, upper respiratory illness. April 5 of ' 12: Wheezing bilaterally. May 4th of '12: Shortness of breath, cough, wheezing. November 10th of 12: Wheezing, shortness of breath. There is a lot in here about wheezing and sometimes it will say bilaterally.
> A. Uh-huh.
> Q. So when a doctor would note wheezing bilaterally, is that from listening to the chest?
> A. Yes.
> Q. Is that an objective finding?
> A. Yes, I mean that would be a physical exam finding and one that – I don't think we've ever heard her wheeze or I don't think we have ever documented it, but certainly if they did, that would be an objective finding for asthma….

Dr. Daniel Sundaresan Paul provided a Pulmonary Function Report on March 12, 2021 and gave the following impression: "This pulmonary function test appears to be within normal limits although the shape of the flow volume loop appears to hint at mild obstructive airway disease. Clinical correlation is suggested."

Dr. Cheryl A. Fulton reported on March 19, 2021:

> Ms. Pineda informed me today, that Tyson requested her job restrictions be reduced, so she can return to work. She has severe persistent asthma as a result of a chemical spill at the Berry Street Tyson plant 9 years ago. Exposure to chemicals or cold air aggravates her asthma, and she cannot breathe easily. She can return to work if she is not exposed to chemicals or cold air. If she will be exposed to cold air or chemicals, she is not able to work in this type of environment.

Dr. Paul stated in part on March 30, 2021, "Patient carries a diagnosis of asthma which needs to be confirmed….My concern with her chemical exposure in 2011 is whether she has reactive airway dysfunction syndrome or chronic hypersensitivity pneumonitis." Dr. Paul planned additional diagnostic testing.

A pre-hearing order was filed on October 20, 2021. The claimant contended that she sustained "a compensable lung injury" and that she was entitled to additional medical treatment. The respondents contended that the claimant "did not sustain a compensable injury as that term is defined by Act 796." The parties agreed to litigate the following issues:

1. Compensability of injury to the claimant's lungs on June 27, 2011.
2. The claimant's entitlement to medical treatment.

Dr. Paul reported on November 23, 2021:

> 1. This is a never smoker presenting for evaluation of longstanding shortness of breath cough and wheezing. She has previously been diagnosed with asthma. Current PFTs are entirely within normal limits except perhaps for mild OAD based on the shape of the flow-volume loop. The methacholine challenge test done showed that it was highly positive with a PC 20 of 0.154 mg/mL. Patient had

already been started on Trelegy 100 and she was advised to continue the same….
I told the patient that clearly there is a risk of triggering asthma and making it worse by exposure to industrial chemicals at work and therefore she should not be exposed to any industrial chemicals at work.

2. Follow-up with rheumatology….
Patient carries a diagnosis of asthma which has now been confirmed. My concern with her chemical exposure in 2011 is whether she has reactive airway dysfunction syndrome or chronic hypersensitivity pneumonitis. HRCT did not show any ILD to suggest chronic HP. Additional diagnostic considerations include excessive central airway collapse (EDAC)….
She can use albuterol 2 puffs every 8 hours as needed by inhaler or she can take the albuterol nebulizer solution 1 vial every 8 hours as needed for breakthrough shortness of breath. I have refilled all of her medications today and gave her 2 more samples of Trelegy Ellipta….
Return in about 6 months (around 5/23/2022)….

The respondents' attorney examined Dr. Paul in a deposition taken January 27, 2022:

> Q. And what is your working diagnosis for Ms. Pineda?
> A. My working diagnosis is asthma, but she had a history of exposure to a chemical spill in 2011, so I also raised the possibility that we might be dealing with a related condition called reactive airways dysfunction syndrome.
> Q. And my question to you, Doctor, is based on what your diagnosis is, as we sit here today, can you tell me with a reasonable degree of medical certainty that that diagnosis was caused by an alleged chemical spill in 2011?
> A. Only the historical information as given by the patient, but the history that she gave makes me have a reasonable degree of certainty that the symptoms were related to that exposure.
> Q. What do you base that on?
> A. Two things. One is the patient's history that prior to that she never had any lung symptoms and the symptoms of her shortness of breath and wheezing and cough began right after

that. The second is the lab results which I did a methacholine challenge test. It was very, very highly positive indicating severe reactivity. And the third is I had reviewed some of her previous records from another pulmonologist, Dr. Hardy, and he had been the one seeing her before I saw her and her – and his nurse practitioner had also seen, so I reviewed all of those records which seemed to point in that direction….
Q. If she has asthma, would that have been caused by the chemical exposure?
A. That is speculation on my part, so there is no way to prove it. If we had had a breathing test prior to that exposure and if I could have had a history as to how she was personally, then I would have been able to tell for sure. But as such being remote 10 years, almost, from the date of the alleged spill, I have to go by the patient's history that she claimed that she had no lung symptoms and then right after that spill she had these lung symptoms. So the circumstantial evidence led me to suspect that it could be related to the spill, but I have no way to prove it….
Q. Do you know what gas she was exposed to?
A. I do not.
Q. Is that not something you need to know to be able to state an opinion that that exposure caused this condition?
A. I don't have to know the gas. I only need to know whether it happened right then and thereafter she was exposed, which I took it at face value. I have no way to confirm whether she was telling the truth or not. I anticipate that my patients tell the truth….
Q. And as I understand what you told me earlier, if she has reactive airway disease, then you feel comfortable saying to a reasonable degree of medical certainty that was caused to this chemical exposure. Correct?
A. Correct. And that is entirely based on the patient's record and I have to take that at face value and say, okay, if the patient gives a history that I didn't have any lung symptoms and then I had this exposure to this spill and then I started having lung symptoms, then I have to ask like, okay, if that patient is telling the truth, as I believe she is, then I am going to just take it that that was the start of it….
Q. And what I understood you to say earlier is linking asthma to this event would require speculation on your part?
A. Correct.

A hearing was held on March 23, 2022. The claimant testified that she continued to suffer from symptoms related to the June 27, 2011 chemical spill at work. The claimant testified, "I always have trouble breathing. I get - I cough all the time and it bothers me. I even get – even I get – my throat hurts from it sometimes. And my chest, it feels like it is really tight. It doesn't let me breathe."

An administrative law judge filed an opinion on April 25, 2022. The administrative law judge found that the claimant proved she sustained a compensable injury. The administrative law judge awarded reasonably necessary medical treatment and fees for legal services. The respondents appeal to the Full Commission.

II. ADJUDICATION

Act 796 of 1993, as codified at Ark. Code Ann. §11-9-114(Repl. 2002), provides:

> (a) A cardiovascular, coronary, pulmonary, respiratory, or cerebrovascular accident or myocardial infarction causing injury, illness, or death is a compensable injury only if, in relation to other factors contributing to the physical harm, an accident is the major cause of the physical harm.
> (b) (1) An injury or disease included in subsection (a) of this section shall not be deemed to be a compensable injury unless it is shown that the exertion of the work necessary to precipitate the disability or death was extraordinary and unusual work in the course of the employee's regular employment or, alternately, that some unusual and unpredicted incident occurred which is found to have been the major cause of the physical harm.

> (2) Stress, physical or mental, shall not be considered in determining whether the employee or claimant has met his or her burden of proof.

"Major cause" means more than fifty percent (50%) of the cause, and a finding of major cause shall be established according to the preponderance of the evidence. Ark. Code Ann. §11-9-102(14)(Repl. 2002). Preponderance of the evidence means the evidence having greater weight or convincing force. *Metropolitan Nat'l Bank v. La Sher Oil Co.*, 81 Ark. App. App. 269, 101 S.W.3d 252 (2003).

An administrative law judge found in the present matter, "2. Claimant has met her burden of proving by a preponderance of the evidence that she suffered a compensable injury to her lungs on June 27, 2011." The Full Commission affirms this finding. The claimant testified that she became employed with the respondents in 2009. The parties stipulated that the employment relationship existed on June 27, 2011. The claimant testified that a chemical spill occurred while she was on the respondents' premises and was performing employment services. The claimant testified that she began suffering from a "burning sensation" in her chest as well as difficulty breathing.

The evidence of record corroborated the claimant's testimony. A treatment note at Northwest Medical Center – Bentonville on June 27, 2011 indicated that the claimant was suffering from symptoms related to

exposure to chlorine gas at work. There were objective findings in the form of "bilateral pulmonary infiltrates" as shown on a chest x-ray. A treating physician's impression on June 27, 2011 was "Chlorine gas exposure with acute interstitial edema." An x-ray of the claimant's chest on June 28, 2011 showed "Mild atelectasis right mid lung." The claimant was discharged from the hospital on June 30, 2011 with the accompanying diagnosis, "1. Chlorine gas exposure." However, the claimant treated at Northwest Medical Center Springdale on June 30, 2011 where it was also noted that the claimant had been exposed to chlorine gas at work. A physician's impression on June 30, 2011 was "1. Hyperventilation Syndrome."

The Full Commission finds that the claimant proved by a preponderance of the evidence that she sustained a pulmonary accident at work on June 27, 2011. The Full Commission finds that the June 27, 2011 pulmonary accident was the major cause, that is, more than fifty percent (50%) of the cause, of the claimant's physical harm. We also find that an "unusual and unpredicted accident" occurred which was the major cause of the physical harm. The "unusual and unpredicted accident" was the chlorine gas leak at work on June 27, 2011. The respondents contend, among other things, that the claimant suffered from pre-existing "co-morbidities" such as GERD, allergic rhinitis, and upper respiratory infections. Nevertheless, even if the claimant did suffer from "pre-existing

comorbidities," an employee's pre-existing condition does not preclude a finding that a work-related accident was the major cause of physical harm. *Estate of Slaughter v. City of Hampton*, 98 Ark. App. 409, 255 S.W.3d 872 (2007). In workers' compensation law, an employer takes the employee as he finds her. *Parker v. Atlantic Research Corp.*, 87 Ark. App. 145, 189 S.W.3d 449 (2004). The Full Commission finds in the present matter that the pulmonary accident occurring June 27, 2011 was the major cause of the claimant's physical harm.

The Full Commission finds that the subsequent medical treatment of record provided in connection with the claimant's breathing complaints was reasonably necessary in accordance with Ark. Code Ann. §11-9-508(a)(Repl. 2002). Dr. Archer assessed the following on November 10, 2012: "1. Reactive airway disease. 2. Wheezing. 3. SOB (shortness of breath). 4. Allergic rhinitis, cause unspecified." We find that these diagnosed conditions were causally related to the compensable pulmonary injury occurring June 27, 2011. The Full Commission also finds that Dr. Hardy's assessment of "reactive airways dysfunction syndrome" was causally related to the compensable pulmonary injury. Dr. Hardy expressly noted on April 21, 2016 that the claimant "developed reactive airways dysfunction syndrome after a chemical exposure at work." The Commission has the authority to accept or reject a medical opinion and the

authority to determine its probative value. *Poulan Weed Eater v. Marshall*, 79 Ark. App. 129, 84 S.W.3d 878 (2002). We find in the present matter that Dr. Hardy's opinion is corroborated by the evidence of record and is entitled to significant evidentiary weight. We also attach significant evidentiary weight to Dr. Fulton's treatment note on March 19, 2021, "She has severe persistent asthma as a result of a chemical spill at the Berry Street Tyson plant 9 years ago." Finally, the Full Commission attaches significant evidentiary weight to Dr. Paul's expert opinion that the claimant was suffering from asthma and that the claimant "had a history of exposure to a chemical spill in 2011."

After reviewing the entire record *de novo*, the Full Commission finds that the claimant proved by a preponderance of the evidence that she sustained a compensable lung injury in accordance with Ark. Code Ann. §11-9-114(Repl. 2002). The claimant proved that she sustained a compensable pulmonary accident on June 27, 2011, and that the accident was the major cause of the physical harm. The claimant proved that an unusual and unpredicted incident occurred on June 27, 2011 which was the major cause of the physical harm. The claimant also proved that the treatment of record, including treatment recommendations of Dr. Hardy and Dr. Paul, was reasonably necessary in accordance with Ark. Code Ann. §11-9-508(a)(Repl. 2002). For prevailing on appeal to the Full Commission,

the claimant's attorney is entitled to a fee of five hundred dollars ($500), pursuant to Ark. Code Ann. §11-9-715(b)(Repl. 2002).

IT IS SO ORDERED.

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SCOTTY DALE DOUTHIT, Chairman

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CHRISTOPHER L. PALMER, Commissioner

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M. SCOTT WILLHITE, Commissioner