

APPELLATE PANEL
DECISION AND ORDER
OF THE
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
WCC FILE NO. 1107022

Sandy Chamblee,

APPELLANT,
CLAIMANT,

vs.

RECEIVED

Anderson County Fire Department,

SEP 02 2015

EMPLOYER,

AND

SC Court of Appeals

State Accident Fund ,

CARRIER,
DEFENDANTS/RESPONDENTS

Appellate Panel Review held in Columbia, South Carolina,
on June 15, 2015, per notices timely and properly served
upon all parties of interest.

Appellate Panel Decision and Order filed

August 5th, 2015

APPEARANCES:

Claimant/Appellant represented by Richard E. Thompson,
Jr., Esquire of Thompson & King Law Office in Anderson,
South Carolina.

Defendants/Respondents represented by Ian C. Gohean,
Esquire of Willson Jones Carter & Baxley, P.A. in
Greenville, South Carolina.

STATEMENT OF THE CASE

Claimant alleges she suffered a permanent aggravation of her preexisting asthma/lung condition on May 26, 2011, when she allegedly inhaled smoke when she presented to a fire in the course of her employment with the Anderson County Fire Department. Claimant filed a Form 50, Request for Hearing, seeking a finding of compensability and entitlement to benefits under the Act. Defendants filed a Form 51, Answer, denying the claim, and a hearing was scheduled and held before Commissioner Gene McCaskill (hereafter, "the Single Commissioner") on November 6, 2014.

It was Claimant's position at the hearing that she suffered a permanent aggravation of her preexisting asthma condition as a direct result of smoke exposure on May 26, 2011. Claimant sought a finding of compensability, along with entitlement to medical benefits, temporary disability benefits, and permanent disability benefits. Claimant alleged she is permanently and totally disabled as a direct result of the incident of May 26, 2011. It was Defendants' position at the hearing that Claimant failed to carry her burden of proving a compensable injury by accident, and Defendants requested an order denying the claim in its entirety. In the alternative, Defendants argued that if the claim was compensable, Claimant had not yet reached maximum medical improvement (MMI), and a finding of permanent disability would be premature. On March 2, 2015, the Single Commissioner issued a Decision and Order.

The Single Commissioner made the following Findings of Fact:

1. That Employee, Employer, and Carrier are subject to and bound by the terms and provisions of the South Carolina Workers' Compensation Act, as amended, with Sandy Chamblee as Employee-Claimant and Anderson County Fire Department as Employer and State Accident Fund as Carrier, Defendants.
2. The average weekly wage of Claimant at the time of the above-described accident was \$756.49, with a corresponding compensation rate of \$504.35.
3. Claimant alleges she suffered a permanent aggravation of her preexisting asthma condition arising out of and within the course and scope of her employment on May 26, 2011.

4. It is Claimant's contention that her asthma was aggravated by smoke from a fire in a field near a vehicle in which she was sitting on or about May 26, 2011.
5. Claimant asserts that, as a result of this aggravation, she is permanently and totally disabled.
6. Defendants deny this claim.
7. From a review of the medical records, Claimant has a relatively extensive medical history, and Claimant has a lifelong history of asthma. (Medical Record as a Whole)
 - a) Claimant testified she was first diagnosed with asthma at about six weeks old and has also had lifelong problems with sinuses and allergies. (Testimony of Claimant)
 - b) Claimant was treated at Duke Medicine for a diagnosis of asthma and allergic rhinitis as a child, and she treated numerous times at Duke Medicine from 1969 through 1976. (APA, pp. 200-219)
 - c) Claimant underwent sinus surgeries in both 1984 and 1986. (APA, p. 220)
 - d) On May 17, 1996, Claimant presented to Dr. Jane Reister, an ENT, where Claimant reported the following issues: excessive coughing, throat clearing, laryngeal tension and pain, persistent upper respiratory infections, severe gastric reflux, excessive head/neck/shoulder tension, asthma, sensation of something being caught in her throat, allergies, sinus drainage, quick vocal fatigue, and cigarette exposure. Claimant also reported to Dr. Reister that she had a "hoarse, raspy voice for as long as she could remember." (APA, p. 222)
 - e) Claimant returned to Dr. Reister on July 31, 1996, and Dr. Reister performed a laryngoscopy and vocal cord stripping procedure. (APA, p. 223)
 - f) Dr. Reister's records from 1996 also indicate Claimant was using an asthma inhaler at that time. (APA, p. 220)
 - g) Claimant returned to Dr. Reister on October 13, 2003, and Claimant indicated her current medications included Lexapro, Singular, Advair, Zithromax, Nexium, Zyrtec, Endall HD, and Cipro. Claimant reported to Dr. Reister that she had been "sent to an asthma doctor." (APA, p. 226)
 - h) Claimant returned to Dr. Reister on November 5, 2003, with complaints of post-nasal drainage, and Claimant indicated she was still on all of the same medications. (APA, p. 229)
 - i) Claimant returned to Dr. Reister on November 21, 2003, and Dr. Reister recommended a sinus surgery on account of Claimant's sinusitis, and the surgery was performed on December 17, 2003. (APA, pp. 229, 257)
 - j) Claimant returned to Dr. Reister in March of 2004 with complaints of "significant allergies" and a sore throat. (APA, p. 231)

- k) Claimant returned to Dr. Reister in September 2004, with complaints of being congested and wheezing, and complaints that Claimant's throat and ears hurt and she felt stopped-up. At that time, Claimant's medications included Singular, Advair, hormones, Nexium, Celebrex and Albuterol. (APA, p. 232)
- l) Claimant returned to Dr. Reister in October of 2004, where she complained of sinus trouble, trouble breathing, wheezing, coughing, sore throat, pressure in the ears, and being very stuffy. Dr. Reister indicated she listened to Claimant's lungs and Claimant "sounds like she is wheezing." (APA, p. 232)
- m) Claimant returned to Dr. Reister in March of 2005, and Dr. Reister indicated Claimant was "having same symptoms." (APA, p. 235)
- n) Claimant returned to Dr. Reister in May of 2005, and Dr. Reister indicated Claimant had "significant sore throat." (APA, p. 235)
- o) Claimant returned to Dr. Reister in June of 2005, and Dr. Reister noted the following: "Her asthma has been a problem. I listened to her today and she really did sound like she was not moving a lot of air but she said in the next couple of days she felt she would probably be doing better." Dr. Reister further noted Claimant "...probably would go to a pulmonologist shortly." (APA, p. 234)
- p) Claimant presented to Dr. Gregg Seymour, her primary care physician, on June 20, 2005, with complaints of cough, congestion, and wheezing. (APA, p. 260)
- q) Claimant returned to Dr. Seymour on July 5, 2005, with complaints of shortness of breath and wheezing, and Dr. Seymour ordered spirometry testing and referred Claimant to a pulmonologist. (APA, p. 261)
- r) On July 25, 2005, Claimant presented to Dr. Stephen Hand, a pulmonologist with AnMed Health Carolina Pulmonary Sleep, per the referral of Dr. Seymour. Claimant indicated she had asthma since she was six weeks old, and "it became much worse during her pregnancy three years ago. She has had significant shortness of breath, wheezing, cough, worse with exposure to heat and humidity this summer." Claimant also indicated she "has been on four or five courses of prednisone this year." Claimant also told Dr. Hand, "she feels fatigued most of the time," and she had had "weight gain of approximately 100 pounds in the past three years." Claimant's issues were noted to include throat pain, intermittent hoarseness, snoring and witnessed apneas, shortness of breath, wheezing, cough, headaches, daytime sleepiness, fighting sleep while driving, falling asleep while working, fighting sleep during conversation, intermittent creeping and crawling sensation in her legs, and intermittent anxiety. Claimant also indicated she was suffering from gastro-esophageal reflux, and Dr. Hand indicated, "I have advised her that this could be a contributor to her problems with asthma. She reports her symptoms are difficult to control, and also reports she sometimes has difficulty swallowing liquids." At the time of her evaluation with Dr. Hand, Claimant's current medications included Singular, Advair, Nexium, allergy shots, Albuterol, and nebulizer treatments. Dr. Hand referred Claimant for a sleep study with a diagnosis of obstructive sleep apnea. (APA, pp. 91-94)

- s) Claimant returned to Dr. Seymour on August 16, 2005, with complaints of sinus/chest congestion, dry cough, and a yellow/brown discharge. (APA, p. 262)
- t) Claimant underwent a sleep study on August 26, 2005, per the referral of Dr. Hand, and she was diagnosed with obstructive sleep apnea. (APA, pp. 293-296)
- u) Claimant returned to Dr. Hand on September 6, 2005, for a follow up of her asthma and sleep apnea. Claimant "reports she had another flare of her asthma and was on prednisone briefly," and she also "notes occasional wheezing." Claimant also complained of nasal congestion and drainage, and a headache, and Dr. Hand indicated Claimant was "being set up for CPAP." (APA, p. 95)
- v) Claimant returned to Dr. Hand on October 10, 2005, and Dr. Hand indicated Claimant had increased cough productive of a yellowish sputum for the past week. (APA, p. 96)
- w) Claimant returned to Dr. Reister, the ENT, in 2005, with complaints of nasal congestion, facial pressure, sore throat, and dark green drainage. (APA, p. 234)
- x) Claimant returned to Dr. Reister in January of 2006 and requested a depo medrol shot. Dr. Reister denied Claimant's request, and indicated "pt should see fam MD or pulmonologist." (APA, p. 236)
- y) Claimant returned to Dr. Hand, her pulmonologist, on March 15, 2006, and Dr. Hand noted she "has had two episodes of bronchitis this winter that required an antibiotic and prednisone." (APA, p. 97)
- z) Claimant returned to Dr. Seymour on June 28, 2006, and Dr. Seymour noted Claimant was "known to have asthma. Over the past several days, she has had sinus congestion and drainage. The mucus is thick and yellow. Mild sore throat has been noted. Occasional wheezes. She uses her aerosol at times." (APA, p. 265)
- aa) Claimant returned to Dr. Reister in October of 2006 with complaints of hoarseness. Dr. Reister noted Claimant to be using Singular, Advair, and receiving allergy shots. (APA, p. 237)
- bb) Claimant returned to Dr. Reister in December of 2006 with complaints of sinus congestion and left ear fullness. Claimant indicated she had taken several Goody's headache powders that day. (APA, p. 237)
- cc) Claimant returned to Dr. Reister in June of 2007 with complaints of throat pain and reflux, and having had a nose bleed that day. Claimant's medications on that day included Singular, Advair, Nexium, Amitripline, allergy shots, Elavil, and Albuterol. (APA, pp. 239, 267)
- dd) Claimant returned to Dr. Seymour on July 2, 2007, with complaints of sinus congestion, and again to Dr. Seymour on August 16, 2007, with complaints of sinusitis, bronchitis, and bronchospasm. (APA, p. 271)
- ee) Claimant returned to Dr. Seymour on October 17, 2007, with complaints of chest congestion, shortness of breath, wheezing bronchospasm, and Claimant indicated she

- was out of Albuterol. (APA, p. 271)
- ff) Claimant returned to Dr. Reister in November of 2007 and indicated she had tried to stop her allergy shots but it did not work, and she was advised to continue her allergy shots. (APA, p. 240)
 - gg) Claimant returned to Dr. Seymour on January 31, 2008, with complaints of sinusitis. (APA, p. 272)
 - hh) Claimant returned to Dr. Reister in February of 2008 with complaints of severe sore throat, coughing, wheezing, and nasal congestion with brown colored nasal drainage. (APA, p. 241)
 - ii) Claimant returned to Dr. Reister in March of 2008 with complaints of sore throat, increased facial pressure, and chest congestion, and Claimant indicated she used "last antibiotic this a.m. and believes to be getting sick all over again." Claimant requested a depo medrol shot, and Dr. Reister noted Claimant to have a cough and considerable mucus problem, along with bronchitis. (APA, pp. 242-243)
 - jj) Claimant returned to Dr. Seymour on March 25, 2008, with complaints of cough, shortness of breath, bronchitis, and bronchospasm. (APA, p. 272)
 - kk) Claimant returned to Dr. Hand, her pulmonologist, on October 27, 2008. At that time, Claimant reported she had some problems with her asthma which were improving since going on allergy shots. (APA, p. 98)
 - ll) Claimant underwent a lap band surgery in December of 2008. (APA, p. 132; Testimony of Claimant)
 - mm) Claimant returned to Dr. Seymour on January 12, 2009, with complaints of cough and sinusitis. (APA, p. 273)
 - nn) Claimant returned to Dr. Seymour on April 14, 2009, with complaints of a cough and headache, and complaints of an "exacerbation of asthma." (APA, p. 275)
 - oo) Claimant returned to Dr. Reister in April of 2009, where she complained of "some asthma trouble, was outside on Easter." Claimant indicated she had just had a depo medrol shot that week, along with a Z-Pack and prednisone. (APA, p. 245)
 - pp) Claimant returned to Dr. Seymour on May 28, 2009, with complaints of sinus congestion, dry cough, bronchitis, and bronchospasm. (APA, p. 275)
 - qq) Claimant returned to Dr. Seymour two times in August of 2009 with complaints of chest congestion, wheezing, shortness of breath, and an "exacerbation of asthma," and she received a depo medrol shot. (APA, p. 276-277)
 - rr) Claimant returned to Dr. Seymour on September 28, 2009, with complaints of shortness of breath, cough, wheezing, and an "exacerbation of asthma/bronchitis." (APA, p. 278)
 - ss) Claimant returned to Dr. Reister in December of 2009, with complaints of having chest

tightness during recent skin testing and having had to receive two Albuterol inhaler puffs during the testing, and Claimant also indicated she had been having "a lot of trouble with tomatoes and some wheezing." (APA, p. 246)

- tt) Claimant returned to Dr. Reister on March 3, 2010, with complaints that she was "very congested and has a sore throat and not feeling well, lots of congestion." Claimant also complained of "lots of post nasal drip." (APA, p. 247)
 - uu) Claimant returned to Dr. Seymour on July 23, 2010, with complaints of chest congestion, wheezing, shortness of breath, and dark phlegm, and Dr. Seymour referred Claimant to a pulmonologist. (APA, p. 280)
8. Nine months before the alleged injury, Claimant was referred by her personal physician, Dr. Seymour, to Dr. Gowdhami Mohan, who is a pulmonologist. (APA, pp. 280, 99-101)
- a) In his medical note of August 25, 2010, Dr. Mohan writes in part, "The patient has been suffering from chronic cough for the last 6 months. She has a longstanding history of asthma, but it was well controlled until 2 years ago. For the last 2 years, she has been having trouble with cough, sputum production, etc. The patient has a nebulizer machine and she uses the nebulizer treatment (aerosols 3 to 4 times a day). Currently, also receiving allergy shots on a regular basis. Still continues to have persistent cough. Sputum production has been noted for the last 6 months." (APA, pp. 99-101)
 - b) Dr. Mohan also noted Claimant to be suffering from runny nose and sinus congestion periodically and noted Claimant to have been diagnosed with sleep apnea and to be using a CPAP machine. Dr. Mohan diagnosed chronic persistent asthma, and he noted Claimant "is using nebulizer treatments regularly and despite this having significant dyspnea. Currently, also has bronchitis and has asthma exacerbation." Claimant was prescribed Levaquin, Singulair, Pulmicort aerosols, Brovana, and Combivent inhaler. (APA, pp. 99-101)
9. Claimant and Larry Greer, Jr. presented to a grass fire on May 26, 2011.
- a) No one disputes that Claimant was with Larry Greer, Jr. on their way to install smoke detectors on May 26, 2011, when Mr. Greer stopped the vehicle to assist firefighters with a grass fire.
 - b) No one disputes that Claimant stayed in the vehicle with the air conditioner running during this time.
 - c) Claimant testified that when they arrived at the location of the smoke, Larry parked the truck and got out to assist with fighting the fire, but Claimant sat in the truck and left the truck running with the air conditioner on to "stay out of the smoke." (Hr'g Tr., pp. 12-13)
 - d) When the car was initially parked, Claimant testified she was not in any smoke. She testified she does not really know how long she was in that location, but she estimated it "could have been 30 minutes." (Hr'g Tr., p. 13)
 - e) Claimant testified that as they stayed at that location, the wind changed direction and

the smoke began coming towards the truck. She testified she could smell smoke in the truck, and she wrapped a coat or some other object around her head "to diffuse it." (Hr'g Tr., pp. 13-14)

f) Claimant testified she probably sat in the truck with the smoke coming in her direction for approximately 45 minutes, but it could have been shorter or longer than that.

g) Claimant was asked to describe the location of the truck she was in on May 26, 2011 in relation to the fire. She testified that Larry parked the truck in the front yard of a house. She testified she could not see the fire from her location, and between her truck and the fire were fire trucks, a house, and woods, then there was a field behind the woods where the fire was located. Claimant further testified:

A: "...We were back, way, way back. We were back way, way from it."

Q: "Way back from the house?"

A: "From the fire and all of it." (Hr'g Tr., pp. 56-58)

h) Claimant testified the windows of the truck were closed and she turned the air conditioner to the circulate function and covered her face with a coat. (Hr'g Tr., pp. 56-59)

i) Mr. Greer testified he parked in the front yard of a house, and on the other side of the house was a row of pine trees, and then there was a field on fire behind the pine trees. (Hr'g Tr., pp. 106-107)

j) Mr. Greer testified there was "a light haze of smoke" in the air, but he did not need to wear a mask. (Hr'g Tr., p. 108)

k) Mr. Greer estimated they were at this location for approximately 40 minutes, and Claimant remained in the truck the entire time. (Hr'g Tr., p. 109)

l) When Mr. Greer returned to the truck, he did not notice anything different about Claimant, and he did not notice any complaints of asthma, coughing or wheezing. (Hr'g Tr., p. 109)

m) Mr. Greer testified Claimant "was sick that day anyway at work," but he did not notice anything different about her condition when he returned to the truck. (Hr'g Tr., pp. 109-110)

n) Mr. Greer testified they then left the fire scene and drove to the residence and installed smoke detectors. After installing the smoke detectors, they returned to the Fire Department, and on the way back, Mr. Greer testified Claimant indicated she was not feeling good, but Mr. Greer testified he does not recall Claimant ever stating that her problems were related to the smoke, and Claimant was already sick that day. (Hr'g Tr., pp. 111-112)

- o) On cross-examination by Claimant's attorney, Mr. Greer was again asked about Claimant referencing that she did not feel good on the way back to the Fire Department, and Mr. Greer testified: "She said she – well, she was already feeling bad, but she said again, she said, 'I don't feel – I don't feel good.'" (Hr'g Tr., pp. 112-113)
 - p) Mr. Greer, who is no longer employed with the Anderson County Fire Department, testified that he has known Claimant since she was a teenager.
 - q) Mr. Greer also testified that he knew Claimant had asthma and that she had inhalers lying all over her desk. (Hr'g Tr., p. 105)
10. I find it interesting that Claimant, who alleges she was in great distress in the vehicle because of the fire, did not move the vehicle away from the area, nor did she exit the vehicle and walk a further distance from the area.
11. Claimant's allegation that she was never able to return to work after the fire incident is inaccurate.
- a) The fire was on a Thursday; May 26, 2011.
 - b) Claimant initially testified she had to leave work early on May 26, 2011, because she had gotten sick, and she testified she never worked again after May 26, 2011. (Hr'g Tr., pp. 64-65)
 - c) Claimant's signed timesheet dated May 31, 2011, indicates Claimant worked only four and a half hours on May 26, 2011, because she attended a field day for her son. The timesheet further indicates Claimant worked eight hours on Friday, May 27, 2011, and she worked eight hours on Tuesday, May 31, 2011. (Defendants' Exh. B, p. B1)
 - d) Claimant reviewed Defendants' Exhibit B, and she testified it was her signature at the bottom of the timesheet. She testified the timesheet indicates she only worked four and a half hours on May 26, 2011, due to a field day for her son, and she testified she probably did leave work early or arrive at work late on May 26, 2011 to attend her son's field day. (Testimony of Claimant)
 - e) A Facebook post from Starr Elementary School dated May 21, 2011, indicates the field day for second graders would take place on May 26, 2011, from 8:30 a.m. to 11:00 a.m. (Defendants' Exh. F, p. F1)
 - f) Claimant testified she attends all of her son's field days, and her son attended Starr Elementary School and was a second grader in May of 2011. Claimant testified the field days are outdoors, and she attended the field day on the morning of May 26, 2011, then came into work and worked four and a half hours. (Testimony of Claimant)
 - g) After being presented the timesheet, Claimant admitted she did not leave work early on May 26, 2011. (Testimony of Claimant)
 - h) Claimant further testified that she worked the next day, Friday, May 27, 2011. She testified she was not scheduled to work Saturday, Sunday or Monday (Memorial Day), and she returned to work as scheduled on Tuesday, May 31, 2011. (Hr'g Tr., pp. 65-

70)

- i) Claimant testified she missed no time from work between the time of the smoke incident on May 26, 2011, and the time she presented to Dr. Poon for her pre-scheduled appointment on June 1, 2011. (Hr'g Tr., p. 70)
12. Claimant did not seek immediate medical attention following the smoke incident, and the medical records for the year and a half after the fire do not reference the fire incident at all.
- a) Claimant sought no medical attention on the day of the fire, nor did she seek any medical attention until she returned to her personal care physician, Dr. Glenn Poon, on June 1, 2011, for a previously scheduled appointment to review her physical results. (Medical Record as a Whole; Testimony of Claimant)
 - b) On June 1, 2011, Claimant returned to Dr. Poon for her previously scheduled appointment to review her labs. Dr. Poon's note indicates Claimant presented on that date for "asthma and lab results. With asthma attacks since one month ago and is getting a lot worse." Claimant also presented with nasal congestion and a runny nose. It is important to note that while this visit is just six days after the day of the fire, there is nothing in Dr. Poon's notes referencing the alleged smoke exposure, and the note indicates Claimant's asthma attacks had been occurring for one month. (APA, pp. 141 - 142)
 - c) On June 1, 2011, Dr. Poon admitted Claimant to the hospital for a 10 day stay. The hospital records indicate: "Long history of asthma problems in the past. According to her, she started to have some attacks in between now for a month or so, and it got to the point it was getting a lot worse in the past several days." Claimant was diagnosed with asthma and acute bronchitis. Claimant stayed in the hospital until June 10, 2011, and Claimant's discharge note indicates: "48 year old female patient with long history of asthma problems in the past. According to her, she has been using her nebulizer treatments in the past month or so, and lately is just getting a lot worse. Patient finally came into the office for a checkup." There is no mention of smoke exposure or the fire incident in the hospital records from June 1 to 10, 2011, and the hospital records, in fact, report "no acute" event. (APA, pp. 176-199)
 - d) Claimant presented to AnMed Hospital on June 15, 2011, with complaints of sudden increasing chest pain. The hospital record indicates that during Claimant's initial evaluation, "she was noted to have significant dyspnea, which was pleuritic in nature." The hospital records further indicate: "No history of exposure to any unusual chemicals, fumes, dust, etc." Claimant was seen by Dr. Mohan, her pulmonologist, in the hospital, and Dr. Mohan's note indicates: "OCCUPATIONAL HISTORY: Currently is employed. No history of exposure to any unusual chemicals, fumes, dust, etc." Claimant remained in the hospital until June 18, 2011, at which time she was discharged with diagnoses of non-specific chest pain, asthma exacerbation, constipation, depression with anxiety, and sleep apnea. There is no mention of smoke exposure or the fire incident in the hospital records from June 15 to 18, 2011. (APA, pp. 116-123)
 - e) Claimant returned to Dr. Mohan on July 14, 2011, with a complaint of shortness of

- breath. Dr. Mohan noted Claimant to "have significant psychogenic component to her dyspnea." There is no mention of smoke exposure or the fire incident in Dr. Mohan's record from July 14, 2011. (APA, pp. 102-103)
- f) Claimant returned to Dr. Poon on September 2, 2011, where she presented for a checkup and trouble breathing. There is no notation of any smoke or the fire incident in Dr. Poon's September 2, 2011 report. (APA, pp. 157-158)
 - g) Claimant returned to Dr. Mohan on September 13, 2011. Dr. Mohan indicated Claimant returned for a "recheck of asthma, onset of the asthma has been gradual and has been occurring in a persistent pattern for years. The course has been worsening." Dr. Mohan again noted there to be a "psychogenic component to her problem," and Dr. Mohan noted "the importance of regular follow up visits reinforced." Claimant was instructed to follow up in one month. Again, there was no mention of any smoke exposure or the fire incident in Dr. Mohan's September 13, 2011 record. (APA, pp. 104-107)
 - h) Despite Dr. Mohan's record indicating Claimant was to follow up in one month, Claimant did not return to Dr. Mohan, or any other pulmonologist, until July 10, 2012, nearly nine months later. On that date, Claimant presented with shortness of breath, hoarseness, cough, cold symptoms, and she reported her issues began two months ago. Dr. Mohan prescribed Advair and Singulair and decided to hold off on Prednisone therapy, and again, there is no mention of the fire incident or smoke exposure in Dr. Mohan's July 10, 2012 record. (APA, pp. 285-288; Testimony of Claimant; Medical Record as a Whole)
 - i) Claimant returned to Dr. Mohan on September 20, 2012, and Claimant's medications were refilled and she was instructed to follow up in six months. Again, there was no mention of the fire incident or smoke exposure in Dr. Mohan's September 20, 2012 report. (APA, pp. 289-292)
13. There is no mention or complaint of exposure to smoke in Claimant's post-May 26, 2011 medical records until Claimant was referred by her attorney to Dr. Spandorfer in December of 2012, more than a year and a half after the incident. (Medical Record as a Whole)
14. Claimant presented to Dr. Michael A. Spandorfer of Carolina Lung and Critical Care in Charleston, South Carolina on December 20, 2012, for an independent medical evaluation at the referral of her attorney. (APA, pp. 5-12)
- a) Dr. Spandorfer's record indicates:

The patient reports a prior childhood history of asthma that has acutely worsened since smoke exposure while employed as a fire marshal. The patient reports that prior to her work related exposure, her asthma was relatively stable. The patient reports that she had rare symptoms related to her asthma. Her symptoms included the need for rescue Albuterol approximately two to three times per year without the need for daily usage. (APA, pp. 5-12)

- b) Claimant further reported the following to Dr. Spandorfer:

Her asthma symptoms greatly increased since exposure to a fire in summer of 2010. The patient at that time was employed as a fire fighter training officer whose job did not include active firefighting duties. At the time of the patient's exposure, the patient was riding as a passenger with a fellow fire fighter who decided to respond to an active fire. The patient reports that she remained inside the fire truck with the echo initially running for up to one and a half to two hours in duration. During this time, the patient reports that she was exposed to fumes and smoke related to the fire which led to the immediate onset of cough with shortness of breath, wheezing, chest tightness, as well as dyspnea. The patient attempted to limit her exposure about utilizing a wet towel as a mask. (APA, pp. 5-12)

- c) Dr. Spandorfer indicated that Claimant "has occupationally worsened chronic obstructive asthma with severe air flow limitation and chronic hypoxic respiratory failure." (APA, pp. 5-12)
- d) On November 26, 2013, Dr. Spandorfer assigned Claimant a 55% medical impairment to the bilateral lungs and opined that Claimant is unable to return to work at her previous employment. Dr. Spandorfer opined that Claimant would require future medical care to include use of daily medications including bronchodilator therapy, inhaled steroid therapy, oral steroid therapy, antibiotics, and nebulized bronchodilator therapy, routine physician evaluation with pulmonary function testing at least four times a year, expectation of an emergency room visit at least twice a year, and use of immune modulatory therapy such as Xolair and Leukotriene antagonists. (APA, pp. 5-12)
15. Claimant presented to Dr. Gregory Feldman at Upstate Lung and Critical Care Specialists in Spartanburg, South Carolina on March 5, 2014, for an independent medical evaluation at the referral of Defendants. (APA, pp. 379-386)

- a) Dr. Feldman noted Claimant had a history of asthma since six weeks old, and he went on to note the following history:

She had "cold." While sick with cold she was also exposed to smoke, not in direct proximity but while sitting in the fire truck that had stopped to help with some brush fire in the field some 100 yards away. She did not get exacerbation immediately, but about a week later, she had very severe exacerbation requiring prolonged hospital stay and steroids. Today she is wheezing and has significant chest congestion. (APA, pp. 379-386)

- b) Dr. Feldman went on to opine:

With regard to the etiology of recent hospitalization, she had a cold prior to this. Viral infections are most common triggers of asthma exacerbations. In addition, whatever role, if any, smoke inhalation played, it is impossible to know, except one would expect an immediate reaction with bronchospasm if her exacerbation was due even in part to smoke inhalation.

(APA, pp. 379-386)

- c) Dr. Feldman further issued a letter and written statement opining the following:

Ms. Chamblee is an unfortunate 48 year old female, lifelong non-smoker, with long history of asthma since the age of six weeks. She has had numerous asthma attacks and exacerbations of her asthma throughout her adolescence. She reports that her asthma has gotten better, but about one week after her exposure to smoke, her condition deteriorated. She is attributing this to the incident in question. On May 26, 2011, Ms. Chamblee was in her fire truck, when they had stopped to assist with some fire in a field. She stayed in the truck for approximately 45 minutes, about 100 yards or so away from the fire. Ms. Chamblee had also been suffering from persistent "cold" symptoms for about a week at that time. According to her medical records, she was admitted to Elbert Memorial Hospital on June 1, 2011, with severe asthma exacerbation. At that time, according to Ms. Chamblee, she started to have some attacks in between for about a month prior to her admission. To date, asthma is still not controlled. With regard to exposure to smoke, it is unlikely that smoke exposure has caused or contributed to her asthma. She did not develop an immediate bronchospasm as one would expect in asthma exacerbation secondary to smoke inhalation. She had poorly controlled asthma for weeks prior to exposure and had ongoing "cold" symptoms for several days prior to exposure. There is no doubt that Ms. Chamblee is suffering from lifelong and progressive asthma, but it is multifactorial and not properly managed at this time. (APA, pp. 379-386)

16. The first report of injury, which was filed by Claimant, reads, "IW (injured worker) states she had cold. Went to grass fire. Stayed in truck with air conditioner. Developed into carbon dioxide poisoning." (APA, p. 124)
- a) There is no medical evidence in the record that Claimant suffered from carbon dioxide poisoning. (Medical Record as a Whole)
17. There are several medical opinions in the record with regard to causation of Claimant's condition.
18. On August 1, 2014, Dr. Poon stated to a reasonable degree of medical certainty that Claimant's "...exposure to smoke as described in the attachment most probably caused an aggravation of her prior asthmatic condition ..." (APA, pp. 1-4)
- a) It is important to note that Dr. Poon is not a pulmonologist. None of his records that are contemporaneous with the alleged date of injury mention the alleged exposure to smoke. This statement is signed more than 3 years after the fact. (Medical Record as a Whole)
- b) In a letter dated May 14, 2012, Dr. Poon states: "Since she was under the care of her pulmonologist prior to and after this incident, I think her pulmonologist will be the best to consult. He can provide all your needed answers in detail." Despite this statement

from Dr. Poon, there is no causation statement from Dr. Mohan in the medical records. (APA, p. 369; Medical Record as a Whole)

- c) I give Dr. Poon's statement little weight.
19. Despite the fact that Dr. Mohan was Claimant's treating pulmonologist immediately before and after the smoke incident, and the fact that Dr. Poon indicated Dr. Mohan would be the best person to address causation of Claimant's condition, there is no causation statement from Dr. Mohan.
20. There is testimony from two pulmonologists in the record – Dr. Michael Spandorfer and Dr. Gregory J. Feldman. Both pulmonologists speak to a reasonable degree of medical certainty. While I have read the depositions of both doctors in their entirety and have considered the testimony of both doctors, I am persuaded by the testimony of Dr. Feldman and give it much greater weight.
- a) The parties deposed Dr. Spandorfer on February 25, 2014.
- i. Dr. Spandorfer testified that exposure to smoke can cause mucus production, and the mucus then aggravated Claimant's underlying asthma.
 - ii. Dr. Spandorfer is definitive in his opinion that Claimant's exposure to the grass fire aggravated her pre-existing asthma and is the cause of her current medical condition.
 - iii. Dr. Spandorfer testified in his deposition, "To a reasonable degree of medical certainty, I believe that the patient has occupationally induced – excuse me, occupationally worsened asthma due to her smoke exposure."
 - iv. Dr. Spandorfer assigned Claimant a 55% medical impairment rating.
 - v. There are numerous inconsistencies in Dr. Spandorfer's report, and in much of the history provided to Dr. Spandorfer by Claimant.
 - vi. Dr. Spandorfer testified that Claimant reported the following during the evaluation:

She reported to me that prior to the exposure her asthma was relatively stable and that she had rare symptoms that she related to her asthma. She reported that prior to the fire she only needed to use rescue bronchodilator therapy approximately two or three times a year without the need for daily usage, and she reported that she didn't require oral steroids or inhaled steroids, and she rarely required antibiotics which in our mind, you know, tells us the patient's controlled. They don't require rescue therapy or maintenance medicines or oral steroids and that their asthma is quiescent. (Spandorfer Dep. Tr., p. 15)
 - vii. Dr. Spandorfer further testified that Claimant denied any history of allergies or post nasal drip, she denied any reflux, and she denied allergic rhinitis or allergy sinus disease. (Spandorfer Dep. Tr., p. 16)

- viii. Contrary to Claimant's report to Dr. Spandorfer, Claimant's asthma was not relatively stable prior to May 26, 2011, claimant required rescue bronchodilator therapy, oral steroids, inhaled steroids, and antibiotics, Claimant suffered from nasal drip and reflux, and Claimant suffered from extensive allergy and sinus issues. (Medical Record as a Whole)
 - ix. Dr. Spandorfer reviewed a 2005 spirometry test from AnMed Health, introduced as Exhibit 1 in the deposition, and Dr. Spandorfer testified: "She is not very much different based off of that..." (Spandorfer Dep. Tr., p. 31) Dr. Spandorfer further testified that the spirometry results from 2005 until after the smoke incident "didn't change." (Spandorfer Dep. Tr., pp. 32-33)
 - x. Dr. Spandorfer testified that Claimant did not report to him that she had a cold at the time of the smoke incident. (Spandorfer Dep. Tr., p. 36)
 - xi. Claimant reported to Dr. Michael Spandorfer that she covered her face with a wet towel. In fact, while she may have covered her face, there was not a wet towel in the vehicle. (IME Report of Dr. Spandorfer; Deposition of Dr. Spandorfer; Deposition and Hearing Testimony of Claimant)
- b) The parties deposed Dr. Gregory Feldman on October 20, 2014, and Dr. Feldman offers a very different opinion.
- i. Dr. Feldman testified:

This is a patient that has a very, very severe asthma, longstanding asthma. She has a terrible breathing test preceding her asthma – preceding her fire, and she continued to have a pretty bad cause. The fact that she got in to the hospital, it didn't happen after she was exposed to fire. It happened like a week later. In addition, she has a viral infection, cold symptoms, which is far more likely than fire that caused it, which is what generally we see in the pulmonary practice when severe asthmatics get upper respiratory infection, that would probably put you in the hospital. Far more likely than a fire.
 - ii. Dr. Feldman testified that Claimant suffered from a cold during the week of the smoke exposure, and the cold was far more likely than the smoke exposure to have caused an aggravation of Claimant's asthma.
 - iii. Dr. Feldman testified that the cold causes mucus inflammation, and the mucus then plugs the airways and produces difficulty breathing.
 - iv. Dr. Feldman testified that, if the smoke caused a permanent aggravation of Claimant's asthma, he would have expected an "immediate asthma attack within like seconds or minutes."
 - v. Dr. Feldman testified that, assuming there was an aggravation of Claimant's asthma, it is 99.9% likely that it was caused by her upper respiratory infection (cold), and .01% likely that it was caused by the smoke exposure.

- vi. Dr. Feldman testified that his opinion to a reasonable degree of medical certainty is that any smoke exposure on May 26, 2011, did not cause or contribute to Claimant's asthma condition.
- vii. Dr. Feldman reviewed the deposition transcript of Dr. Spandorfer and testified he disagrees with Dr. Spandorfer's causation opinion.
- viii. Dr. Feldman testified Claimant was many yards away from the fire, Claimant already had significant preexisting symptoms, and Claimant's spirometry readings from 2005 and from after the smoke incident "has not changed." (Feldman Dep. Tr., pp. 16-17)
- ix. Dr. Feldman agreed that the cause of any aggravation of Claimant's asthma was mucus production, but Dr. Feldman testified: "Well, I agree it was mucus, and – and it overwhelmingly likely was a viral infection that caused it. It's not even in my – in my judgment, not even close." (Feldman Dep. Tr., pp. 18-19)
- x. Dr. Feldman testified that Claimant's asthma has been under-treated in the past, and he testified that upper respiratory infections are the most common cause of clinical deterioration in asthma patients. Dr. Feldman testified that Claimant's upper respiratory infection "preexisted the smoke, it continued, and then she finally was so sick that she had to be admitted, okay. If she come to me the day before the fire, I probably would have admitted her too." (Feldman Dep. Tr., pp. 20-21)
- xi. Dr. Feldman further testified: "And I'm telling you, that the most common aggravation of preexisting condition is viral infection. And the fact that there was some smoking seven days prior [to Claimant being admitted to the hospital], okay, it is almost impossible to assign significance to that when we know that she has a viral infection, and that's the most common cause of exacerbation." (Feldman Dep. Tr., p. 42)
- xii. On further questioning about the smoke causing an exacerbation of Claimant's asthma, Dr. Feldman stated: "If she would have gotten sick on the spot, cannot breathe, called the ambulance, I would say you're right. But seven days later, it's an utter speculation and unlikely." (Feldman Dep. Tr., p. 48)
- xiii. Dr. Feldman further stated: "The greatest majority of the people today in every hospital in the United States of America and every other country are because of viral infection.... People are in the hospital today with asthma overwhelmingly because of a viral upper respiratory infection. That's a number one cause of asthma admission." (Feldman Dep. Tr., p. 49)
- xiv. Dr. Feldman testified that Claimant had indicated she had a bad cold at the time of the fire incident, and Dr. Feldman testified: "When people say 'real bad cold,' what they really mean, 'really bad asthma,' okay. Because they ascribe it to cold, when in reality, their symptoms of asthma got bad. That's what they feel." (Feldman Dep. Tr., p. 59)

21. Consistent with Dr. Feldman's causation opinion, the evidence in the record indicates Claimant was suffering from a cold, or upper respiratory infection, during the weeks immediately preceding and following the smoke incident.

- a) At the hearing, Claimant testified to the following:
 - i. Claimant testified she had a cold which began around the beginning of the month in May of 2011, and that cold continued until the date she was admitted to the hospital on June 1, 2011. (Hr'g Tr., pp. 54-55)
 - ii. At the hearing, Claimant testified she had "a really bad head cold" on May 26, 2011. (Hr'g Tr., p. 55)
 - iii. Claimant testified that having a cold causes problems with her asthma. (Hr'g Tr., p. 55)
- b) During her deposition, Claimant testified to the following:
 - i. At the doctor's office on June 1, 2011, Claimant told the doctor: "Well, while you're at it, you might better listen to my lungs because I think I've got a cold." (Claimant's Dep. Tr., pp. 48-49)
 - ii. Claimant further testified at her deposition that on the date of the accident, "I had a really bad cold." (Claimant's Dep. Tr., p. 44)
 - iii. Referring to her return to the Fire Department after installing smoke detectors on May 26, 2011, Claimant testified at her deposition: "I get to the fire department, and I was telling them, I said, 'I've got a cold. I think I'm going to go home early because I've done got sick. I'm real - my head is killing me.'" (Claimant's Dep. Tr., p. 47)
- c) Claimant's mother, Maureen Chamblee, testified she was aware that Claimant had a cold in the weeks prior to the smoke incident.
- d) Referring to the incident on May 26, 2011, Larry Greer, Jr. testified Claimant "was sick that day anyway at work," but he did not notice anything different about her condition when he returned to the truck. (Hr'g Tr., pp. 109-110)
- e) On the drive back to the Fire Department after installing smoke detectors on May 26, 2011, Mr. Greer testified Claimant indicated she was not feeling good, but Mr. Greer testified he does not recall Claimant ever stating that her problems were related to the smoke, and Mr. Greer testified that Claimant was already sick that day. (Hr'g Tr., pp. 111-112) Mr. Greer further testified: "She said she - well, she was already feeling bad, but she said again, she said, 'I don't feel - I don't feel good.'" (Hr'g Tr., pp. 112-113)
- f) Claimant testified she told Dr. Poon she was sick when she presented on June 1, 2011, and she testified she had been sick for about a month at that time. (Hr'g Tr., p. 71)

22. The medical records directly following the May 26, 2011 incident are also consistent with

Dr. Feldman's opinion that any aggravation in Claimant's asthma condition was caused by her upper respiratory infection, or "cold."

- a) As noted above, Claimant testified she suffered from a cold from the beginning of May, 2011, and the cold was still ongoing when she presented to the doctor on June 1, 2011.
 - b) Dr. Poon's June 1, 2011, note indicates Claimant presented, "with asthma attacks since *one month ago* and is getting a lot worse." Claimant also presented with nasal congestion and a runny nose. (APA, pp. 141 – 142, emphasis added)
 - c) On June 1, 2011, the hospital records indicate: "According to her, she started to have some attacks in between now *for a month or so*, and it got to the point it was getting a lot worse in the past several days." Claimant was diagnosed with asthma and acute bronchitis. Claimant stayed in the hospital until June 10, 2011, and Claimant's discharge note indicates: "According to her, she has been using her nebulizer treatments in *the past month or so*, and lately is just getting a lot worse." (APA, pp. 176-199, emphasis added)
 - d) Dr. Mohan's September 13, 2011, narrative indicates Claimant returned for a "recheck of asthma, *onset of the asthma has been gradual and has been occurring in a persistent pattern for years.*" (APA, pp. 104-107)
23. Claimant testified she has remained on nasal oxygen since her hospitalizations following the May 26, 2011 incident, and she wears the oxygen "most all the time." (Hr'g Tr., pp. 22-23)
 24. There is video evidence in this case that shows Claimant in a much better condition than she presented at the hearing. (Defendants' Exhibit C)
 25. Claimant reviewed Defendants' Exhibit C, and she testified the Exhibit is comprised of two videos of herself singing karaoke at the restaurant Mi Fiesta. She testified her son recorded the videos and posted them to Claimant's Facebook page, and she is the individual on the left side of the videos. Claimant testified she was not wearing oxygen while she sang karaoke. (Hr'g Tr., pp. 81-83)
 26. Claimant stated that she has good days and bad days.
 27. When I consider the evidence as a whole, I believe Claimant is convinced that this event on May 26, 2011, is the cause of an aggravation to her asthmatic condition. However, that conclusion is simply not supported by the facts in this case.
 - a) Claimant testified it remains her opinion that, prior to May 26, 2011, her asthma had been the same for twenty years, it had been well-controlled, and it was not getting any worse in the two to five years leading up to May 26, 2011. (Hr'g Tr., p. 44) This is inconsistent with the medical evidence outlined above, and most notably, the August 25, 2010, report of Dr. Mohan. (Medical Evidence as a Whole; APA, pp. 99-101)
 - b) Claimant's assertion that she believed her asthma was well-controlled and was not worsening is consistent with Dr. Feldman's deposition testimony with regard to asthmatic patients.

- i. Dr. Feldman testified that Claimant's asthma was far worse than Claimant realized for a long time.
 - ii. Dr. Feldman testified, in referring to asthmatic patients, that "you cannot rely on the patient for assessing their asthma control; they're notoriously terrible, okay. They come in and tell you, 'I feel okay.' Why they say the feel okay, because they got used to not being okay." (Feldman Dep. Tr., p. 63)
- i. Claimant's mother, Maureen Chamblee, testified Claimant worked the day after the smoke incident, and Claimant has a habit of going into work even when she does not feel like it.
 - ii. Ms. Chamblee testified Claimant has a personality that she will try to fight through things and she has always had that type of personality, and Claimant has always gone to work even when she does not feel like it.
28. The medical records are replete with references to Claimant's asthma. Not only does the narrative that results when one reviews the chronological history of her asthma not support a finding for Claimant, it paints a very clear picture that her underlying health conditions – unrelated to the events of May 26, 2011 – are much more likely the cause of her current condition.
29. Claimant has failed to meet her burden of proving she sustained an aggravation of her preexisting asthma condition which is causally-related to exposure to smoke on May 26, 2011, and her claim for benefits under the South Carolina Workers' Compensation Act ("the Act") is hereby denied.
30. Claimant has failed to meet her burden of showing she suffered an injurious exposure or accident arising out of and within the course and scope of her employment on May 26, 2011.
31. Claimant is not entitled to any benefits under the Act and the case is dismissed.

The Single Commissioner made the following Conclusions of Law:

1. Under § 42-1-130, Claimant was a covered employee at the time in question; and under § 42-1-140, Defendant/Employer was a covered employer under the Act.
2. Under § 42-1-160, Claimant has failed to carry her burden of proving an injurious exposure or compensable injury by accident arising out of and within the course and scope of her employment on or about May 26, 2011, and her claim for benefits under the Act is hereby denied.
3. Under § 42-9-35, has failed to carry her burden of proving she sustained an aggravation of her preexisting asthma/lung condition which is causally-related to exposure to smoke on or about May 26, 2011, and her claim for benefits under the Act is hereby denied.
4. Under § 42-1-160 and § 42-9-35, Claimant's request for benefits is hereby denied and this case is dismissed.

On March 13, 2015, Claimant timely appealed the Single Commissioner's Decision and Order via filing of a Form 30, Request for Commission Review, and oral arguments were heard by the undersigned Commissioners of the Appellate Panel on June 15, 2015. The Appellate Panel hereby affirms the Order of the Single Commissioner, with amendments, and makes the following Findings of Fact and Conclusions of Law.

FINDINGS OF FACT

Based upon the documentary evidence submitted by the respective parties, pursuant to the Administrative Procedures Act, and the Commission's file relative to this claim, WE, THE APPELLATE PANEL, FIND THE FOLLOWING AS FACT:

1. That Employee, Employer, and Carrier are subject to and bound by the terms and provisions of the South Carolina Workers' Compensation Act, as amended, with Sandy Chamblee as Employee-Claimant and Anderson County Fire Department as Employer and State Accident Fund as Carrier, Defendants.
2. The average weekly wage of Claimant at the time of the above-described accident was \$756.49, with a corresponding compensation rate of \$504.35.
3. Claimant alleges she suffered a permanent aggravation of her preexisting asthma condition arising out of and within the course and scope of her employment on May 26, 2011.
4. It is Claimant's contention that her asthma was aggravated by smoke from a fire in a field near a vehicle in which she was sitting on or about May 26, 2011.
5. Claimant asserts that, as a result of this aggravation, she is permanently and totally disabled.
6. Defendants deny this claim.
7. From a review of the medical records, Claimant has a relatively extensive medical history, and Claimant has a lifelong history of asthma. (Medical Record as a Whole)
 - a) Claimant testified she was first diagnosed with asthma at about six weeks old and has also had lifelong problems with sinuses and allergies. (Testimony of Claimant)
 - b) Claimant was treated at Duke Medicine for a diagnosis of asthma and allergic rhinitis as a child, and she treated numerous times at Duke Medicine from 1969 through 1976. (APA, pp. 200-219)
 - c) Claimant underwent sinus surgeries in both 1984 and 1986. (APA, p. 220)

- d) On May 17, 1996, Claimant presented to Dr. Jane Reister, an ENT, where Claimant reported the following issues: excessive coughing, throat clearing, laryngeal tension and pain, persistent upper respiratory infections, severe gastric reflux, excessive head/neck/shoulder tension, asthma, sensation of something being caught in her throat, allergies, sinus drainage, quick vocal fatigue, and cigarette exposure. Claimant also reported to Dr. Reister that she had a "hoarse, raspy voice for as long as she could remember." (APA, p. 222)
- e) Claimant returned to Dr. Reister on July 31, 1996, and Dr. Reister performed a laryngoscopy and vocal cord stripping procedure. (APA, p. 223)
- f) Dr. Reister's records from 1996, also indicate Claimant was using an asthma inhaler at that time. (APA, p. 220)
- g) Claimant returned to Dr. Reister on October 13, 2003, and Claimant indicated her current medications included Lexapro, Singular, Advair, Zithromax, Nexium, Zyrtec, Endall HD, and Cipro. Claimant reported to Dr. Reister that she had been "sent to an asthma doctor." (APA, p. 226)
- h) Claimant returned to Dr. Reister on November 5, 2003, with complaints of post-nasal drainage, and Claimant indicated she was still on all of the same medications. (APA, p. 229)
- i) Claimant returned to Dr. Reister on November 21, 2003, and Dr. Reister recommended a sinus surgery on account of Claimant's sinusitis, and the surgery was performed on December 17, 2003. (APA, pp. 229, 257)
- j) Claimant returned to Dr. Reister in March of 2004, with complaints of "significant allergies" and a sore throat. (APA, p. 231)
- k) Claimant returned to Dr. Reister in September 2004, with complaints of being congested and wheezing, and complaints that Claimant's throat and ears hurt and she felt stopped-up. At that time, Claimant's medications included Singular, Advair, hormones, Nexium, Celebrex and Albuterol. (APA, p. 232)
- l) Claimant returned to Dr. Reister in October of 2004, where she complained of sinus trouble, trouble breathing, wheezing, coughing, sore throat, pressure in the ears, and being very stuffy. Dr. Reister indicated she listened to Claimant's lungs and Claimant "sounds like she is wheezing." (APA, p. 232)
- m) Claimant returned to Dr. Reister in March of 2005, and Dr. Reister indicated Claimant was "having same symptoms." (APA, p. 235)
- n) Claimant returned to Dr. Reister in May of 2005, and Dr. Reister indicated Claimant had "significant sore throat." (APA, p. 235)
- o) Claimant returned to Dr. Reister in June of 2005, and Dr. Reister noted the following: "Her asthma has been a problem. I listened to her today and she really did sound like she was not moving a lot of air but she said in the next couple of days she felt she would probably be doing better." Dr. Reister further noted Claimant "...probably

- would go to a pulmonologist shortly.” (APA, p. 234)
- p) Claimant presented to Dr. Gregg Seymour, her primary care physician, on June 20, 2005, with complaints of cough, congestion, and wheezing. (APA, p. 260)
 - q) Claimant returned to Dr. Seymour on July 5, 2005, with complaints of shortness of breath and wheezing, and Dr. Seymour ordered spirometry testing and referred Claimant to a pulmonologist. (APA, p. 261)
 - r) On July 25, 2005, Claimant presented to Dr. Stephen Hand, a pulmonologist with AnMed Health Carolina Pulmonary Sleep, per the referral of Dr. Seymour. Claimant indicated she had asthma since she was six weeks old, and “it became much worse during her pregnancy three years ago. She has had significant shortness of breath, wheezing, cough, worse with exposure to heat and humidity this summer.” Claimant also indicated she “has been on four or five courses of prednisone this year.” Claimant also told Dr. Hand, “she feels fatigued most of the time,” and she had had “weight gain of approximately 100 pounds in the past three years.” Claimant’s issues were noted to include throat pain, intermittent hoarseness, snoring and witnessed apneas, shortness of breath, wheezing, cough, headaches, daytime sleepiness, fighting sleep while driving, falling asleep while working, fighting sleep during conversation, intermittent creeping and crawling sensation in her legs, and intermittent anxiety. Claimant also indicated she was suffering from gastro-esophageal reflux, and Dr. Hand indicated, “I have advised her that this could be a contributor to her problems with asthma. She reports her symptoms are difficult to control, and also reports she sometimes has difficulty swallowing liquids.” At the time of her evaluation with Dr. Hand, Claimant’s current medications included Singular, Advair, Nexium, allergy shots, Albuterol, and nebulizer treatments. Dr. Hand referred Claimant for a sleep study with a diagnosis of obstructive sleep apnea. (APA, pp. 91-94)
 - s) Claimant returned to Dr. Seymour on August 16, 2005, with complaints of sinus/chest congestion, dry cough, and a yellow/brown discharge. (APA, p. 262)
 - t) Claimant underwent a sleep study on August 26, 2005, per the referral of Dr. Hand, and she was diagnosed with obstructive sleep apnea. (APA, pp. 293-296)
 - u) Claimant returned to Dr. Hand on September 6, 2005, for a follow up of her asthma and sleep apnea. Claimant “reports she had another flare of her asthma and was on prednisone briefly,” and she also “notes occasional wheezing.” Claimant also complained of nasal congestion and drainage, and a headache, and Dr. Hand indicated Claimant was “being set up for CPAP.” (APA, p. 95)
 - v) Claimant returned to Dr. Hand on October 10, 2005, and Dr. Hand indicated Claimant had increased cough productive of a yellowish sputum for the past week. (APA, p. 96)
 - w) Claimant returned to Dr. Reister, the ENT, in 2005, with complaints of nasal congestion, facial pressure, sore throat, and dark green drainage. (APA, p. 234)
 - x) Claimant returned to Dr. Reister in January of 2006 and requested a depo medrol shot. Dr. Reister denied Claimant’s request, and indicated “pt should see fam MD or

- pulmonologist.” (APA, p. 236)
- y) Claimant returned to Dr. Hand, her pulmonologist, on March 15, 2006, and Dr. Hand noted she “has had two episodes of bronchitis this winter that required an antibiotic and prednisone.” (APA, p. 97)
 - z) Claimant returned to Dr. Seymour on June 28, 2006, and Dr. Seymour noted Claimant was “known to have asthma. Over the past several days, she has had sinus congestion and drainage. The mucus is thick and yellow. Mild sore throat has been noted. Occasional wheezes. She uses her aerosol at times.” (APA, p. 265)
 - aa) Claimant returned to Dr. Reister in October of 2006, with complaints of hoarseness. Dr. Reister noted Claimant to be using Singular, Advair, and receiving allergy shots. (APA, p. 237)
 - bb) Claimant returned to Dr. Reister in December of 2006, with complaints of sinus congestion and left ear fullness. Claimant indicated she had taken several Goody’s headache powders that day. (APA, p. 237)
 - cc) Claimant returned to Dr. Reister in June of 2007, with complaints of throat pain and reflux, and having had a nose bleed that day. Claimant’s medications on that day included Singular, Advair, Nexium, Amitripline, allergy shots, Elavil, and Albuterol. (APA, pp. 239, 267)
 - dd) Claimant returned to Dr. Seymour on July 2, 2007, with complaints of sinus congestion, and again to Dr. Seymour on August 16, 2007, with complaints of sinusitis, bronchitis, and bronchospasm. (APA, p. 271)
 - ee) Claimant returned to Dr. Seymour on October 17, 2007, with complaints of chest congestion, shortness of breath, wheezing bronchospasm, and Claimant indicated she was out of Albuterol. (APA, p. 271)
 - ff) Claimant returned to Dr. Reister in November of 2007, and indicated she had tried to stop her allergy shots but it did not work, and she was advised to continue her allergy shots. (APA, p. 240)
 - gg) Claimant returned to Dr. Seymour on January 31, 2008, with complaints of sinusitis. (APA, p. 272)
 - hh) Claimant returned to Dr. Reister in February of 2008, with complaints of severe sore throat, coughing, wheezing, and nasal congestion with brown colored nasal drainage. (APA, p. 241)
 - ii) Claimant returned to Dr. Reister in March of 2008 with complaints of sore throat, increased facial pressure, and chest congestion, and Claimant indicated she used “last antibiotic this a.m. and believes to be getting sick all over again.” Claimant requested a depo medrol shot, and Dr. Reister noted Claimant to have a cough and considerable mucus problem, along with bronchitis. (APA, pp. 242-243)
 - jj) Claimant returned to Dr. Seymour on March 25, 2008, with complaints of cough,

- shortness of breath, bronchitis, and bronchospasm. (APA, p. 272)
- kk) Claimant returned to Dr. Hand, her pulmonologist, on October 27, 2008. At that time, Claimant reported she had some problems with her asthma which were improving since going on allergy shots. (APA, p. 98)
 - ll) Claimant underwent a lap band surgery in December of 2008. (APA, p. 132; Testimony of Claimant)
 - mm) Claimant returned to Dr. Seymour on January 12, 2009, with complaints of cough and sinusitis. (APA, p. 273)
 - nn) Claimant returned to Dr. Seymour on April 14, 2009, with complaints of a cough and headache, and complaints of an "exacerbation of asthma." (APA, p. 275)
 - oo) Claimant returned to Dr. Reister in April of 2009, where she complained of "some asthma trouble, was outside on Easter." Claimant indicated she had just had a depo medrol shot that week, along with a Z-Pack and prednisone. (APA, p. 245)
 - pp) Claimant returned to Dr. Seymour on May 28, 2009, with complaints of sinus congestion, dry cough, bronchitis, and bronchospasm. (APA, p. 275)
 - qq) Claimant returned to Dr. Seymour two times in August of 2009, with complaints of chest congestion, wheezing, shortness of breath, and an "exacerbation of asthma," and she received a depo medrol shot. (APA, p. 276-277)
 - rr) Claimant returned to Dr. Seymour on September 28, 2009, with complaints of shortness of breath, cough, wheezing, and an "exacerbation of asthma/bronchitis." (APA, p. 278)
 - ss) Claimant returned to Dr. Reister in December of 2009, with complaints of having chest tightness during recent skin testing and having had to receive two Albuterol inhaler puffs during the testing, and Claimant also indicated she had been having "a lot of trouble with tomatoes and some wheezing." (APA, p. 246)
 - tt) Claimant returned to Dr. Reister on March 3, 2010, with complaints that she was "very congested and has a sore throat and not feeling well, lots of congestion." Claimant also complained of "lots of post nasal drip." (APA, p. 247)
 - uu) Claimant returned to Dr. Seymour on July 23, 2010, with complaints of chest congestion, wheezing, shortness of breath, and dark phlegm, and Dr. Seymour referred Claimant to a pulmonologist. (APA, p. 280)
8. Nine months before the alleged injury, Claimant was referred by her personal physician, Dr. Seymour, to Dr. Gowdhami Mohan, who is a pulmonologist. (APA, pp. 280, 99-101)
- a) In his medical note of August 25, 2010, Dr. Mohan writes in part, "The patient has been suffering from chronic cough for the last 6 months. She has a longstanding history of asthma, but it was well controlled until 2 years ago. For the last 2 years, she has been having trouble with cough, sputum production, etc. The patient has a nebulizer machine and she uses the nebulizer treatment (aerosols 3 to 4 times a day). Currently,

also receiving allergy shots on a regular basis. Still continues to have persistent cough. Sputum production has been noted for the last 6 months.” (APA, pp. 99-101)

- b) Dr. Mohan also noted Claimant to be suffering from runny nose and sinus congestion periodically and noted Claimant to have been diagnosed with sleep apnea and to be using a CPAP machine. Dr. Mohan diagnosed chronic persistent asthma, and he noted Claimant “is using nebulizer treatments regularly and despite this having significant dyspnea. Currently, also has bronchitis and has asthma exacerbation.” Claimant was prescribed Levaquin, Singulair, Pulmicort aerosols, Brovana, and Combivent inhaler. (APA, pp. 99-101)

9. Claimant and Larry Greer, Jr. presented to a grass fire on May 26, 2011.

- a) No one disputes that Claimant was with Larry Greer, Jr. on their way to install smoke detectors on May 26, 2011, when Mr. Greer stopped the vehicle to assist firefighters with a grass fire.
- b) No one disputes that Claimant stayed in the vehicle with the air conditioner running during this time.
- c) Claimant testified that when they arrived at the location of the smoke, Larry parked the truck and got out to assist with fighting the fire, but Claimant sat in the truck and left the truck running with the air conditioner on to “stay out of the smoke.” (Hr’g Tr., pp. 12-13)
- d) When the car was initially parked, Claimant testified she was not in any smoke. She testified she does not really know how long she was in that location, but she estimated it “could have been 30 minutes.” (Hr’g Tr., p. 13)
- e) Claimant testified that as they stayed at that location, the wind changed direction and the smoke began coming towards the truck. She testified she could smell smoke in the truck, and she wrapped a coat or some other object around her head “to diffuse it.” (Hr’g Tr., pp. 13-14)
- f) Claimant testified she probably sat in the truck with the smoke coming in her direction for approximately 45 minutes, but it could have been shorter or longer than that.
- g) Claimant was asked to describe the location of the truck she was in on May 26, 2011, in relation to the fire. She testified that Larry parked the truck in the front yard of a house. She testified she could not see the fire from her location, and between her truck and the fire were fire trucks, a house, and woods, then there was a field behind the woods where the fire was located. Claimant further testified:

A: “... We were back, way, way back. We were back way, way from it.”

Q: “Way back from the house?”

A: “From the fire and all of it.” (Hr’g Tr., pp. 56-58)

- h) Claimant testified the windows of the truck were closed and she turned the air conditioner to the circulate function and covered her face with a coat. (Hr'g Tr., pp. 56-59)
 - i) Mr. Greer testified he parked in the front yard of a house, and on the other side of the house was a row of pine trees, and then there was a field on fire behind the pine trees. (Hr'g Tr., pp. 106-107)
 - j) Mr. Greer testified there was "a light haze of smoke" in the air, but he did not need to wear a mask. (Hr'g Tr., p. 108)
 - k) Mr. Greer estimated they were at this location for approximately 40 minutes, and Claimant remained in the truck the entire time. (Hr'g Tr., p. 109)
 - l) When Mr. Greer returned to the truck, he did not notice anything different about Claimant, and he did not notice any complaints of asthma, coughing or wheezing. (Hr'g Tr., p. 109)
 - m) Mr. Greer testified Claimant "was sick that day anyway at work," but he did not notice anything different about her condition when he returned to the truck. (Hr'g Tr., pp. 109-110)
 - n) Mr. Greer testified they then left the fire scene and drove to the residence and installed smoke detectors. After installing the smoke detectors, they returned to the Fire Department, and on the way back, Mr. Greer testified Claimant indicated she was not feeling good, but Mr. Greer testified he does not recall Claimant ever stating that her problems were related to the smoke, and Claimant was already sick that day. (Hr'g Tr., pp. 111-112)
 - o) On cross-examination by Claimant's attorney, Mr. Greer was again asked about Claimant referencing that she did not feel good on the way back to the Fire Department, and Mr. Greer testified: "She said she – well, she was already feeling bad, but she said again, she said, 'I don't feel – I don't feel good.'" (Hr'g Tr., pp. 112-113)
 - p) Mr. Greer, who is no longer employed with the Anderson County Fire Department, testified that he has known Claimant since she was a teenager.
 - q) Mr. Greer also testified that he knew Claimant had asthma and that she had inhalers lying all over her desk. (Hr'g Tr., p. 105)
10. We find it interesting that Claimant, who alleges she was in great distress in the vehicle because of the fire, did not move the vehicle away from the area, nor did she exit the vehicle and walk a further distance from the area.
11. Claimant's allegation that she was never able to return to work after the fire incident is inaccurate.
- a) The fire was on a Thursday; May 26, 2011.
 - b) Claimant initially testified she had to leave work early on May 26, 2011, because she

had gotten sick, and she testified she never worked again after May 26, 2011. (Hr'g Tr., pp. 64-65)

- c) Claimant's signed timesheet dated May 31, 2011, indicates Claimant worked only four and a half hours on May 26, 2011, because she attended a field day for her son. The timesheet further indicates Claimant worked eight hours on Friday, May 27, 2011, and she worked eight hours on Tuesday, May 31, 2011. (Defendants' Exh. B, p. B1)
 - d) Claimant reviewed Defendants' Exhibit B, and she testified it was her signature at the bottom of the timesheet. She testified the timesheet indicates she only worked four and a half hours on May 26, 2011, due to a field day for her son, and she testified she probably did leave work early or arrive at work late on May 26, 2011, to attend her son's field day. (Testimony of Claimant)
 - e) A Facebook post from Starr Elementary School dated May 21, 2011, indicates the field day for second graders would take place on May 26, 2011, from 8:30 a.m. to 11:00 a.m. (Defendants' Exh. F, p. F1)
 - f) Claimant testified she attends all of her son's field days, and her son attended Starr Elementary School and was a second grader in May of 2011. Claimant testified the field days are outdoors, and she attended the field day on the morning of May 26, 2011, then came into work and worked four and a half hours. (Testimony of Claimant)
 - g) After being presented the timesheet, Claimant admitted she did not leave work early on May 26, 2011. (Testimony of Claimant)
 - h) Claimant further testified that she worked the next day, Friday, May 27, 2011. She testified she was not scheduled to work Saturday, Sunday or Monday (Memorial Day), and she returned to work as scheduled on Tuesday, May 31, 2011. (Hr'g Tr., pp. 65-70)
 - i) Claimant testified she missed no time from work between the time of the smoke incident on May 26, 2011, and the time she presented to Dr. Poon for her pre-scheduled appointment on June 1, 2011. (Hr'g Tr., p. 70)
12. Claimant did not seek immediate medical attention following the smoke incident, and the medical records for the year and a half after the fire do not reference the fire incident at all.
- a) Claimant sought no medical attention on the day of the fire, nor did she seek any medical attention until she returned to her personal care physician, Dr. Glenn Poon, on June 1, 2011, for a previously scheduled appointment to review her physical results. (Medical Record as a Whole; Testimony of Claimant)
 - b) On June 1, 2011, Claimant returned to Dr. Poon for her previously scheduled appointment to review her labs. Dr. Poon's note indicates Claimant presented on that date for "asthma and lab results. With asthma attacks since one month ago and is getting a lot worse." Claimant also presented with nasal congestion and a runny nose. It is important to note that while this visit is just six days after the day of the fire, there is nothing in Dr. Poon's notes referencing the alleged smoke exposure, and the note

indicates Claimant's asthma attacks had been occurring for one month. (APA, pp. 141 - 142)

- c) On June 1, 2011, Dr. Poon admitted Claimant to the hospital for a 10 day stay. The hospital records indicate: "Long history of asthma problems in the past. According to her, she started to have some attacks in between now for a month or so, and it got to the point it was getting a lot worse in the past several days." Claimant was diagnosed with asthma and acute bronchitis. Claimant stayed in the hospital until June 10, 2011, and Claimant's discharge note indicates: "48 year old female patient with long history of asthma problems in the past. According to her, she has been using her nebulizer treatments in the past month or so, and lately is just getting a lot worse. Patient finally came into the office for a checkup." There is no mention of smoke exposure or the fire incident in the hospital records from June 1 to 10, 2011, and the hospital records, in fact, report "no acute" event. (APA, pp. 176-199)
- d) Claimant presented to AnMed Hospital on June 15, 2011, with complaints of sudden increasing chest pain. The hospital record indicates that during Claimant's initial evaluation, "she was noted to have significant dyspnea, which was pleuritic in nature." The hospital records further indicate: "No history of exposure to any unusual chemicals, fumes, dust, etc." Claimant was seen by Dr. Mohan, her pulmonologist, in the hospital, and Dr. Mohan's note indicates: "OCCUPATIONAL HISTORY: Currently is employed. No history of exposure to any unusual chemicals, fumes, dust, etc." Claimant remained in the hospital until June 18, 2011, at which time she was discharged with diagnoses of non-specific chest pain, asthma exacerbation, constipation, depression with anxiety, and sleep apnea. There is no mention of smoke exposure or the fire incident in the hospital records from June 15 to 18, 2011. (APA, pp. 116-123)
- e) Claimant returned to Dr. Mohan on July 14, 2011, with a complaint of shortness of breath. Dr. Mohan noted Claimant to "have significant psychogenic component to her dyspnea." There is no mention of smoke exposure or the fire incident in Dr. Mohan's record from July 14, 2011. (APA, pp. 102-103)
- f) Claimant returned to Dr. Poon on September 2, 2011, where she presented for a checkup and trouble breathing. There is no notation of any smoke or the fire incident in Dr. Poon's September 2, 2011, report. (APA, pp. 157-158)
- g) Claimant returned to Dr. Mohan on September 13, 2011. Dr. Mohan indicated Claimant returned for a "recheck of asthma, onset of the asthma has been gradual and has been occurring in a persistent pattern for years. The course has been worsening." Dr. Mohan again noted there to be a "psychogenic component to her problem," and Dr. Mohan noted "the importance of regular follow up visits reinforced." Claimant was instructed to follow up in one month. Again, there was no mention of any smoke exposure or the fire incident in Dr. Mohan's September 13, 2011, record. (APA, pp. 104-107)
- h) Despite Dr. Mohan's record indicating Claimant was to follow up in one month, Claimant did not return to Dr. Mohan, or any other pulmonologist, until July 10, 2012, nearly nine months later. On that date, Claimant presented with shortness of breath,

hoarseness, cough, cold symptoms, and she reported her issues began two months ago. Dr. Mohan prescribed Advair and Singulair and decided to hold off on Prednisone therapy, and again, there is no mention of the fire incident or smoke exposure in Dr. Mohan's July 10, 2012 record. (APA, pp. 285-288; Testimony of Claimant; Medical Record as a Whole)

- i) Claimant returned to Dr. Mohan on September 20, 2012, and Claimant's medications were refilled and she was instructed to follow up in six months. Again, there was no mention of the fire incident or smoke exposure in Dr. Mohan's September 20, 2012 report. (APA, pp. 289-292)
13. There is no mention or complaint of exposure to smoke in Claimant's post-May 26, 2011, medical records until Claimant was referred by her attorney to Dr. Spandorfer in December of 2012, more than a year and a half after the incident. (Medical Record as a Whole)
14. Claimant presented to Dr. Michael A. Spandorfer of Carolina Lung and Critical Care in Charleston, South Carolina on December 20, 2012, for an independent medical evaluation at the referral of her attorney. (APA, pp. 5-12)
 - a) Dr. Spandorfer's record indicates:

The patient reports a prior childhood history of asthma that has acutely worsened since smoke exposure while employed as a fire marshal. The patient reports that prior to her work related exposure, her asthma was relatively stable. The patient reports that she had rare symptoms related to her asthma. Her symptoms included the need for rescue Albuterol approximately two to three times per year without the need for daily usage. (APA, pp. 5-12)
 - b) Claimant further reported the following to Dr. Spandorfer:

Her asthma symptoms greatly increased since exposure to a fire in summer of 2010. The patient at that time was employed as a fire fighter training officer whose job did not include active firefighting duties. At the time of the patient's exposure, the patient was riding as a passenger with a fellow fire fighter who decided to respond to an active fire. The patient reports that she remained inside the fire truck with the echo initially running for up to one and a half to two hours in duration. During this time, the patient reports that she was exposed to fumes and smoke related to the fire which led to the immediate onset of cough with shortness of breath, wheezing, chest tightness, as well as dyspnea. The patient attempted to limit her exposure about utilizing a wet towel as a mask. (APA, pp. 5-12)
 - c) Dr. Spandorfer indicated that Claimant "has occupationally worsened chronic obstructive asthma with severe air flow limitation and chronic hypoxic respiratory failure." (APA, pp. 5-12)
 - d) On November 26, 2013, Dr. Spandorfer assigned Claimant a 55% medical impairment to the bilateral lungs and opined that Claimant is unable to return to work at her

previous employment. Dr. Spandorfer opined that Claimant would require future medical care to include use of daily medications including bronchodilator therapy, inhaled steroid therapy, oral steroid therapy, antibiotics, and nebulized bronchodilator therapy, routine physician evaluation with pulmonary function testing at least four times a year, expectation of an emergency room visit at least twice a year, and use of immune modulatory therapy such as Xolair and Leukotriene antagonists. (APA, pp. 5-12)

15. Claimant presented to Dr. Gregory Feldman at Upstate Lung and Critical Care Specialists in Spartanburg, South Carolina on March 5, 2014, for an independent medical evaluation at the referral of Defendants. (APA, pp. 379-386)

a) Dr. Feldman noted Claimant had a history of asthma since six weeks old, and he went on to note the following history:

She had "cold." While sick with cold she was also exposed to smoke, not in direct proximity but while sitting in the fire truck that had stopped to help with some brush fire in the field some 100 yards away. She did not get exacerbation immediately, but about a week later, she had very severe exacerbation requiring prolonged hospital stay and steroids. Today she is wheezing and has significant chest congestion. (APA, pp. 379-386)

b) Dr. Feldman went on to opine:

With regard to the etiology of recent hospitalization, she had a cold prior to this. Viral infections are most common triggers of asthma exacerbations. In addition, whatever role, if any, smoke inhalation played, it is impossible to know, except one would expect an immediate reaction with bronchospasm if her exacerbation was due even in part to smoke inhalation. (APA, pp. 379-386)

c) Dr. Feldman further issued a letter and written statement opining the following:

Ms. Chamblee is an unfortunate 48 year old female, lifelong non-smoker, with long history of asthma since the age of six weeks. She has had numerous asthma attacks and exacerbations of her asthma throughout her adolescence. She reports that her asthma has gotten better, but about one week after her exposure to smoke, her condition deteriorated. She is attributing this to the incident in question. On May 26, 2011, Ms. Chamblee was in her fire truck, when they had stopped to assist with some fire in a field. She stayed in the truck for approximately 45 minutes, about 100 yards or so away from the fire. Ms. Chamblee had also been suffering from persistent "cold" symptoms for about a week at that time. According to her medical records, she was admitted to Elbert Memorial Hospital on June 1, 2011, with severe asthma exacerbation. At that time, according to Ms. Chamblee, she started to have some attacks in between for about a month prior to her admission. To date, asthma is still not controlled. With regard to exposure to smoke, it is unlikely that smoke exposure has caused or contributed to her asthma. She did not develop an immediate

bronchospasm as one would expect in asthma exacerbation secondary to smoke inhalation. She had poorly controlled asthma for weeks prior to exposure and had ongoing "cold" symptoms for several days prior to exposure. There is no doubt that Ms. Chamblee is suffering from lifelong and progressive asthma, but it is multifactorial and not properly managed at this time. (APA, pp. 379-386)

16. The first report of injury, which was filed by Claimant, reads, "IW (injured worker) states she had cold. Went to grass fire. Stayed in truck with air conditioner. Developed into carbon dioxide poisoning." (APA, p. 124)
 - a) There is no medical evidence in the record that Claimant suffered from carbon dioxide poisoning. (Medical Record as a Whole)
17. There are several medical opinions in the record with regard to causation of Claimant's condition.
18. On August 1, 2014, Dr. Poon stated to a reasonable degree of medical certainty that Claimant's "...exposure to smoke as described in the attachment most probably caused an aggravation of her prior asthmatic condition ..." (APA, pp. 1-4)
 - a) It is important to note that Dr. Poon is not a pulmonologist. None of his records that are contemporaneous with the alleged date of injury mention the alleged exposure to smoke. This statement is signed more than 3 years after the fact. (Medical Record as a Whole)
 - b) In a letter dated May 14, 2012, Dr. Poon states: "Since she was under the care of her pulmonologist prior to and after this incident, I think her pulmonologist will be the best to consult. He can provide all your needed answers in detail." Despite this statement from Dr. Poon, there is no causation statement from Dr. Mohan in the medical records. (APA, p. 369; Medical Record as a Whole)
 - c) We give Dr. Poon's statement little weight.
19. Despite the fact that Dr. Mohan was Claimant's treating pulmonologist immediately before and after the smoke incident, and the fact that Dr. Poon indicated Dr. Mohan would be the best person to address causation of Claimant's condition, there is no causation statement from Dr. Mohan.
20. There is testimony from two pulmonologists in the record – Dr. Michael Spandorfer and Dr. Gregory J. Feldman. Both pulmonologists speak to a reasonable degree of medical certainty. While we have read the depositions of both doctors in their entirety and have considered the testimony of both doctors, we are persuaded by the testimony of Dr. Feldman and give it much greater weight.
 - a) The parties deposed Dr. Spandorfer on February 25, 2014.
 - i. Dr. Spandorfer testified that exposure to smoke can cause mucus production, and the mucus then aggravated Claimant's underlying asthma.

- ii. Dr. Spandorfer is definitive in his opinion that Claimant's exposure to the grass fire aggravated her pre-existing asthma and is the cause of her current medical condition.
- iii. Dr. Spandorfer testified in his deposition, "To a reasonable degree of medical certainty, I believe that the patient has occupationally induced – excuse me, occupationally worsened asthma due to her smoke exposure."
- iv. Dr. Spandorfer assigned Claimant a 55% medical impairment rating.
- v. There are numerous inconsistencies in Dr. Spandorfer's report, and in much of the history provided to Dr. Spandorfer by Claimant.
- vi. Dr. Spandorfer testified that Claimant reported the following during the evaluation:

She reported to me that prior to the exposure her asthma was relatively stable and that she had rare symptoms that she related to her asthma. She reported that prior to the fire she only needed to use rescue bronchodilator therapy approximately two or three times a year without the need for daily usage, and she reported that she didn't require oral steroids or inhaled steroids, and she rarely required antibiotics which in our mind, you know, tells us the patient's controlled. They don't require rescue therapy or maintenance medicines or oral steroids and that their asthma is quiescent. (Spandorfer Dep. Tr., p. 15)
- vii. Dr. Spandorfer further testified that Claimant denied any history of allergies or post nasal drip, she denied any reflux, and she denied allergic rhinitis or allergy sinus disease. (Spandorfer Dep. Tr., p. 16)
- viii. Contrary to Claimant's report to Dr. Spandorfer, Claimant's asthma was not relatively stable prior to May 26, 2011, claimant required rescue bronchodilator therapy, oral steroids, inhaled steroids, and antibiotics, Claimant suffered from nasal drip and reflux, and Claimant suffered from extensive allergy and sinus issues. (Medical Record as a Whole)
- ix. Dr. Spandorfer reviewed a 2005 spirometry test from AnMed Health, introduced as Exhibit 1 in the deposition, and Dr. Spandorfer testified: "She is not very much different based off of that..." (Spandorfer Dep. Tr., p. 31) Dr. Spandorfer further testified that the spirometry results from 2005, until after the smoke incident "didn't change." (Spandorfer Dep. Tr., pp. 32-33)
- x. Dr. Spandorfer testified that Claimant did not report to him that she had a cold at the time of the smoke incident. (Spandorfer Dep. Tr., p. 36)
- xi. Claimant reported to Dr. Michael Spandorfer that she covered her face with a wet towel. In fact, while she may have covered her face, there was not a wet towel in the vehicle. (IME Report of Dr. Spandorfer; Deposition of Dr. Spandorfer; Deposition and Hearing Testimony of Claimant)

b) The parties deposed Dr. Gregory Feldman on October 20, 2014, and Dr. Feldman offers a very different opinion.

i. Dr. Feldman testified:

This is a patient that has a very, very severe asthma, longstanding asthma. She has a terrible breathing test preceding her asthma – preceding her fire, and she continued to have a pretty bad cause. The fact that she got in to the hospital, it didn't happen after she was exposed to fire. It happened like a week later. In addition, she has a viral infection, cold symptoms, which is far more likely than fire that caused it, which is what generally we see in the pulmonary practice when severe asthmatics get upper respiratory infection, that would probably put you in the hospital. Far more likely than a fire.

- ii. Dr. Feldman testified that Claimant suffered from a cold during the week of the smoke exposure, and the cold was far more likely than the smoke exposure to have caused an aggravation of Claimant's asthma.
- iii. Dr. Feldman testified that the cold causes mucus inflammation, and the mucus then plugs the airways and produces difficulty breathing.
- iv. Dr. Feldman testified that, if the smoke caused a permanent aggravation of Claimant's asthma, he would have expected an "immediate asthma attack within like seconds or minutes."
- v. Dr. Feldman testified that, assuming there was an aggravation of Claimant's asthma, it is 99.9% likely that it was caused by her upper respiratory infection (cold), and .01% likely that it was caused by the smoke exposure.
- vi. Dr. Feldman testified that his opinion to a reasonable degree of medical certainty is that any smoke exposure on May 26, 2011, did not cause or contribute to Claimant's asthma condition.
- vii. Dr. Feldman reviewed the deposition transcript of Dr. Spandorfer and testified he disagrees with Dr. Spandorfer's causation opinion.
- viii. Dr. Feldman testified Claimant was many yards away from the fire, Claimant already had significant preexisting symptoms, and Claimant's spirometry readings from 2005, and from after the smoke incident "has not changed." (Feldman Dep. Tr., pp. 16-17)
- ix. Dr. Feldman agreed that the cause of any aggravation of Claimant's asthma was mucus production, but Dr. Feldman testified: "Well, I agree it was mucus, and – and it overwhelmingly likely was a viral infection that caused it. It's not even in my – in my judgment, not even close." (Feldman Dep. Tr., pp. 18-19)
- x. Dr. Feldman testified that Claimant's asthma has been under-treated in the past, and he testified that upper respiratory infections are the most common cause of clinical deterioration in asthma patients. Dr. Feldman testified that Claimant's

upper respiratory infection “preexisted the smoke, it continued, and then she finally was so sick that she had to be admitted, okay. If she come to me the day before the fire, I probably would have admitted her too.” (Feldman Dep. Tr., pp. 20-21)

- xi. Dr. Feldman further testified: “And I’m telling you, that the most common aggravation of preexisting condition is viral infection. And the fact that there was some smoking seven days prior [to Claimant being admitted to the hospital], okay, it is almost impossible to assign significance to that when we know that she has a viral infection, and that’s the most common cause of exacerbation.” (Feldman Dep. Tr., p. 42)
 - xii. On further questioning about the smoke causing an exacerbation of Claimant’s asthma, Dr. Feldman stated: “If she would have gotten sick on the spot, cannot breathe, called the ambulance, I would say you’re right. But seven days later, it’s an utter speculation and unlikely.” (Feldman Dep. Tr., p. 48)
 - xiii. Dr. Feldman further stated: “The greatest majority of the people today in every hospital in the United States of America and every other country are because of viral infection.... People are in the hospital today with asthma overwhelmingly because of a viral upper respiratory infection. That’s a number one cause of asthma admission.” (Feldman Dep. Tr., p. 49)
 - xiv. Dr. Feldman testified that Claimant had indicated she had a bad cold at the time of the fire incident, and Dr. Feldman testified: “When people say ‘real bad cold,’ what they really mean, ‘really bad asthma,’ okay. Because they ascribe it to cold, when in reality, their symptoms of asthma got bad. That’s what they feel.” (Feldman Dep. Tr., p. 59)
21. Consistent with Dr. Feldman’s causation opinion, the evidence in the record indicates Claimant was suffering from a cold, or upper respiratory infection, during the weeks immediately preceding and following the smoke incident.
- a) At the hearing, Claimant testified to the following:
 - i. Claimant testified she had a cold which began around the beginning of the month in May of 2011, and that cold continued until the date she was admitted to the hospital on June 1, 2011. (Hr’g Tr., pp. 54-55)
 - ii. At the hearing, Claimant testified she had “a really bad head cold” on May 26, 2011. (Hr’g Tr., p. 55)
 - iii. Claimant testified that having a cold causes problems with her asthma. (Hr’g Tr., p. 55)
 - b) During her deposition, Claimant testified to the following:
 - i. At the doctor’s office on June 1, 2011, Claimant told the doctor: “Well, while you’re at it, you might better listen to my lungs because I think I’ve got a cold.” (Claimant’s Dep. Tr., pp. 48-49)

- ii. Claimant further testified at her deposition that on the date of the accident, "I had a really bad cold." (Claimant's Dep. Tr., p. 44)
 - iii. Referring to her return to the Fire Department after installing smoke detectors on May 26, 2011, Claimant testified at her deposition: "I get to the fire department, and I was telling them, I said, 'I've got a cold. I think I'm going to go home early because I've done got sick. I'm real - my head is killing me.'" (Claimant's Dep. Tr., p. 47)
 - c) Claimant's mother, Maureen Chamblee, testified she was aware that Claimant had a cold in the weeks prior to the smoke incident.
 - d) Referring to the incident on May 26, 2011, Larry Greer, Jr. testified Claimant "was sick that day anyway at work," but he did not notice anything different about her condition when he returned to the truck. (Hr'g Tr., pp. 109-110)
 - e) On the drive back to the Fire Department after installing smoke detectors on May 26, 2011, Mr. Greer testified Claimant indicated she was not feeling good, but Mr. Greer testified he does not recall Claimant ever stating that her problems were related to the smoke, and Mr. Greer testified that Claimant was already sick that day. (Hr'g Tr., pp. 111-112) Mr. Greer further testified: "She said she - well, she was already feeling bad, but she said again, she said, 'I don't feel - I don't feel good.'" (Hr'g Tr., pp. 112-113)
 - f) Claimant testified she told Dr. Poon she was sick when she presented on June 1, 2011, and she testified she had been sick for about a month at that time. (Hr'g Tr., p. 71)
22. The medical records directly following the May 26, 2011, incident are also consistent with Dr. Feldman's opinion that any aggravation in Claimant's asthma condition was caused by her upper respiratory infection, or "cold."
- a) As noted above, Claimant testified she suffered from a cold from the beginning of May, 2011, and the cold was still ongoing when she presented to the doctor on June 1, 2011.
 - b) Dr. Poon's June 1, 2011, note indicates Claimant presented, "with asthma attacks since *one month ago* and is getting a lot worse." Claimant also presented with nasal congestion and a runny nose. (APA, pp. 141 - 142, emphasis added)
 - c) On June 1, 2011, the hospital records indicate: "According to her, she started to have some attacks in between now *for a month or so*, and it got to the point it was getting a lot worse in the past several days." Claimant was diagnosed with asthma and acute bronchitis. Claimant stayed in the hospital until June 10, 2011, and Claimant's discharge note indicates: "According to her, she has been using her nebulizer treatments in *the past month or so*, and lately is just getting a lot worse." (APA, pp. 176-199, emphasis added)
 - d) Dr. Mohan's September 13, 2011, narrative indicates Claimant returned for a "recheck of asthma, *onset of the asthma has been gradual and has been occurring in a persistent pattern for years.*" (APA, pp. 104-107)

23. Claimant testified she has remained on nasal oxygen since her hospitalizations following the May 26, 2011, incident, and she wears the oxygen "most all the time." (Hr'g Tr., pp. 22-23)
24. There is video evidence in this case that shows Claimant in a much better condition than she presented at the hearing. (Defendants' Exhibit C)
25. Claimant reviewed Defendants' Exhibit C, and she testified the Exhibit is comprised of two videos of herself singing karaoke at the restaurant Mi Fiesta. She testified her son recorded the videos and posted them to Claimant's Facebook page, and she is the individual on the left side of the videos. Claimant testified she was not wearing oxygen while she sang karaoke. (Hr'g Tr., pp. 81-83)
26. Claimant stated that she has good days and bad days.
27. When we consider the evidence as a whole, we believe that Claimant's contention that the May 26, 2011 incident is the cause of an aggravation to her asthmatic condition is simply not supported by the facts in this case.
 - a) Claimant testified it remains her opinion that, prior to May 26, 2011, her asthma had been the same for twenty years, it had been well-controlled, and it was not getting any worse in the two to five years leading up to May 26, 2011. (Hr'g Tr., p. 44) This is inconsistent with the medical evidence outlined above, and most notably, the August 25, 2010, report of Dr. Mohan. (Medical Evidence as a Whole; APA, pp. 99-101)
 - b) Claimant's assertion that she believed her asthma was well-controlled and was not worsening is consistent with Dr. Feldman's deposition testimony with regard to asthmatic patients.
 - i. Dr. Feldman testified that Claimant's asthma was far worse than Claimant realized for a long time.
 - ii. Dr. Feldman testified, in referring to asthmatic patients, that "you cannot rely on the patient for assessing their asthma control; they're notoriously terrible, okay. They come in and tell you, 'I feel okay.' Why they say the feel okay, because they got used to not being okay." (Feldman Dep. Tr., p. 63)
 - iii. Claimant's mother, Maureen Chamblee, testified Claimant worked the day after the smoke incident, and Claimant has a habit of going into work even when she does not feel like it.
 - iv. Ms. Chamblee testified Claimant has a personality that she will try to fight through things and she has always had that type of personality, and Claimant has always gone to work even when she does not feel like it.
28. The medical records are replete with references to Claimant's asthma. Not only does the narrative that results when one reviews the chronological history of her asthma not support a finding for Claimant, it paints a very clear picture that her underlying health conditions – unrelated to the events of May 26, 2011, – are much more likely the cause of her current condition.

29. Claimant has failed to meet her burden of proving she sustained an aggravation of her preexisting asthma condition which is causally-related to exposure to smoke on May 26, 2011, and her claim for benefits under the South Carolina Workers' Compensation Act ("the Act") is hereby denied.
30. Claimant has failed to meet her burden of showing she suffered an injurious exposure or accident arising out of and within the course and scope of her employment on May 26, 2011.
31. Claimant is not entitled to any benefits under the Act and the case is dismissed.

CONCLUSIONS OF LAW

In view of those Findings of Fact, and as provided in the South Carolina Code of Laws,

WE, THE APPELLATE PANEL, CONCLUDE THE FOLLOWING AS MATTERS OF LAW:

1. Under § 42-1-130, Claimant was a covered employee at the time in question; and under § 42-1-140, Defendant/Employer was a covered employer under the Act.
2. Under § 42-1-160, Claimant has failed to carry her burden of proving an injurious exposure or compensable injury by accident arising out of and within the course and scope of her employment on or about May 26, 2011, and her claim for benefits under the Act is hereby denied.
3. Under § 42-9-35, Claimant has failed to carry her burden of proving she sustained an aggravation of her preexisting asthma/lung condition which is causally-related to exposure to smoke on or about May 26, 2011, and her claim for benefits under the Act is hereby denied.
4. Under § 42-1-160 and § 42-9-35, Claimant's request for benefits is hereby denied and this case is dismissed.

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law,

IT IS, THEREFORE, ORDERED that Claimant has failed to carry her burden of proving an injurious exposure or compensable injury by accident arising out of and within the course and scope of her employment on or about May 26, 2011, and her claim for benefits under the Act is hereby denied.

IT IS FURTHER ORDERED that Claimant has failed to carry her burden of proving she sustained an aggravation of her preexisting asthma/lung condition which is causally-related

to exposure to smoke on or about May 26, 2011, and her claim for benefits under the Act is hereby denied.

AND IT IS SO ORDERED.

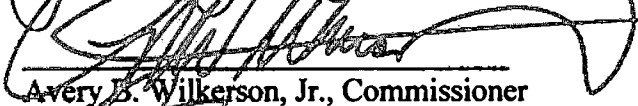
**AFFIRMED WITH
AMENDMENTS:**

CONCUR:


**SOUTH CAROLINA WORKERS'
COMPENSATION COMMISSION**



Susan S. Barden, Commissioner



Avery B. Wilkerson, Jr., Commissioner



T. Scott Beck, Commissioner

CERTIFICATE OF SERVICE

This is to certify that the undersigned has on this date served a copy of this order in the above entitled action upon all parties to this case by sending an electronic copy hereof by electronic mail addressed to the attorneys for said parties; or if there is an unrepresented party(ies), by depositing a copy hereof, postage paid in the United States mail, first class, addressed to the unrepresented party(ies) and to the attorney(s) for the represented party(ies).

By Kim Falls on August 5, 2015