

<b>STATE OF COLORADO</b> <b>OFFICE OF ADMINISTRATIVE COURTS</b> 1525 Sherman Street, 4 <sup>th</sup> Floor, Denver, CO 80203	
In the Matter of the Workers' Compensation Claim of:  <b>CONNIE FREEMYER,</b> Claimant,  vs.  <b>NOW OR NEVER TRUCKING</b> Employer, and  <b>PINNACOL ASSURANCE</b> Insurer, Respondents.	
	<p style="text-align: center;">▲ <b>COURT USE ONLY</b> ▲</p> <b>CASE NUMBER:</b>  <b>WC NO. 4-955-886-01</b>
	<b>FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER</b>

Administrative Law Judge Peter J. Cannici presided at the hearings in this matter on March 16, 2015 and May 18, 2015 at the Office of Administrative Courts in Denver, Colorado. Brett M. Busch, Esq. represented Claimant Connie Freemyer. Lynda S. Newbold, Esq. represented Respondents Now or Never Trucking and Pinnacol Assurance. The Judge digitally recorded the March 16, 2015 proceedings in Courtroom 1 from approximately 8:30 a.m. until 5:00 p.m. The Judge digitally recorded the May 18, 2015 proceedings in Courtroom 3 from approximately 8:30 a.m. until 5:00 p.m. He admitted Exhibits 1-28, 30 and 35 for Claimant into evidence. He also admitted Exhibits A-L for Respondents. The Judge held the record open until June 12, 2015 so that the parties could submit position statements.

In this order, Connie Freemyer, the widow of deceased employee Jim P. Freemyer, will be referred to as "Claimant" and Jim P. Freemyer will be referred to as "Decedent." Now or Never Trucking will be referred to as "Employer" and Pinnacol Assurance will be referred to as "Insurer." Employer and Insurer will be referred to collectively as "Respondents."

Also in this order, "Judge" refers to the Administrative Law Judge, "C.R.S." refers to Colorado Revised Statutes (2014); "OACRP" refers to the Office of Administrative Courts Rules of Procedure, 1 CCR 104-1, and "WCRP" refers to Workers' Compensation Rules of Procedure, 7 CCR 1101-3.

## CERTIFICATE OF SERVICE

I hereby certify that I have served true and correct copies of the foregoing **FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER** by electronic mail addressed as follows:

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Date: 7/8/15

Gabriela Chavez  
Court Clerk

**OFFICE OF ADMINISTRATIVE COURTS  
STATE OF COLORADO  
WORKERS' COMPENSATION NO. 4-955-886-01**

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**ISSUES**

1. Whether Claimant has demonstrated by a preponderance of the evidence that Decedent's July 13, 2014 death occurred during the course and scope of his employment with Employer and she is thus entitled to receive death benefits pursuant to §§8-42-114 & 8-42-115 C.R.S.

2. Whether Respondents have proven by a preponderance of the evidence that Decedent willfully failed to obey a safety rule in violation of §8-42-112(1)(b) C.R.S. on July 13, 2014.

**STIPULATIONS**

The parties agreed to the following if the claim is found compensable:

1. Decedent earned an Average Weekly Wage (AWW) of \$1007.00.
2. Respondents will pay the statutory maximum for Decedent's funeral expenses pursuant to §8-42-123 C.R.S.
3. Claimant is Decedent's sole dependent for purposes of receiving death benefits pursuant to §§8-42-114 & 8-42-115 C.R.S.

**FINDINGS OF FACT**

1. Employer hired Decedent on May 27, 2014 as a Driver. On July 13, 2014 Decedent was found unresponsive on top of a crude oil production tank. He was pronounced dead at the scene. Decedent was 59 years old at the time of his death.

2. Employer is a crude oil transportation company that has been in operation for roughly 20 years. On any given day there are up to 45 drivers working for Employer. The drivers operate oil pumping trucks and visit production tank sites for the purpose of transporting crude oil from the well production sites to refineries or rail points for sale. The oil production facilities generally contain batteries of crude oil storage tanks that are connected by pipelines allowing the flow of oil into and among the tanks. The drivers are required to sample the oil in the tanks to determine whether the oil will be purchased, gauge the amount of oil in the tanks, pump the oil from the tanks to the trucks and haul it to the distributor. The process usually entails climbing stairs to a catwalk located near the top of the tanks, opening "blow down valves" and opening the "thief hatch." Once the driver completes his tasks he closes down the tank hatches and valves, returns to the truck and loads the oil from the tank into the truck for transport.

3. In order to test the oil the driver lowers vials into the tank to obtain samples. Generally two samples are sufficient to determine if the tank is appropriate for purchase. The samples are transferred to heated bottles in order to determine the water content of the product. Gauging involves dropping a device similar to a tape measure into the tank until it hits bottom, retrieving the gauge by winding it up and noting the measurement of the oil depth on the tape.

4. Employer's Operations Manager Lee Mulkey testified at the hearing in this matter. He and Fleet Manager David Holt are responsible for Employer's safety program. Mr. Mulkey explained that the tanks visited by Employer's drivers are not considered "frack" tanks or "flowback" tanks. Flowback tanks are used and operated immediately following extraction of the drilling fluids from the ground and are located near the actual wellhead. The tanks are used to hold the initially extracted oil and gas prior to separation of the various components.

5. Mr. Mulkey remarked that he is fairly familiar with the Gaddis Production Facility where Claimant was working on July 13, 2014. The Gaddis location consists of two rows of crude oil production tanks. The tanks on each side are connected but Mr. Mulkey was not aware of any crossover pipe connecting the north and south rows.

6. Employer offers extensive training to its drivers to familiarize them with applicable industry regulations and safety procedures. Additional mandatory training is given to each new hire on using personal protection equipment, safety regulations of the company and procedures and regulations specific to the production sites. Training topics include opening and working around crude oil tanks and operating the Drager Four Gas Detection Monitor.

7. The training Decedent received included instruction on the specific procedures for working on and around crude oil tanks. Because the tanks contain petroleum products, the drivers wear protective goggles and gloves, as well as four gas detection monitors. The Noble Energy training documents contain instruction that, prior to opening the thief hatch, the pressure in the tanks must be equalized by opening blow down valves. The procedure releases the pressure in the tank so that the worker may safely open the thief hatch to complete oil sampling and gauging. Mr. Mulkey explained that drivers are instructed to first identify wind direction using several methods including wind socks located on production sites or the movement of pipe fitting thread tape. The driver is instructed to open multiple blow down valves, beginning downwind of the tank to be gauged, and moving back upwind. The procedure also instructs the driver to open multiple thief hatches starting downwind of the tank to be gauged. The driver then waits a sufficient period of time to allow the pressure to equalize, or a minimum of three minutes, prior to opening the thief hatch on the tank to be gauged.

8. Mr. Holt testified at the hearing in this matter. After receiving in-house instruction and training, the new hires are assigned to another driver for a period of time to learn the required procedures for performing the job. The training can last anywhere from six days up to one month depending on how quickly the new driver learns the process. When the experienced driver feels the new hire is ready, Mr. Holt or Mr.

Mulkey will conduct a field inspection of the new hire to ensure that the driver is sufficiently trained and skilled to perform the job. The process involves riding along with the new driver through the entire process to ensure that all driving, gauging, loading and safety procedures are followed. Mr. Holt testified he personally conducted Decedent's field inspection. Decedent passed the field inspection driving test, applied appropriate operating and safety procedures and properly used the Drager gas monitor. More specifically, Mr. Holt commented that he observed Decedent correctly following the procedure for opening multiple blow down valves and thief hatches prior to sampling the crude oil.

9. Mr. Holt also testified that he personally instructs new hires in the use, maintenance and proper operation of the Drager gas monitors. The monitors are designed to measure the driver's immediate breathing space for four potentially noxious conditions: (1) low oxygen levels; (2) the presence of hydrogen sulfide; (3) the presence of carbon monoxide; and (4) Lower Explosive Limits (LEL%) of volatile hydrocarbons. Mr. Holt covers the Drager training including a video, a question and answer sheet and a checklist reflecting that the driver understands the use of the monitor. Instruction includes turning the monitor on and off, how to perform fresh air calibrations (required daily) and bump tests (required weekly) and what to do when the monitor signals an A1 or A2 alarm.

10. Mr. Holt explained that he reviews all monitor data weekly. When an over range alarm occurs, the driver is taught to descend the tank, turn the monitor off and back on, and then return to the top of the tank. Drivers are also trained that when they are on a production location or at the refinery the monitor should be in the "on" position. A driver could not easily turn the monitor off using just one hand. Turning the monitor off requires pressing and holding two buttons on opposite sides of the device for three seconds.

11. Mr. Mulkey remarked that drivers have been disciplined for failing to follow safety procedures when Employer becomes aware of the infractions. One driver was disciplined for not opening multiple blow down valves or thief hatches. Another employee has been disciplined for failing to properly remove himself from a contaminated area in response to an alarm. Mr. Mulkey noted that violations rarely occur because most drivers follow proper procedures.

12. On June 25, 2014 Decedent was gauging a tank at the Phelps location. Coworker Joe Morales found Decedent disoriented, confused, making tank gauging gestures with his hands while not actually doing anything and unresponsive atop of the oil holding tank with his face over the open thief hatch. After Decedent failed to respond to inquiries about his well-being, Mr. Morales realized he needed help and assisted Decedent down from the tank. Mr. Morales noticed large amounts of mucous dripping from Decedent's nose. Decedent's gas monitor was alarming and the data demonstrated very low oxygen levels. Channel 4 revealed values in excess of 100% of the LEL for methane. Decedent was transported to the Platte Valley Medical Center and reported dizziness related to gas exposure that resolved after leaving the exposure area.

13. Mr. Mulkey testified that he did not discipline Decedent for standing over the hatch or ignoring his alarm because he believed Decedent's confusion was caused by his diabetic condition. His conclusion was based on his knowledge of Decedent's medical history and comments at the scene. Mr. Mulkey believed Decedent was experiencing difficulties with his blood sugar because he had not yet eaten on that day.

14. Based on Decedent's request, Mr. Mulkey took Decedent to Becker Safety & Supply to obtain a respirator. He remarked that he required Decedent to pay for the respirator out of his next paycheck. Decedent was not fit tested nor was any hazard analysis performed to determine if Decedent obtained the correct respirator.

15. Mr. Mulkey is familiar with the Drager monitor printout data and proper interpretation. When a monitor alarms after registering 100% LEL, the display shows the user two backward "L's" and will no longer give the user specific values. In order to again receive specific values the monitor must be turned off and on again in fresh air. The user would not be able to see actual values if LEL went into over range and the printout would continuously show OVR on every line until the monitor was turned off and restarted. The alarm will continue to sound if the worker steps back into a contaminated environment but will not give the user a specific LEL value. An A1 alarm will cause the monitor to beep until levels returns to a normal range. In an A2 situation the monitor will beep until the user manually acknowledges it. The over range reading will cause the Drager monitor to enter blocking alarm mode that can only be cleared by turning the monitor off and on again.

16. On July 13, 2014 Decedent arrived at the Gaddis oil holding tank site to haul his second load of the day at approximately 12:00 p.m. Decedent took two samples from a tank. At approximately 1:35 p.m. driver Stan Linker found Decedent unresponsive on top of an oil tank. Deputy J. Pastrana was the first Weld County Sheriff to be dispatched to the scene. He immediately interviewed Mr. Linker and recorded the following information. Mr. Linker had arrived at the location at approximately 1:15 p.m. and had begun the process of loading a tanker with oil. When he climbed the tank to perform his gauging and sampling, he discovered Decedent. Deputy Pastrana's report specifically noted the following:

Stanley stated that [Decedent] was bent forward at the waist, lying over face first over the tank. Stanley stated the thief hatch was open, and so was the blow off valve. Stanley said [Decedent] was wearing a respirator, with the respirator lying over the open hatch. Stanley said the other half of [Decedent's] face was on the tank. Stanley stated he pulled Decedent on to the catwalk and started CPR. Stanley stated it appeared [Decedent] had already gauged and sampled the tank he was working on, which should have taken him 15-20 minutes.

Mr. Linker further reported that Decedent's gas monitor was in the "off" position when he was found. Decedent was pronounced dead at the scene at 1:56 p.m.

17. Decedent was wearing the same Drager gas monitor on July 13, 2014 that

he had been wearing during the June 25, 2014 exposure. Mr. Mulkey and Devin Becker from Becker Safety & Supply downloaded and provided the June 25, 2014 and July 13, 2014 data to Detective Reed. Detective Reed noted that the times referenced in the data are Eastern Daylight Time, so a two-hour adjustment was necessary to convert to Mountain Daylight Time. Decedent turned off his monitor on July 13, 2014 and ended the printout information at 12:15:56 p.m. M.D.T.

18. The data extracted from the Drager gas monitor shortly after Decedent arrived at the Gaddis site on July 13, 2014 reveals the device alarmed A1 (oxygen) on channels zero and four and A2 (LEL) on channel four at 12:09 p.m. Channel zero (oxygen) continued to alarm for several minutes until 12:15:56 p.m. Channel four continued to show levels over 100% of LEL for methane. Because the monitor had been calibrated on March 12, 2014, July 13, 2014 was within the manufacturer's six-month calibration guideline. The monitor was tested on July 7 and 17, 2014. The "bump test" revealed passing results and excellent sensor reserves for all four channels. The results suggested proper functioning prior to July 13, 2014 and four days later. Drager wrote a letter to Employer dated July 23, 2014 stating that, based on the data, the Drager monitor was properly functioning on July 13, 2014 and there were significant exposures to CO and LEL. There were also low oxygen levels.

19. The medical records reflect that Decedent had significant pre-existing comorbid medical conditions. He had long term, poorly controlled Type II diabetes. Decedent was also treated for hypertension and hypercholesterolemia. By May 5, 2014 Decedent's most recent lipid panel showed "dangerously elevated" triglycerides. From March 2013 to April 29, 2014, Decedent's triglyceride levels rose from 1650 to 1686 or in the "Upper Panic" level. Normal reference ranges for triglyceride testing are between 0-149. A driving fitness examination revealed that Decedent had COPD changes in his lungs..

20. Decedent had prior problems with his heart resulting in angiogram procedures in August 2010. Prior to undergoing a stress test Decedent reported a history of hypertension, hyperlipidemia, chest pain, diabetes, shortness of breath, dizziness and lightheadedness. The test was recommended because he not only had complaints of chest pain and shortness of breath but also an abnormal ECG. At the time of the test Decedent had an abnormal perfusion study suggesting left anterior descending artery ischemia. Decedent thus underwent an angiogram that reflected a 40% blockage in the right coronary artery. Four years later during Decedent's autopsy the blockage had increased to 90%.

21. Forensic Pathologist James A. Wilkerson, M.D. performed Decedent's autopsy and testified at the hearing in this matter. On August 19, 2014 Dr. Wilkerson initially concluded that Decedent's causes of death were atherosclerotic cardiovascular disease, diabetes, hypertriglyceridemia and tobacco use (chewing tobacco). He also noted that "Toxic gas inhalation and oxygen displacement by volatile hydrocarbons may also have been contributory." Dr. Wilkerson mentioned the absence of cardiovascular thrombosis (coagulation or clotting) and the lack of thrombus or embolus in the lungs. Microscopic examination revealed no acute cardiovascular changes.

22. On September 3, 2014 Coroner Mark Ward concluded that, based on Dr. Wilkerson's report and the "circumstances of this death," Decedent "experience[d] a cardiac death in a hostile atmosphere." Moreover, blood toxicology ordered by Dr. Wilkerson revealed exposures to methane, hydrocarbons C1-C7 (ethane, propane, benzene, pentane, hexane) and thiosulfate.

23. Dr. Wilkerson amended his conclusion after receipt of further information regarding the interpretation of the Drager gas monitor data. He testified that amending his conclusions is not uncommon after receipt of additional evidence. The revised Death Certificate reflects that Decedent suffered a sudden cardiac death due to toxic gas inhalation and oxygen displacement by volatile hydrocarbons and atherosclerotic cardiovascular disease.

24. In his February 4, 2015 response to Claimant's request for further information, Dr. Wilkerson explained that Decedent's pre-existing cardiovascular disease rendered him unable to survive the toxic environment he encountered on July 13, 2014. He stated that without the exposure Decedent would not have died when he did. Because Decedent already had limited capacity to oxygenate his heart muscle due to atherosclerosis, he could not tolerate the reduced oxygen environment caused by oxygen displacing hydrocarbons. Dr. Wilkerson also determined that the manner of death was accidental.

25. Dr. Wilkerson testified that in Weld County three other deaths occurred under similar circumstances to those of Decedent. He commented that the other deaths occurred while the individual was sampling oil over an open thief hatch. In his initial conclusion Dr. Wilkerson noted that toxic gas inhalation and oxygen displacement were contributing factors to Decedent's death. He included the toxic fumes and oxygen displacement as contributing factors because of Decedent's environment, the Drager gas monitor data and the toxicology results. Dr. Wilkerson stated that he amended his conclusion because of the availability of new or clarified information. Dr. Wilkerson explained that he obtained a better understanding of the gas monitor data. He amended his determination that toxic fumes and low oxygen were contributing factors to explain that they constituted causative factors in Decedent's death. Decedent's underlying coronary artery disease was secondary. Dr. Wilkerson thus ultimately determined that Decedent would not have died on July 13, 2014 but for his exposure to the low oxygen, toxic environment.

26. Forensic Pathology Consultant Amy Martin, M.D. performed a record review of Decedent's July 13, 2014 death. Dr. Martin explained that Decedent suffered from "significant heart disease that would put him at risk for sudden cardiac death from ischemic heart disease." However, Decedent collapsed and died under circumstances that predisposed him to arrhythmia "either by the presence of the toxic fumes themselves or by asphyxia due to displacement of O<sub>2</sub> by those fumes, or a combination of those factors." Dr. Martin thus concluded that Decedent's cause of death was "cardiopulmonary arrest due to asphyxia by O<sub>2</sub> displacement by gases and/or the direct toxic effect of those gases." She noted that Decedent's "underlying coronary atherosclerosis and cardiomegaly" were significant contributing factors.

27. Michael Kosnett, M.D. testified as an expert in medical toxicology, occupational and environmental medicine, and internal medicine. Dr. Kosnett noted that Decedent's Drager gas monitor data from July 13, 2014 reflected oxygen levels below normal levels of 20.9% for a sustained period of time while the LEL for methane was in excess of 100%. He noted that the corresponding hydrocarbon concentration was fifty to one hundred thousand parts per million. Dr. Kosnett commented that Decedent's respirator was not adequate to protect him against the toxic environments while gauging tanks. He concurred with Drs. Wilkerson and Martin that Decedent succumbed to an oxygen deficient environment with airborne hydrocarbons. Dr. Kosnett noted that the environment in which Decedent was found along with the timing of when he was exposed strongly support that the toxic and oxygen deprived environment was the cause of death. He remarked that the gas monitor data supports the same conclusion because oxygen levels were as low as 6.9% and can cause unconsciousness in 30 seconds if sustained. Dr. Kosnett explained that an oxygen deficient environment causes rapid decline in arterial oxygen saturation and reduces oxygen delivery to the heart. The process results in acute hypoxia and releases adrenalin. The adrenalin further stresses the heart by increasing heart rate and blood pressure. Dr. Kosnett commented that the preceding factors cause myocardial ischemia in individuals with coronary artery disease and can trigger lethal arrhythmias such as ventricular fibrillation. The sequence of events can ultimately cause sudden cardiac death. Dr. Kosnett explained that the hydrocarbon exposure put Decedent at further risk due to its propensity to cause ventricular fibrillation. Based on the totality of the evidence Dr. Kosnett agreed with forensic pathologists Wilkerson and Martin that Decedent perished due to an oxygen deficient and elevated hydrocarbon environment.

28. Dr. Kosnett testified that Decedent's respirator was insufficient to protect him from the exposures he encountered gauging tanks because it was designed to filter air rather than supply oxygen. He noted that the instructions supplied with the respirator specifically state that it is not appropriate for low oxygen environments. Dr. Kosnett explained that there was no fit testing despite Decedent's mustache, the service life of the respirator cartridges was too short and rendered them saturated in Decedent's working environment and the concentrations were measured at levels in excess of the respirator's capabilities.

29. Jeffery Rubinstein, M.D. authored a report dated October 12, 2014 and testified at the hearing as an expert in cardiology. Dr. Rubinstein noted that the autopsy revealed no signs of myocardial infarction or heart attack and the blood toxicology results contained increased levels of benzene, thiosulfate and hydrocarbons. Dr. Rubinstein concurred with Drs. Wilkerson, Martin, and Kosnett that Decedent died because the low oxygen environment caused low oxygen saturation and ultimately unconsciousness and death. Dr. Rubinstein maintained that toxic fumes alone increase heart rate and blood pressure and can result in a life threatening arrhythmia. He acknowledged Decedent's coronary artery disease, but explained that there was no evidence that his condition was unstable.

30. Dr. Rubinstein testified that, although Decedent had coronary artery disease, there was no evidence of a heart attack. He explained that the autopsy

revealed no occlusion in the arteries, no clot, no thrombosis and the valves were unremarkable. Dr. Rubinstein remarked that Decedent was not at significant risk for sudden cardiac death because he was functional at his job and there were no other signs of an unstable cardiac condition such as chest pain or shortness of breath. Dr. Rubinstein noted that Decedent's 2010 stress test and coronary angiography did not reveal tight blockages. He detailed that Decedent's 40% lesions were usually not functionally significant. Dr. Rubinstein also deciphered the 53% ejection fraction noted in 2010. He explained that 55% is considered normal and 53% is "low normal." Dr. Rubinstein concluded that Decedent's heart was functioning normally in 2010 and the doctors in 2010 did not discover sufficient blockages to tie the chest pain to a coronary etiology. Based on Decedent's cardiac condition evident from the autopsy, Dr. Rubinstein determined that Decedent was predisposed to death from low oxygen levels and hydrocarbon exposure. He summarized that low oxygen environments stress the heart and cause arrhythmias.

31. Dr. Rubenstein constructed the following scenario to illustrate that, although Decedent suffered heart disease, the low oxygen environment and hydrocarbon exposure were the cause of his death:

I kind of see this case as a patient goes to autopsy, and he has two blocked arteries like this fellow does, but he has a bullet in his brain. And I can't ignore that bullet in the brain, because that is very hard to ignore when the guy had died suddenly. And if it looks like the bullet was shot within seconds of his death, nobody sitting here would be arguing about how much the blockage in his coronaries caused his death, despite the stress of being shot in the head ... So, to me, when we have this guy's head sitting above toxic fumes, that is the sudden bullet in his brain. He had no other reason to die at that time, at that moment. And it could have easily happened without the blocked arteries. In this case, he did have blocked arteries, so maybe that made it more likely to happen.

32. Industrial Hygienist Holli Merchant authored a report and testified at the hearing in this matter. She noted that the Drager gas monitor was calibrated consistently with manufacturer's recommendations on March 12, 2014 and bump tested on July 7, 2014. The bump test demonstrated proper functioning. Ms. Merchant stated that the oxygen levels on June 25, 2014 and July 13, 2014 were normal when the monitor was turned on at the beginning of those days. She noted the NEG readings for carbon monoxide and LEL (methane) suggested that the levels were reading below zero. Ms. Merchant explained that a fresh air calibration would bring those readings up to zero and stated that the NEG notation did not suggest the monitor was not properly functioning. In fact, the NEG notation demonstrated that the LEL readings were actually under-reported. She noted that the June 25, 2014 data revealed a flammable gas incident in excess of OSHA's requirement of less than 10% LEL that caused oxygen levels to decrease. Ms. Merchant explained that the same scenario occurred on July 13, 2014 based on the OVR notation and the documented 6.9% oxygen levels. Ms. Merchant acknowledged that, while the LEL sensor was not set to zero, the LEL reading

was so far above the allowable level that the specific amount was not material. Accordingly, she testified that there is no question that significant exposures occurred, especially considering OSHA's hazardous environment threshold of less than 10% LEL. Decedent's environment was documented in excess of 100% LEL.

33. Ms. Merchant noted the inefficacy of the respirator for the reasons outlined by Dr. Kosnett. She testified that Employer should have given Decedent a supplied air respirator because OSHA requires them for individuals working in oxygen deficient atmospheres. Ms. Merchant concluded by stating that Decedent's respirator provided no protection.

34. Edward Cetaruk, M.D. authored a report and testified at the hearing in this matter as an expert in emergency medicine and medical toxicology. Dr. Cetaruk explained that there is a difference between an "exposure" and a "toxic exposure." Exposure means that one has simply been exposed to a particular compound, chemical or medicine. A toxic exposure is a dose that exceeds a cutoff and actually causes injury. The intensity and duration of the exposure assist in determining the actual dose of the exposure. Medical literature exists to address accepted exposures to workers in the oil fields as opposed to members of the general public. Certain compounds are expected to be seen in oil field workers in general, such as hydrocarbons, benzene and hydrogen sulfide. Dr. Cetaruk explained that it is not surprising to see the compounds in Decedent's toxicology results. However, the only conclusion that can be made about the toxicology results in the present case is that Decedent was exposed to the preceding compounds. The toxicology results do not help in ascertaining dose or degree of exposure. Dr. Cetaruk thus determined that it is not possible to draw any conclusions from the results regarding the levels of hydrocarbons in Decedent's blood at the time of death.

35. Dr. Cetaruk testified that the available evidence is unreliable and insufficient to conclude that Decedent died as a result of a toxicological exposure. There is uncertainty as to the available data and there is missing data that would have been helpful. Decedent's heart disease is certainly a reasonable alternative diagnosis. Dr. Cetaruk noted that the toxicology results are likely a cumulative finding reflecting both exposures from the day of death as well as the preceding days. Dr. Cetaruk reviewed the monitor printout data and considered it in forming his opinions. He did not believe the monitor data established a hypoxic event sufficient to cause Decedent's death. The data reflects that the oxygen levels on July 13, 2014 hovered around the normal level of 19.5. Specifically, the oxygen levels fluctuated frequently during the three minute period from 12:09:41 to 12:12:41. The evidence thus does not reveal any persistently low oxygen levels. Rather, the values are variable and would be anticipated in a transiently gaseous environment.

36. Cinthia Bateman, M.D. testified as an expert in the fields of internal medicine, general cardiology, nuclear cardiology and interventional cardiology. Dr. Bateman reviewed the investigative materials from the sheriff's office, the autopsy and toxicology results and Decedent's prior medical records. Dr. Bateman concluded that the most probable cause of Decedent's death was a cardiac arrhythmia or sudden

cardiac death that was most likely a ventricular fibrillation. Dr. Bateman's opinion was partially based on Decedent's extensive risk factors, including uncontrolled diabetes, hypertension, obesity or elevated BMI, tobacco use and triglyceride levels she described as "off the chart." All of the preceding factors would cause a general cardiologist to believe Decedent was at a very high risk for a coronary event.

37. The most common cause of ventricular fibrillation is occlusion of an artery that causes reduced blood flow to a certain portion of the heart resulting in electrical differences in the tissues. The second most common cause is scarring in the myocardium that can also cause electrical differences in the tissues. An enlarged heart is another factor that can place a person at high risk for ventricular fibrillation. The autopsy results confirmed that Decedent had a dilated or enlarged, heart. Dr. Bateman summarized that the most likely cause of the ventricular fibrillation in the present case was Decedent's multiple nearly occlusive blockages in many of the smaller arteries of the heart that caused significant subendocardial ischemia.

38. Decedent's triglyceride levels were 1686 on April 29, 2014. With triglyceride levels of even 700 Dr. Bateman would have made a specialist referral to University Hospital for assessment. Dr. Bateman explained that high triglyceride levels increase the overall inflammation of the vasculature and cause infarctions as well as arrhythmias. Extremely elevated triglyceride levels cannot simply be attributed to an unhealthy lifestyle. The levels are indicative of something occurring genetically that warrants an expert consult to assist with treating the condition.

39. Dr. Bateman summarized that the most probable cause of the arrhythmia resulting in Decedent's death was atherosclerotic heart disease and probably a dilated heart. She remarked that the autopsy report revealed Decedent had severe obstructive coronary artery disease including 90% lesions of two out of the three major coronary vessels and 100% blockages in smaller vessels. Dr. Bateman's report confirms that Decedent was in the "highest risk category using the risk stratification scores available to us. His life expectancy was shorter than your average male counterpart. I believe to a reasonable degree of medical probability that [Decedent] had sudden cardiac death due to his many risk factors and severe coronary artery disease."

40. Industrial Hygienist Eric Rasmuson testified at the hearing in this matter. Mr. Rasmuson reviewed extensive technical data and information sheets regarding the specific Drager monitor Decedent used on July 13, 2014. He concluded that the monitor was appropriate for Decedent's job duties. Calibration drift occurs to sensors when they are not properly calibrated. The monitors require regular "bump tests" that will confirm the sensors can be reached by the gases and the alarms are properly functioning. A fresh air calibration (FAC) is slightly different. It is used when the instrument is turned on to correct any shift that has occurred in the calibration. The user can take the monitor to fresh air and perform the FAC to reset the parameters to zero except for oxygen levels that reset to 20.0.

41. Mr. Rasmuson explained that the monitor data from July 13, 2014 reflects that, when the instrument was turned on, there should have been an FAC performed

because the LEL and carbon monoxide channels read NEG. However, there is no evidence that Decedent performed an FAC on July 13, 2014. The main reason to calibrate is to remove the drift factor because the drift can either overestimate underestimate the readings. Because the monitor data reflected multiple readings recorded as NEG the readings were simply not reliable.

42. An OVR reading reflects that for at least one second out of a sixty second integration period the LEL levels overstepped the reading bounds of the sensor. At that point, the instrument goes into a blocking alarm mode and remains in that mode until the instrument is turned off and back on again. Once an OVR occurs, the subsequent measurements may read higher than expected. Between 12:10 p.m. and 12:15 p.m. on the July 13, 2014 monitor printout, the LEL channel reads OVR six times. The data reveal an OVR reading at 12:10:41 for at least one second out of that one minute period. The subsequent OVR readings reflect blocking alarms that would continue until reset by turning off the device. Mr. Rasmuson thus determined that the OVR points cannot be interpreted as actual readings of 100% LEL. Ms. Merchant was incorrect in testifying that there were actual 100% LEL readings. Mr. Rasmuson noted that her testimony is simply inconsistent with the functioning of the Drager monitor. The available monitor printout data did not provide an accurate representation of any potential toxic exposure.

43. Mr. Rasmuson explained that the Drager gas monitor printout reflects that, during the roughly six minutes prior to when the monitor was turned off, the oxygen level was hovering around 19.5. The oxygen sensor A1 alarm was turning on and off repeatedly. There was a transient gas emission but not a sustained exposure. After the monitor was turned off at 12:15:56 on July 13, 2014 there is no information regarding concentration of gases in the air.

44. Claimant has demonstrated that it is more probably true than not that Decedent's July 13, 2014 death occurred during the course and scope of his employment with Employer and she is thus entitled to receive death benefits pursuant to §§8-42-114 & 8-42-115 C.R.S. On July 13, 2014 Decedent was found unresponsive on top of a crude oil production tank while performing his job duties for Employer. He was pronounced dead at the scene. The medical records reflect that Decedent had significant pre-existing co-morbid medical conditions. He had long term, poorly controlled Type II diabetes. Decedent was also treated for hypertension and hypercholesterolemia. From March 2013 to April 29, 2014 Decedent's triglyceride levels rose from 1650 to 1686 or in the "Upper Panic" level. The autopsy report revealed Decedent had severe obstructive coronary artery disease including 90% lesions of two out of the three major coronary vessels and 100% blockages in smaller vessels. Despite Decedent's significant pre-existing coronary artery disease the persuasive medical evidence reveals that Decedent died as a result of the low oxygen and high hydrocarbon environment while gauging oil tanks. His job duties and work environment aggravated, accelerated or combined with his pre-existing coronary artery disease to cause his death on July 13, 2014.

45. Dr. Wilkerson persuasively concluded that Decedent's pre-existing cardiovascular disease rendered him unable to survive the toxic environment he encountered on July 13, 2014. He stated that without the exposure Decedent would not have died when he did. Because Decedent already had limited capacity to oxygenate his heart muscle due to atherosclerosis, he could not tolerate the reduced oxygen environment caused by oxygen displacing hydrocarbons. Moreover, Dr. Martin concluded that Decedent's cause of death was "cardiopulmonary arrest due to asphyxia by O<sub>2</sub> displacement by gases and/or the direct toxic effect of those gases." Decedent's underlying coronary atherosclerosis was a significant contributing factor. Furthermore, Dr. Kosnett persuasively explained that the environment in which Decedent was found, along with the timing of when he was exposed, strongly support that the toxic and oxygen deprived environment was the cause of death. The Drager gas monitor data revealed an oxygen deficient environment that causes rapid decline in arterial oxygen saturation and reduces oxygen delivery to the heart. The process results in acute hypoxia and releases adrenalin. The adrenalin further stresses the heart by increasing heart rate and blood pressure. The sequence of events can ultimately cause sudden cardiac death. Dr. Kosnett explained that the hydrocarbon exposure put Decedent at further risk because of their propensity to cause ventricular fibrillation. Based on the totality of the evidence Dr. Kosnett agreed with forensic pathologists doctors Wilkerson and Martin that Decedent perished due to an oxygen deficient and elevated hydrocarbon environment. Notably, Ms. Merchant testified that the Drager gas monitor was calibrated consistent with manufacturer's recommendations on March 12, 2014 and was bump tested on July 7, 2014. She summarized that there is no question based on the monitor readings that significant exposures occurred and Decedent was subjected to a low oxygen and elevated hydrocarbon environment on July 13, 2014. Finally, Dr. Rubinstein noted that the autopsy revealed no signs of myocardial infarction or heart attack and the blood toxicology results contained increased levels of benzene, thiosulfate and hydrocarbons. Dr. Rubinstein concurred with Drs. Wilkerson, Martin, and Kosnett that Decedent died because the low oxygen environment caused low oxygen saturation and ultimately unconsciousness and death. Based on Decedent's cardiac condition evident from the autopsy, Dr. Rubinstein determined that Decedent was predisposed to death from low oxygen levels and hydrocarbon exposure.

46. In contrast, Dr. Cetaruk testified that the available evidence is unreliable and insufficient to conclude that Decedent died as a result of a toxicological exposure. He thus determined that it is not possible to draw any conclusions from the results regarding the levels of hydrocarbons in Decedent's blood at the time of death. Dr. Cetaruk commented that the evidence also does not reveal any persistently low oxygen levels. Rather, the values are variable and would be anticipated in a transiently gaseous environment. Dr. Cetaruk thus concluded that Decedent's heart disease constitutes a reasonable alternative diagnosis. Moreover, Dr. Bateman concluded that the most probable cause of Decedent's death was a cardiac arrhythmia or sudden cardiac event that was most likely a ventricular fibrillation. She remarked that the autopsy report revealed Decedent had severe obstructive coronary artery disease including 90% lesions of two out of the three major coronary vessels and 100% blockages in smaller vessels. Dr. Bateman summarized that, to a reasonable degree of medical probability Decedent had sudden cardiac death due to his multiple risk factors

and severe coronary artery disease. Finally, Mr. Rasmuson explained that the Drager gas monitor printout data did not provide an accurate representation of any potential toxic exposure. After the monitor was turned off at 12:15:56 on July 13, 2014 there is no information regarding concentration of gases in the air.

47. Despite the reports and testimony of Dr. Cetaruk, Dr. Bateman and Mr. Rasmuson, the bulk of the persuasive evidence reflects that Decedent's exposure to a low oxygen and high hydrocarbon environment on July 13, 2014 aggravated, accelerated or combined with his pre-existing coronary artery disease to cause his death. The testimony of Dr. Cetaruk, Dr. Bateman and Mr. Rasmussen suggests that Decedent may not have been exposed to a low oxygen and high hydrocarbon environment and instead suffered a sudden cardiac death based on his multiple pre-existing risk factors. However, in the absence of monitor data at the exact time of Decedent's death, the data earlier on the day of his death reveals that he was working in a low oxygen and high hydrocarbon environment with an open thief hatch on top of an oil tank. The most reasonable inference in the absence of data at the time of death, in conjunction with the location of Decedent's death and the persuasive reports and testimony of Drs. Wilkerson, Martin, Kosnett and Rubenstein, is that Decedent's work environment aggravated, accelerated or combined with his pre-existing coronary condition to cause his death.

48. Respondents assert that Decedent willfully violated two safety rules prior to his death on July 13, 2014 and seek a 50% reduction in Claimant's death benefits. Respondents first contend that Decedent failed to open multiple blow down valves and thief hatches prior to sampling or gauging the oil tank on July 13, 2014. Second, Respondents assert that Decedent failed to remove himself from a hazardous environment when his monitor alarm sounded on July 13, 2014. However, the persuasive evidence demonstrates that Respondents have not proven that it is more probably true than not that Decedent willfully failed to obey a safety rule in violation of §8-42-112(1)(b) C.R.S. on July 13, 2014.

49. Mr. Mulkey explained that drivers are instructed to open multiple blow down valves, beginning downwind of the tank to be gauged, and move back upwind. The procedure also instructs the driver to open multiple thief hatches starting downwind of the tank to be gauged. The driver then waits a sufficient period of time to allow the pressure to equalize, or a minimum of three minutes, prior to opening the thief hatch on the tank to be gauged. However, it is unclear from the evidence whether Decedent failed to open multiple blow down valves and thief hatches prior to sampling or gauging the oil tank on July 13, 2014. More specifically, Respondents did not produce persuasive evidence that Decedent failed to open multiple thief hatches or blow down valves on July 13, 2014. In fact, it is unclear whether there are multiple blow down valves or thief hatches at the Gaddis facility where Decedent was working on July 13, 2014. Furthermore, Decedent's actions could have resulted from thoughtlessness or negligence. Based on the circumstantial evidence it is speculative to infer that Decedent acted with deliberate intent in failing to open multiple blow down valves or thief hatches at the Gaddis facility on the date of his death. Accordingly Respondents have failed to sustain their burden that Decedent acted willfully in failing to open multiple

blow down valves and thief hatches while sampling or gauging an oil tank on July 13, 2014.

50. Mr. Holt explained that when an over range alarm occurs, the driver is taught to descend the tank, turn the monitor off and back on, and then return to the top of the tank. Mr. Mulkey noted that another employee had been disciplined for failing to properly remove himself from a contaminated area in response to an alarm. However, Respondents have failed to provide persuasive evidence that Decedent's failure to remove himself from the area was willful. Mr. Morales described Decedent's state during the June 25, 2014 exposure as unresponsive, confused, making nonsensical hand motions with mucous streaming from his nose. Considering the magnitude of the July 13, 2014 exposure, it is likely that Decedent's judgment was similarly impaired. Second, Drs. Kosnett and Rubinstein testified that exposures to low oxygen and high hydrocarbons causes dizziness and confusion. Dr. Bateman remarked that individuals experiencing arrhythmias present standing up but are otherwise confused and semi-responsive. It is thus more likely that Decedent's actions in failing to remove himself from a hazardous environment when his monitor alarm sounded was the product of mere thoughtlessness or negligence. Accordingly, Respondents have failed to sustain their burden that Decedent acted with deliberate intent in failing to remove himself from the low oxygen and high hydrocarbon environment on July 13, 2014.

### **CONCLUSIONS OF LAW**

1. The purpose of the "Workers' Compensation Act of Colorado" (Act) is to assure the quick and efficient delivery of disability and medical benefits to injured workers at a reasonable cost to employers, without the necessity of any litigation. §8-40-102(1), C.R.S. A claimant in a Workers' Compensation claim has the burden of proving entitlement to benefits by a preponderance of the evidence. §8-42-101, C.R.S. A preponderance of the evidence is that which leads the trier-of-fact, after considering all of the evidence, to find that a fact is more probably true than not. *Page v. Clark*, 197 Colo. 306, 592 P.2d 792 (1979); *People v. M.A.*, 104 P.3d 273, 275 (Colo. App. 2004). The facts in a Workers' Compensation case are not interpreted liberally in favor of either the rights of the injured worker or the rights of the employer. §8-43-201, C.R.S. A Workers' Compensation case is decided on its merits. §8-43-201, C.R.S.

2. The Judge's factual findings concern only evidence that is dispositive of the issues involved; the Judge has not addressed every piece of evidence that might lead to a conflicting conclusion and has rejected evidence contrary to the above findings as unpersuasive. See *Magnetic Engineering, Inc. v. ICAO*, 5 P.3d 385, 389 (Colo. App. 2000).

3. When determining credibility, the fact finder should consider, among other things, the consistency or inconsistency of the witness's testimony and actions; the reasonableness or unreasonableness (probability or improbability) of the testimony and actions; the motives of the witness; whether the testimony has been contradicted; and bias, prejudice, or interest. See *Prudential Insurance Co. v. Cline*, 98 Colo. 275, 57 P.2d 1205 (1936); *CJI*, Civil 3:16 (2007).

## Compensability

4. For a claim to be compensable under the Act, a claimant has the burden of proving that he suffered a disability that was proximately caused by an injury arising out of and within the course and scope of employment. §8-41-301(1)(c) C.R.S.; *In re Swanson*, W.C. No. 4-589-645 (ICAP, Sept. 13, 2006). Proof of causation is a threshold requirement that an injured employee must establish by a preponderance of the evidence before any compensation is awarded. *Faulkner v. Industrial Claim Appeals Office*, 12 P.3d 844, 846 (Colo. App. 2000); *Singleton v. Kenya Corp.*, 961 P.2d 571, 574 (Colo. App. 1998). The question of causation is generally one of fact for determination by the Judge. *Faulkner*, 12 P.3d at 846.

5. A pre-existing condition or susceptibility to injury does not disqualify a claim if the employment aggravates, accelerates, or combines with the pre-existing condition to produce a need for medical treatment. *Duncan v. Industrial Claim Appeals Office*, 107 P.3d 999, 1001 (Colo. App. 2004). However, when a claimant experiences symptoms while at work, it is for the ALJ to determine whether a subsequent need for medical treatment was caused by an industrial aggravation of the pre-existing condition or by the natural progression of the pre-existing condition. *In re Cotts*, W.C. No. 4-606-563 (ICAP, Aug. 18, 2005).

6. As found, Claimant has demonstrated by a preponderance of the evidence that Decedent's July 13, 2014 death occurred during the course and scope of his employment with Employer and she is thus entitled to receive death benefits pursuant to §§8-42-114 & 8-42-115 C.R.S. On July 13, 2014 Decedent was found unresponsive on top of a crude oil production tank while performing his job duties for Employer. He was pronounced dead at the scene. The medical records reflect that Decedent had significant pre-existing co-morbid medical conditions. He had long term, poorly controlled Type II diabetes. Decedent was also treated for hypertension and hypercholesterolemia. From March 2013 to April 29, 2014 Decedent's triglyceride levels rose from 1650 to 1686 or in the "Upper Panic" level. The autopsy report revealed Decedent had severe obstructive coronary artery disease including 90% lesions of two out of the three major coronary vessels and 100% blockages in smaller vessels. Despite Decedent's significant pre-existing coronary artery disease the persuasive medical evidence reveals that Decedent died as a result of the low oxygen and high hydrocarbon environment while gauging oil tanks. His job duties and work environment aggravated, accelerated or combined with his pre-existing coronary artery disease to cause his death on July 13, 2014.

7. As found, Dr. Wilkerson persuasively concluded that Decedent's pre-existing cardiovascular disease rendered him unable to survive the toxic environment he encountered on July 13, 2014. He stated that without the exposure Decedent would not have died when he did. Because Decedent already had limited capacity to oxygenate his heart muscle due to atherosclerosis, he could not tolerate the reduced oxygen environment caused by oxygen displacing hydrocarbons. Moreover, Dr. Martin concluded that Decedent's cause of death was "cardiopulmonary arrest due to asphyxia by O<sub>2</sub> displacement by gases and/or the direct toxic effect of those gases." Decedent's

underlying coronary atherosclerosis was a significant contributing factor. Furthermore, Dr. Kosnett persuasively explained that the environment in which Decedent was found, along with the timing of when he was exposed, strongly support that the toxic and oxygen deprived environment was the cause of death. The Drager gas monitor data revealed an oxygen deficient environment that causes rapid decline in arterial oxygen saturation and reduces oxygen delivery to the heart. The process results in acute hypoxia and releases adrenalin. The adrenalin further stresses the heart by increasing heart rate and blood pressure. The sequence of events can ultimately cause sudden cardiac death. Dr. Kosnett explained that the hydrocarbon exposure put Decedent at further risk because of their propensity to cause ventricular fibrillation. Based on the totality of the evidence Dr. Kosnett agreed with forensic pathologists doctors Wilkerson and Martin that Decedent perished due to an oxygen deficient and elevated hydrocarbon environment. Notably, Ms. Merchant testified that the Drager gas monitor was calibrated consistent with manufacturer's recommendations on March 12, 2014 and was bump tested on July 7, 2014. She summarized that there is no question based on the monitor readings that significant exposures occurred and Decedent was subjected to a low oxygen and elevated hydrocarbon environment on July 13, 2014. Finally, Dr. Rubinstein noted that the autopsy revealed no signs of myocardial infarction or heart attack and the blood toxicology results contained increased levels of benzene, thiosulfate and hydrocarbons. Dr. Rubinstein concurred with Drs. Wilkerson, Martin, and Kosnett that Decedent died because the low oxygen environment caused low oxygen saturation and ultimately unconsciousness and death. Based on Decedent's cardiac condition evident from the autopsy, Dr. Rubinstein determined that Decedent was predisposed to death from low oxygen levels and hydrocarbon exposure.

8. As found, in contrast, Dr. Cetaruk testified that the available evidence is unreliable and insufficient to conclude that Decedent died as a result of a toxicological exposure. He thus determined that it is not possible to draw any conclusions from the results regarding the levels of hydrocarbons in Decedent's blood at the time of death. Dr. Cetaruk commented that the evidence also does not reveal any persistently low oxygen levels. Rather, the values are variable and would be anticipated in a transiently gaseous environment. Dr. Cetaruk thus concluded that Decedent's heart disease constitutes a reasonable alternative diagnosis. Moreover, Dr. Bateman concluded that the most probable cause of Decedent's death was a cardiac arrhythmia or sudden cardiac event that was most likely a ventricular fibrillation. She remarked that the autopsy report revealed Decedent had severe obstructive coronary artery disease including 90% lesions of two out of the three major coronary vessels and 100% blockages in smaller vessels. Dr. Bateman summarized that, to a reasonable degree of medical probability Decedent had sudden cardiac death due to his multiple risk factors and severe coronary artery disease. Finally, Mr. Rasmuson explained that the Drager gas monitor printout data did not provide an accurate representation of any potential toxic exposure. After the monitor was turned off at 12:15:56 on July 13, 2014 there is no information regarding concentration of gases in the air.

9. As found, despite the reports and testimony of Dr. Cetaruk, Dr. Bateman and Mr. Rasmuson, the bulk of the persuasive evidence reflects that Decedent's exposure to a low oxygen and high hydrocarbon environment on July 13, 2014

aggravated, accelerated or combined with his pre-existing coronary artery disease to cause his death. The testimony of Dr. Cetaruk, Dr. Bateman and Mr. Rasmussen suggests that Decedent may not have been exposed to a low oxygen and high hydrocarbon environment and instead suffered a sudden cardiac death based on his multiple pre-existing risk factors. However, in the absence of monitor data at the exact time of Decedent's death, the data earlier on the day of his death reveals that he was working in a low oxygen and high hydrocarbon environment with an open thief hatch on top of an oil tank. The most reasonable inference in the absence of data at the time of death, in conjunction with the location of Decedent's death and the persuasive reports and testimony of Drs. Wilkerson, Martin, Kosnett and Rubenstein, is that Decedent's work environment aggravated, accelerated or combined with his pre-existing coronary condition to cause his death.

### *Safety Rule Violation*

10. Section 8-42-112(1)(b) C.R.S. authorizes a fifty percent reduction in compensation for an employee's "willful failure to obey any reasonable rule adopted by the employer for the safety of the employee." A safety rule does not have to be either formally adopted or in writing to be effective. *Lori's Family Dining, Inc. v. Industrial Claim Appeals Office*, 907 P.2d 715, 719 (Colo. App. 1995). To establish that a violation of §8-42-112(1)(b), C.R.S. has been willful, a respondent must prove by a preponderance of the evidence that a claimant acted with "deliberate intent." *In re Alverado*, W.C. No. 4-559-275 (ICAP, Dec. 10, 2003). Willful conduct may be proven by circumstantial evidence including "evidence of frequent warnings, the obviousness of the risk, and the extent of deliberation evidenced by claimant's conduct." *Id.*

11. Respondents need not establish that an employee had the safety rule in mind and decided to break it. *In re Alverado*, W.C. No. 4-559-275 (ICAP, Dec. 10, 2003). Rather, it is sufficient to show the employee knew the rule and deliberately performed the forbidden act. *Id.* However, willfulness will not be established if the conduct is the result of thoughtlessness or negligence. *In re Bauer*, W.C. No. 4-495-198 (ICAO, Oct. 20, 2003). "Willfulness" also does not encompass "the negligent deviation from safe conduct dictated by common sense." *In re Gutierrez*, W.C. No. 4-561-352 (ICAP, Apr. 29, 2004). Whether an employee has deliberately violated a safety rule is a question of fact to be determined by the ALJ. *Lori's Family Dining, Inc.*, 907 P.2d at 719.

12. As found, Respondents assert that Decedent willfully violated two safety rules prior to his death on July 13, 2014 and seek a 50% reduction in Claimant's death benefits. Respondents first contend that Decedent failed to open multiple blow down valves and thief hatches prior to sampling or gauging the oil tank on July 13, 2014. Second, Respondents assert that Decedent failed to remove himself from a hazardous environment when his monitor alarm sounded on July 13, 2014. However, the persuasive evidence demonstrates that Respondents have not proven by a preponderance of the evidence that Decedent willfully failed to obey a safety rule in violation of §8-42-112(1)(b) C.R.S. on July 13, 2014.

13. As found, Mr. Mulkey explained that drivers are instructed to open multiple blow down valves, beginning downwind of the tank to be gauged, and move back upwind. The procedure also instructs the driver to open multiple thief hatches starting downwind of the tank to be gauged. The driver then waits a sufficient period of time to allow the pressure to equalize, or a minimum of three minutes, prior to opening the thief hatch on the tank to be gauged. However, it is unclear from the evidence whether Decedent failed to open multiple blow down valves and thief hatches prior to sampling or gauging the oil tank on July 13, 2014. More specifically, Respondents did not produce persuasive evidence that Decedent failed to open multiple thief hatches or blow down valves on July 13, 2014. In fact, it is unclear whether there are multiple blow down valves or thief hatches at the Gaddis facility where Decedent was working on July 13, 2014. Furthermore, Decedent's actions could have resulted from thoughtlessness or negligence. Based on the circumstantial evidence it is speculative to infer that Decedent acted with deliberate intent in failing to open multiple blow down valves or thief hatches at the Gaddis facility on the date of his death. Accordingly Respondents have failed to sustain their burden that Decedent acted willfully in failing to open multiple blow down valves and thief hatches while sampling or gauging an oil tank on July 13, 2014.

14. As found, Mr. Holt explained that when an over range alarm occurs, the driver is taught to descend the tank, turn the monitor off and back on, and then return to the top of the tank. Mr. Mulkey noted that another employee had been disciplined for failing to properly remove himself from a contaminated area in response to an alarm. However, Respondents have failed to provide persuasive evidence that Decedent's failure to remove himself from the area was willful. Mr. Morales described Decedent's state during the June 25, 2014 exposure as unresponsive, confused, making nonsensical hand motions with mucous streaming from his nose. Considering the magnitude of the July 13, 2014 exposure, it is likely that Decedent's judgment was similarly impaired. Second, Drs. Kosnett and Rubinstein testified that exposures to low oxygen and high hydrocarbons causes dizziness and confusion. Dr. Bateman remarked that individuals experiencing arrhythmias present standing up but are otherwise confused and semi-responsive. It is thus more likely that Decedent's actions in failing to remove himself from a hazardous environment when his monitor alarm sounded was the product of mere thoughtlessness or negligence. Accordingly, Respondents have failed to sustain their burden that Decedent acted with deliberate intent in failing to remove himself from the low oxygen and high hydrocarbon environment on July 13, 2014.

## **ORDER**

Based upon the preceding findings of fact and conclusions of law, the Judge enters the following order:

1. Claimant has demonstrated that Decedent's July 13, 2014 death occurred during the course and scope of his employment with Employer and she is thus entitled to receive death benefits pursuant to §§8-42-114 & 8-42-115 C.R.S.

2. Respondents have failed to prove that Decedent willfully failed to obey a safety rule in violation of §8-42-112(1)(b) C.R.S. on July 13, 2014.

3. Decedent earned an AWW of \$1007.00.

4. Respondents shall pay the statutory maximum for Decedent's funeral expenses pursuant to §8-42-123 C.R.S.

5. Claimant is Decedent's sole dependent for purposes of receiving death benefits pursuant to §§8-42-114 & 8-42-115 C.R.S.

6. Any issues not resolved in this order are reserved for future determination.

If you are a party dissatisfied with the Judge's order, you may file a Petition to Review the order with the Denver Office of Administrative Courts, 1525 Sherman Street, 4th Floor, Denver, CO 80203. You must file your Petition to Review within twenty (20) days after mailing or service of the order, as indicated on certificate of mailing or service; otherwise, the Judge's order will be final. You may file the Petition to Review by mail, as long as the certificate of mailing attached to your petition shows: (1) That you mailed it within twenty (20) days after mailing or service of the order of the Judge; and (2) That you mailed it to the above address for the Denver Office of Administrative Courts. *For statutory reference, see section 8-43-301(2), C.R.S. (as amended, SB09-070). For further information regarding procedures to follow when filing a Petition to Review, see Rule 26, OACRP. You may access a form for a petition to review at <http://www.colorado.gov/dpa/oac/forms-WC.htm>.*

DATED: July 6, 2015.

DIGITAL SIGNATURE:  


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Peter J. Cannici  
Administrative Law Judge  
Office of Administrative Courts  
1525 Sherman Street, 4<sup>th</sup> Floor  
Denver, CO 80203