Award No. 40
Case No. 40

PUBLIC LAW BOARD NO. 7120

PARTIES TO DISPUTE: (BROTHERHOOD OF MAINTENANCE OF WAY
(EMPLOYES DIVISION
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(CSX TRANSPORTATION, INC.

STATEMENT OF CHARGE:

By letter dated July 29, 2008, from D. L. McCarty, Manager System Production Team Operations, R. S. Swafford ("the Claimant") was notified to attend a formal Investigation in Nashville, Tennessee, on August 13, 2008, "to ascertain the facts and determine your responsibility, if any, in connection with information that I received on July 17, 2008 from Lisa Gray (Manager Safety Department) concerning your alleged injury incident that occurred on the R1 System Rail Team. She informed me," the letter continued, "that she had obtained medical information concerning your alleged incident where you admitted to an attending physician that you were having problems for four weeks with your leg prior to the alleged injury incident." The letter stated that the Claimant was "charged with failure to properly and safely perform the responsibilities of your assignment, conduct unbecoming a CSX employee and possible falsification of an injury." Further, "there may have been a violation [of] CSX Operating Rules, Safety Rules, and Procedures," the letter proceeded, and the "purpose of the formal investigation will be to discover whether or not any rules were violated." By mutual agreement of the parties the hearing was postponed until October 9, 2008.

FINDINGS:

Public Law Board No. 7120, upon the whole record and all the evidence, finds that:

The carrier or carriers and the employee or employees involved in this dispute are respectively carrier and employee within the meaning of the Railway Labor Act, as approved June 21, 1934.

The Board has jurisdiction over the dispute involved herein.

Parties to said dispute were given due notice of hearing thereon.

The Claimant was hired by the Carrier on June 16, 1976, and in June, 2008, was working as a Machine Operator on a System Production Gang. He became sick at work on June 3, 2008. He was working in temperature of around 100 degrees Fahrenheit and thought that he had heat exhaustion. He reported his condition to his supervisor who arranged for the Claimant to be taken to the Regional Hospital of Jackson, Tennessee.

At first the Claimant was seen in the emergency room. The emergency room doctor determined that the Claimant's condition warranted hospitalization, and sometime after midnight he was admitted to the hospital. He remained hospitalized until June 7, 2008, when he was released with antibiotic medications to be taken for ten days.

The Carrier sent Supervisor Shelton Tackett and Assistant Foreman and Timekeeper Kenneth Richard Radford to look after the Claimant's interests while hospitalized and to have him fill out an Employee's Injury And/Or Illness Report Form

PI-1A. Because of his medical condition they were not able to obtain a report from the Claimant the evening of June 3.

The next morning, however, both Supervisor Tackett and Assistant Foreman Radford were permitted to visit the Claimant in his room in the hospital. Supervisor Tackett inquired if the Claimant felt that he was able to fill out the Form PI-1A. The Claimant stated that he felt that he could do it. After the Claimant filled out and signed the form, Mr. Radford looked through it to make sure that all of the entries were filled in. Then Supervisor Tackett witnessed the Claimant's signature. The Claimant dated the form 6-4-08.

On the form, in the space for NATURE OF COMPLAINT, the Claimant wrote "Heat exhaustion." In answer to DESCRIBE MEDICAL/FIRST-AID TREATMENT RECEIVED, the Claimant stated "IV & Shots." In the box for DESCRIBE THE INCIDENT, the Claimant wrote, "Was working lineing [sic] plates got very Hot & went & got dizzy & that's what happen [sic]." The Claimant answered NO to all of the following questions: IS THIS A RECURRENCE?, WAS ANYONE AT FAULT?, DID DEFECTIVE TOOL OR EQUIPMENT CAUSE INCIDENT?, WAS THERE ANY FAILURE TO GIVE USUAL OR NECESSARY SIGNALS, WARNINGS OR PROTECTION? He answered, "Yes," to the question DID EMPLOYEE HAVE A SAFE PLACE IN WHICH TO WORK? To the question WILL INCIDENT RESULT IN LOST WORKDAYS?, the Claimant placed a question mark in the space for the answer.

Assistant Foreman Radford testified that he went back that afternoon to check on the Claimant, and the Claimant said that he would like to fill out another PI-1A. Mr. Radford stated that he believed that it was the next day that he brought a second Form PI-1A to the Claimant. According to Mr. Radford, he gave the form to the Claimant in the morning and said that he would come back in the afternoon to pick it up. He did come back in the afternoon, Mr. Radford stated, and witnessed the Claimant's signature on the form.

The second PI-1A form filled out and signed by the Claimant was dated 6-6-08. In the space for NATURE OF COMPLAINT, the Claimant wrote "Heat Exhaustion & Staff [sic] Infection." For DESCRIBE MEDICAL ATTENTION PROVIDED he stated, "I.V. & shots." For DESCRIBE THE INCIDENT he stated the following:

> Was working line plates while doing this I skinned my left shin But I wiped it off & kept working. Then I got dizzy & crawled up in welding truck to be out of the way. Also the day before we laid 10,000 ft & was 6 men short[.] I may have gotten to [sic] hot then. No gater Ade or Fruit cups.

The Claimant answered "No" to the following questions: IS THIS A RECURRENCE?, DID DEFECTIVE TOOL OR EQUIPMENT CAUSE INCIDENT?, WAS THERE ANY FAILURE TO GIVE USUAL OR NECESSARY SIGNALS, WARNINGS OR PROTECTION? He answered "Yes," however, to the question WAS ANYONE AT FAULT? and to the follow-up question, IF YES, WHO AND TO WHAT EXTENT?, he wrote, "Foreman & Supervisor NOT Having enough manpower."

On the first form the Claimant left a blank in the ADDITIONAL SPACE FOR REPORT INFORMATION, but on the second form he wrote, "All we have had is Squencher [an electrolyte drink]. Since Tues. or my Accident They have plenty of Gaterade & Fruit Bowls." To the question DID EMPLOYEE HAVE A SAFE PLACE IN WHICH TO WORK?, the Claimant answered "Yes."

Assistant Foreman Radford was asked by the Claimant's representative if, when he went to the hospital on the morning of June 4th, the Claimant was on any kind of medication. He stated, "He was on some kind of medication they got a bag that they were putting the medication in." Asked whether the Claimant seemed like himself, Mr. Radford answered, "Uh no. That could be wishy-washy I mean he felt, talked like hisself and said he was still hurting." The Claimant's representative then asked Mr. Radford if it was "possible that by Mr. Swafford being on this medication the next morning that there [was] a probability that he took that uh, not knowing what he was doing when he filled out the PI-1A." He answered, "Yes."

Asked whether "before the incident happened on June 3, '08 have you had any problems with Mr. Swafford," Mr Radford answered, "No." The Claimant, Mr. Radford testified, showed up every day for work. "He did his work," Mr. Radford testified. Mr. Radford's attention was called to the statement on the second PI-1A form, "Was working line plates while doing this I skinned my left shin," and asked whether at the time that the Claimant put that on the form he (Mr. Radford) or Supervisor Tackett took exception to

it. Mr. Radford stated, "No."

D. L. McCarty Jr., Manager of Program Construction on the Atlanta Division and formerly Manager System Production Team Operations, testified that on July 14, 2008, Lee Miller called him and said that the Claimant had contacted him concerning an advancement on a claim of an alleged injury on June 3, 2008. Mr. McCarty had been told that the hospital had mailed a medical form called CJ-24 to the Claimant's home. The same day, July 14, 2008, Mr. McCarty sent a certified letter to the Claimant stating that on June 3, 2008, "you were transported for medical attention concerning a Non Occupational Illness and the Carrier was informed that the medical form, CJ-24, was mailed to you by the treating physician." The letter requested the Claimant to fax the paperwork to Mr. McCarty within five days of receipt of the letter.

After receipt of the letter, Mr. McCarty testified, the Claimant called him on or about July 16th and said that the paperwork had been sent to the Carrier's Medical Department. The Claimant told Mr. McCarty that he would get in touch with the hospital for them to get the paperwork to him. On July 17, 2008, Lisa Gray of the Safety Department called and informed Mr. McCarty that she had some medical paperwork regarding the incident that she had received from the Medical Department.

Mr. McCarty testified that he examined the medical reports from the hospital to see if he had to change the reporting he had previously entered for the Claimant's hospitalization as a nonoccupational hospitalization. Mr. McCarty explained that

employees cannot self-diagnose and that, in the absence of medical paperwork, he had classified the Claimant's hospitalization as nonoccupational. The medical documentation from the hospital that Mr. McCarty obtained from the Carrier's Medical Department stated as follows:

> ADMISSION DATE: 06/04/2008
>
> HISTORY AND PHYSICAL
>
> HISTORY OF PRESENTING ILLNESS: The patient is a 53-year old Caucasian male who was admitted for chest pain intermittently with headache. He also complained of fever. He initially thought he was under too much heat and was the reason why he was running a fever. He had a little cough. He denied abdominal pain, nausea, vomiting, diarrhea, but while talking to him he then told me that he has had swelling in his left leg for the past 4 weeks. Initially said he did not know how long he has had it but on further questioning, he said 4 weeks. He denied dysuria.
>
> PAST MEDICAL HISTORY: Hypertension, has had traumatic subdural hematoma.
>
> SURGICAL HISTORY: Tonsillectomy, appendectomy, craniotomy, and hematoma evacuation. 2 years ago.
>
> * * *
>
> REVIEW OF SYSTEMS: Positive for fever, headache, difficulty walking. Denies shortness of breath, cough, chest pain, palpitations, PND. Denied nausea, vomiting, diarrhea, abdominal pain. The rest of the review of systems negative.
>
> PHYSICAL EXAM
> GENERAL: Middle-aged male who is not in acute distress, very febrile, temperature 102, not pale, anicteric.
> VITAL SIGNS: Temperature 102 degrees, blood pressure 154/69.
> HEENT: Normocephalic. No trauma seen.
> CHEST: Clear to auscultation bilaterally.

CARDIOVASCULAR: Regular S1, S2. No murmur, no regurgitation.
* * *
EXTREMITIES: No pedal edema. No calf tenderness. There is a local swollen area on the anterior part of the left leg about 6 x 6 cm, erythematous, swollen, tender, and warm to touch, not fluctuant.
SKIN: Normal color. Warm and dry.
NEUROLOGICAL: Alert and oriented to time, person, and place. Cranial nerves II-XII intact. Grip symmetrical. No focal deficit.

LABS: White count 15,000. Cardiac enzymes negative. Urinalysis negative. Chest x-ray: No acute infiltrate. . . .

ASSESSMENT
1. Fever/left leg cellulitis.

PLAN: Obtain blood cultures, start antibiotic coverage for MRSA with vancomycin and Zosyn, antipyretic medication.

2. Chest pain. Patient ruled out with cardiac enzymes.

DISCHARGE DATE: 06/07/2008

DISCHARGE SUMMARY

FINAL DIAGNOSES
1. Left leg cellulitis.
2. Hypertension.

BRIEF HISTORY AND HOSPITAL COURSE: The patient is a 53-year -old male who was admitted with fever and left leg swelling. He does not remember any insect bite or spider bite. He said all of a sudden his left leg started getting swollen and started having fever in it and became very painful. Has a history of hypertension. On admission temperature was 102.0. Blood pressure was 154/69. The lower left leg was swollen especially in the anterior part was erythematous, tender and warm to touch. White count was 15,000 at the time. Blood cultures were taken. IV antibiotics with MRSA coverage was given to him. He started getting better and the next day temperature was coming down but still high and today he is feeling much better. Fever has broken. Will discharge him on Septra DS for the next 10 days. Asked him to follow with his primary care.

CONDITION: Stable

DISPOSITION: Home

MEDICATIONS: Septra DS 1 b.i.d. for 10 days, metoprolol 50 mg b.i.d.

One thing that concerned him in the medical documentation, Mr. McCarty stated, was that the chief complaint that was stated by the Claimant to the medical facility was "chest pain on and off." After reading "HISTORY OF PRESENTING ILLNESS" on the medical report and the two Form P I-1As submitted by the Claimant, Mr. McCarty testified, "I determined that Mr. Swafford after he was communicating with the claim agent requesting monetary compensation it was my assumption that Mr. Swafford was trying to defraud CSX out of money for a false claim of an injury and that's when I proceeded to charge Mr. Swafford." He then called the Claimant, he stated, and instructed him that he was removing him from service. The Claimant asked Mr. McCarty why. Mr. McCarty, according to his testimony, told the Claimant that he was trying to defraud CSX out of money for an alleged injury that it looks like he had had problems with four weeks prior to filling out the form on June 3rd.

Lee Allen Miller, Manager of Field Investigations, testified that on July 2, 2008, he received a telephone call from the Claimant who said that he had been off—"I believe he said two to three months"—injured and in need of financial assistance. He wanted to meet with Mr. Miller and see if there was something that Miller could do to help hm out. Mr. Miller, according to his testimony, told the Claimant "that that was the first

knowledge that I had that he had been injured but I'd be glad to and try to work with him and see what was going on."

Mr. Miller told the Claimant that he needed medical documentation supporting the fact that the Claimant was off for a work-related injury. In addition, Mr. Miller told the Claimant that he would have to interview him and needed a copy of the personal injury report. In the next couple of weeks, according to Mr. Miller, after the Claimant filled out a release form, he was able to get medical documentation from the hospital, which he forwarded to the CSX Medical Department. After the CSX Medical Department and CSX Safety Department reviewed the documentation, Mr. Miller testified, "they let me know that it was not a work related injury that it was more a medical condition."

Before he got the word back that his condition was not a work-related injury, Mr. Miller stated, he told the Claimant that he had received everything that he needed and had forwarded it to Medical in Jacksonville and was waiting to hear back from them. Mr. Miller believed he had that conversation with the Claimant on a Thursday and that the next day the Safety Department representative indicated that it was not work-related. When he got back to the office the next Monday, Mr. Miller testified, the Claimant had left him a message saying "if I could help him out, great, if I couldn't that's fine too."

The Claimant testified that his position with CSX is Machine Operator and that he has held that position off and on for 32 years. Asked by the hearing officer to state the facts, the Claimant testified as follows. He got injured on June 3rd and filled out the

accident report to the best of his knowledge. Both PI-1A forms were filled out and signed by him on the dates shown on the forms. After they were completed he gave both forms to Mr. Radford. The reason that he wrote on the second form and not the first that he skinned his left shin was that "Due to my medical conditions, I didn't remember filling out the first one. Then when I was informed I filled out the first one because I didn't know nothing about PI list thing, the infection until the next day." When he wrote "staff infection" on the second form, he meant "staph infection."

The reason that on the second form he wrote that the foreman and the supervisor were at fault but not on the first form, the Claimant testified, was that he was clear headed. Asked by the hearing officer whether it was his testimony that he had no knowledge of filling out the first PI-1A, the Claimant stated, "Well my condition that morning was very, very vague. I don't remember."

Asked when he decided to do a second PI-1A, the Claimant stated, "When my medical condition got better." Until he got better, the Claimant testified, his fever was 102.8 and he was being given Demerol and morphine continuously in his IV. At the time he filled out the second PI-1A, the Claimant testified, the nurses had told him what was wrong.

When he contacted Mr. Miller of the Claims Department, the Claimant testified, he knew of the diagnoses of staph infection and heat exhaustion, but he did not know if it was reportable. He did not tell Mr. Miller his diagnosis, the Claimant stated. He (Mr.

Miller), according to the Claimant, had to find that out himself. The Claimant was asked by the hearing officer, "Okay, were you aware that the doctor didn't diagnose you with heat exhaustion he diagnosed you with left leg cellulitis and hypertension." The Claimant answered, "None of this was made aware to me." The Claimant was again asked, "Okay so at the time you talked to Mr. Miller you were not aware of what doctor had diagnosed you with—that is discharged you in June?" He answered, "I wasn't aware. I had not been told whether it was reportable or non reportable."

The Claimant testified that he did not tell Mr. Miller that he had been off two months. "I told him," the Claimant stated, "I'd been off 5 weeks, that was the fifth week and that the reason I called him, I'd been off for brain surgery in 2006 and I couldn't go draw no check off of disability. And I was behind on my rent and my alimony and needed some help." After that conversation, the Claimant testified, they had one more. Then, the Claimant stated, he got the July 14 letter from Mr. McCarty that it was unreportable, and he had no more calls with Mr. Miller.

The Claimant testified that he did not remember making the statement to the doctor that he had swelling in his left leg for the past four weeks and that initially he said that he did not know how long he had the swelling. Asked if in his opinion he ever tried to defraud the company out of any money, the Claimant testified, "No, sir, I have not."

The hearing officer asked the Claimant whether he had had any problems with his left leg for the four weeks preceding the incident. He answered, "No. The job I had was

lining plates and you have to do it while walking." The Claimant testified that he did not have the medical records in his personal possession, that he had to release them from Jackson Hospital to Mr. Miller, and that he had not seen them previously.

Regarding the skinning of his shin on June 3rd, the Claimant testified, "We had a box down on the plate . . . and it hit me in the shin and skinned and I just took a paper towel out of my back pocket and wiped it off and it was skinned up a little bit and that's all I did and went on down the road."

In follow-up questioning the hearing officer explored with the Claimant the condition of his left leg prior to June 3, 2008:

Q. And it's your contention that these documents are in error when it says you told them you'd been having trouble with your left leg for four weeks prior?

A. I don't remember making that statement.

Q. But it is not true that you had had trouble with your leg four weeks prior . . .

A. . . . Right . . .

Q. . . . that's your contention?

A. uh, well, I couldn't a done my job with leg looking like that. (Long pause) I don't know if you've ever lined plates before but it's a job you have to be moving all the time.

Following the hearing, by letter dated October 28, 2008, L. E. Houser, Assistant Chief Engineer System Production, informed the Claimant of his decision on the charges as follows:

> Upon review of the transcript, the facts support and confirm that the charges placed against you were valid and proven. Based on evidence and testimony from the witnesses and yourself during the course of this hearing, sufficient proof exists to demonstrate that you were guilty of the infractions upon which you were charged and that your actions clearly violated CSX Operating Rules, Safety Rules, and procedures.
>
> Through this review, and because all charges assessed were properly proven, it is my decision that the discipline to be assessed is your immediate dismissal in all capacities from CSX Transportation.

The Carrier contends that the Claimant was provided a fair and impartial investigation, that it produced substantial evidence of the Claimant's guilt, and that the discipline assessed was fully justified. It notes the Organization's contention that the proceeding was not fair because Mr. McCarty was the charging officer and had had conversations and interactions with the Claimant and argues that this did not affect the fairness of the hearing.

On the merits the Carrier contends that it rightfully determined that the Claimant was guilty as charged when he submitted two different PI-1A forms and then sought monies from a claim agent for an on-duty injury. The Carrier asserts that the Claimant's testimony was convoluted and that he was inconsistent in answering questions. As an example of an inconsistency, it notes his testimony that he was injured on June 3, 2008, and further testimony that his diagnosed condition was a medical condition and not an injury.

The Carrier asserts that the Claimant said that he was not aware of the medical

diagnosis of leg cellulitis and hypertension before contacting claim agent Miller but admitted calling Mr. Miller and advising him that he had been off work five weeks for an on-duty injury, being behind in his alimony, and needing some help. There was a major discrepancy between the testimony of the Carrier witnesses and Claimant Stafford, the Carrier argues, and it is well-established that an appellate body will uphold the deciding tribunal's credibility determinations. Dismissal, the Carrier contends, was appropriate discipline for falsifying an injury report.

The charging letter states that the Claimant is "charged with . . . possible falsification of an injury." The deciding letter of October 28, 2008, states that the charges placed against the Claimant "were valid and proven" and that he was "guilty of the infractions" upon which he was charged. Neither the charge letter or the decision letter, however, states specifically in what way the Claimant falsified an injury.

The Board will consider the two possibilities raised by the evidence presented in the Investigation. One possibility is that the Carrier is claiming that the second PI-1A form submitted by the Claimant was false. The PI-1A form signed and submitted by the Claimant on June 6, 2008, gives heat exhaustion and a staph infection as the NATURE OF COMPLAINT. The history given in the medical report from Regional Hospital of Jackson includes the statement, "He [the Claimant] initially thought he was under too much heat and was the reason why he was running a fever." The doctor's statement shows that the claim of heat exhaustion on the PI-1A form was a true statement in terms

of the Claimant's belief of his condition, that he wrote "heat exhaustion" on the form in good faith.

The Injury Report form also lists staph infection, although, on the form, the Claimant misspelled "staph." He did have a staph infection in the form of cellulitis. Therefore the Claimant was truthful in stating staph infection.

The form also states, "I skinned my left shin." Carrier witness Assistant Foreman and Timekeeper Radford was asked whether at the time the Claimant wrote in the Injury Report that he skinned his left shin either he or Supervisor Tackett took exception to the statement, and he answered, "No." There was no testimony given at the hearing by any Carrier representative that the Carrier believed that statement to be false.

The Claimant gave credible testimony at the hearing how he hit his leg against a box that was sitting on a plate and skinned the leg "a little bit"; and how he then took a paper towel from his back pocket and wiped his leg. In the absence of any allegation in the charge letter, the decision letter, or in the testimony of any witness that the statement in the Injury Report that the Claimant skinned his leg was false, the Board accepts the statement as true. The Board finds that the record does not establish that the Form PI-1A dated June 6, 2008, submitted by the Claimant contained any false statement of fact.[1]

The second possibility is that the Carrier is contending that the Claimant falsified

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[1]The Board makes no finding regarding certain opinions expressed in the document regarding whether anyone was at fault or there was sufficient manpower. Those matters are outside the scope of this proceeding.

an injury by calling Manager of Field Investigations Miller (hereinafter "the Claim Manager"), telling him that he was injured on June 3, 2008, and asking the Claim Manager if he could help him out because he was in need of financial assistance. To prevail on that position the Carrier would have to prove by substantial evidence that the Claimant did not in good faith believe that the condition for which he was hospitalized was related to an occupational injury.

Mr. McCarty testified that after reading the HISTORY OF PRESENTING ILLNESS portion of the medical report from Regional Hospital of Jackson and the two Form PI-1As submitted by the Claimant he concluded that by communicating with the claim agent and requesting monetary compensation, Claimant Swafford was trying to defraud CSX out of money by making a false claim of injury. Mr. McCarty stated that he then called the Claimant and told him that he was removing him from service. The Claimant asked him why, and Mr. McCarty, according to his testimony, told the Claimant that "he [the Claimant] was trying to defraud CSX out of money for an alleged injury that it looks like he had had problems with 4 weeks prior to him going to the document [sic] on June 3rd."

The Board is not persuaded that the medical evidence relied on by Mr. McCarty shows that the Claimant was trying to defraud the Carrier out of money for an injury that never occurred. It is true that the history on the medical report states that the Claimant told the doctor "that he has had swelling in his left leg for the past 4 weeks." However,

the same doctor wrote on the DISCHARGE SUMMARY in the section headed BRIEF HISTORY AND HOSPITAL COURSE, "He said all of a sudden his left leg started getting swollen and started having fever in it and became very painful." That statement would indicate that even if there had been swelling in the leg previously, the swelling increased and the Claimant had new symptoms not previously experienced, namely, significant pain and fever.

From the fact that the Claimant's leg was swollen for four weeks prior to June 3, 2008, the Carrier could not reasonably conclude, without any supporting medical authority, that the new symptoms that he experienced on June 3, 2008, were not brought on by a supervening injury such as the shin injury that the Claimant suffered on that date or the very hot environment in which the Claimant was working.

There is no evidence that the Claimant had a fever prior to June 3. When seen by the doctor on the first day of his hospitalization, however, his temperature was 102 degrees. According to the evidence he worked every day and had to do considerable walking as part of his job. There is no evidence that he had any difficulty walking or had pain in his leg prior to June 3. The hospital medical report, however, on the first page in the part headed REVIEW OF SYSTEMS includes the statement, "difficulty walking" and the BRIEF HISTORY in the discharge summary, as noted, stated that the leg was "very painful." Mr. McCarty provided no explanation why, if the Claimant had leg cellulitis prior to June 3, 2008, he had no fever, pain, or difficulty walking prior to that date.

The Carrier might argue that the disease had taken its normal course over a four-week period and had manifested itself in an acute stage on June 3rd. That might be true, but it might not be true. Only a medical expert could give informative testimony on that question, and there is no evidence that Mr. McCarty possesses that expertise or consulted anyone with such expertise on that question before removing the Claimant from service. Nor was any such expert testimony provided in the record to permit this Board to make such a conclusion.

Without medical evidence on the issue, this Board has no basis for finding that the shin injury suffered by the Claimant or the very hot environment in which he was working on June 3rd was not a contributory cause to his staph infection in the form of cellulitis, even if not the sole cause. Even a contributory cause, if work-related, could arguably be a proper basis for filing a compensation claim.

The issue, however, is not whether the shin injury or the hot environment caused or contributed to the cellulitis. The issue is whether the Claimant as of July 2, 2008 (the date he called the Claim Manager), could reasonably have believed that his June 3-7 hospitalization was work-related. If he had a good faith belief that his medical condition could have been work-related, then he had the right without fear of discipline to call the Claim Manager and inquire if he was entitled to compensation.

As of July 2, 2008, when the Claimant first communicated with the Claim Manager, someone in the Claimant's position could reasonably have believed that he was

injured at work on June 3, 2008, in that he had skinned his shin and, in his own perception, been overcome by heat. Even if we accept that the Claimant's left leg had been swollen for four weeks, and that he was aware of that fact, there is no evidence that he had any acute symptoms during that period such as fever, pain in the leg, or difficulty in walking.

As a layperson, the Claimant could reasonably believe that the events of June 3, namely, the skinning of his left shin and perceived heat exhaustion, brought on the acute symptoms of fever, leg pain, difficulty in walking, and staph infection. The hospital medical report and the Form PI-1As document that the Claimant believed that he had been overcome by heat on June 3rd. There is no evidence that he no longer believed that as of July 2nd.

In addition, in his testimony at the hearing, when asked why he stated on the second form, but not on the first, that he had skinned his left shin, he answered that he did not know about the infection until the next day. (Tr. 61). This indicates that the Claimant associated the shin injury with the infection. In fact, in the absence of medical evidence to the contrary, this Board is not able to rule out the possibility that the shin injury or exposure to the high temperature caused or contributed to the staph infection. It is common knowledge that one can sometimes obtain a severe infection from a slight break in the skin if the required pathogens are on the skin and the body is unable to neutralize them. From the Claimant's description of how he lay in the hospital in his dirty clothes

waiting for a doctor (Tr. 77), one can conclude that he was not working in the most hygienic conditions.

Certainly the skinning of the Claimant's shin was an injury. Heat exhaustion, whether an injury or an illness, could surely be considered occupational if it occurs on the job. It would not be fraudulent to put the question to a Claim Manager as to whether the condition was compensable. According to the Claim Manager's testimony, the Claimant made an inquiry of him as to whether the Claim Manager could help him out. Thus the Claim Manager testified regarding their first conversation:

> He indicated to me that he had been off for – I believe he said two to three months, injured and that he was in need of financial assistance and that he would – he wanted to meet with me and see if there was something I could do to help him out. (Tr. 52).

The Board sees no falsification of an injury in the foregoing account of the conversation between the Claimant and the Claim Manager. The Claimant had, in fact, been injured in the shin at work and believed, also, that he suffered heat exhaustion at work. Thus in the HISTORY section of the hospital medical report the doctor wrote, "He initially thought he was under too much heat and was the reason why he was running a fever." "Heat exhaustion" is defined in Webster's Ninth New Collegiate Dictionary (1989) as "a condition marked by weakness, nausea, dizziness, and profuse sweating that results from physical exertion in a hot environment." The Claimant was working in 100

degrees temperature. In both PI-1A forms he complained of heat exhaustion and dizziness.

The word "injury" is defined in the same dictionary as "an act that damages or hurts . . . ." The usage note in the dictionary for the word "injure" states "INJURE implies the inflicting of anything detrimental to one's looks, comfort, health, or success." It would not be incorrect to consider heat exhaustion as an injury to one's body. The Board finds no falsification of an injury in the initial communication between the Claimant and the Claim Manager.

Nor does the Board find evidence of falsification of an injury in the subsequent conversations between the Claimant and the Claim Manager after July 2nd. The Claimant cooperated in every way with the Claim Manager to provide him with the medical documentation he requested. There is no evidence of any false statement made by the Claimant to the Claim Manager. There is no evidence that prior to the removal of the Claimant from service the Claim Manager, or any supervisor or manager, had even interviewed the Claimant regarding the events that caused his hospitalization so that it might be argued that his answers or statements were untrue, evasive, or incomplete.

It is to be noted that when the Claim Manager received all of the medical documentation that was introduced into evidence in this proceeding, he did not independently conclude that the Claimant's condition was not work-related. It was only after he received an interpretation of the medical data from the Safety Department, which,

in turn, had been in touch with the Medical Department, that he informed the Claimant that he was not entitled to compensation. According to the evidence, after he was informed by the Carrier that he was not entitled to compensation for any of his medical issues, the Claimant made no attempt to pursue a claim against the Carrier.[2]

In sum, there is no substantial evidence in the record that the Claimant falsified an injury. There is no evidence of any false statement of fact in the Form PI-1A filled out by the Claimant on June 6, 2009 and submitted to the Carrier. With regard to the Claimant's communication with the Claim Manager, an employee in the Claimant's position on the date that he called the Claim Manager could reasonably have believed that he suffered an injury at work that would justify making an inquiry of the Claim Manager as to whether he could receive compensation for the injury. There is no evidence of any false statement made by the Claimant to the Claim Manager, and, affirmatively, the record shows that the Claimant cooperated in every way in providing the medical documentation requested by the Claim Manager. The evidence does not support the charges against the Claimant. The Claim will be sustained. The Claimant is entitled to be made whole for all wages lost as a result of being removed from service by the Carrier and the disciplinary action imposed.

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[2]This Board expresses no opinion as to whether the Claimant is or is not entitled to any compensation for any lost time from work in connection with the medical conditions referred to in the Form PI-1A completed by the Claimant on June 6, 2008.

AWARD

Claim sustained.

ORDER

This Board, after consideration of the dispute identified above, hereby orders that an award favorable to the Claimant be made. The Carrier is ordered to make the Award effective on or before 30 days following the postmark date the Award is transmitted to the parties.

Sinclair Kossoff, Referee & Neutral Member

Chicago, Illinois
May 12, 2009