COMMONWEALTH OF MASSACHUSETTS

DIVISION OF ADMINISTRATIVE LAW APPEALS

Leonard Albanese,
Petitioner

v. Docket Nos. CR-24-0240, CR-25-0278, CR-25-0279

Chelsea Retirement Board,
Respondent

Appearance for Petitioner:

Leigh A. Panetierre, Esq.

Appearance for Respondent:

Brian P. Monahan, Esq.

Administrative Magistrate:

Kenneth Bresler

SUMMARY OF DECISION

Retired fire chief is not eligible for accidental disability retirement benefits under the Heart Law because, among several reasons, he did not have a physical examination upon entry into service or pass the examination. He is not eligible for disability benefits without the benefit the Heart Law because, for one reason, the medical panel that examined him was negative. The retirement board properly denied his applications for disability benefits and his motion to reconsider.

DECISION

The petitioner, Leonard Albanese, appeals three adverse decisions of the Chelsea Retirement Board (CRB) related to his applications for accidental disability retirement benefits.

I held a hearing on November 4, 2025, which I recorded. Mr. Albanese was the only witness. I admitted Exhibits 1 through 53 at the hearing. After the hearing, I admitted new exhibits attached to Mr. Albanese's post-hearing brief, Exhibit 27A and Attachments A through K. Both parties submitted post-hearing briefs in January 2026.[1]

Medical Articles

I am mindful of three things. I don't have medical training. I'm not permitted to search for medical information that is not part of the record. *Hollup v. Worcester Retirement Board*, 103 Mass. App. Ct. 157, 161-62 (2022). And medical questions are generally "beyond the competence" of a retirement board, *e.g.*, *Malden Retirement Board v. Contributory Retirement Appeal Board*, 1 Mass. App. Ct. 420, 424 (1973); *Frederick W. Wilson v. Malden Retirement Board*, CR-17-104 (DALA Dec. 15, 2023) – and beyond me.

The topic of medical articles arose when CRB, in its first set of clarification questions, asked the medical panelists to "cite any professionally accepted sources and scholarly articles upon which they rely." (Ex. 26) Two of the three panelists did not respond with citations to specific articles. One panelist referred CRB to "the American Heart Association web site" for "information regarding calcium score and the importance and use of calcium score in Mr. Albanese's risk factors." (Ex. 37) One panelist answered:

[1] Mr. Albanese's post-hearing brief includes an objection to my excluding his proposed Exhibit 30A. (Pet. br. 14) I apparently did not exclude the proposed exhibit on the record. (See Tr. 3) I do so now: A disability retirement benefits application requires a Treating Physician's Statement to advance. G.L. c. 32, §8(1), 860 CMR 10.06.1.b. The proposed exhibit seems like an addendum to the statement, not provided by statute, prepared for litigation, and going to key issues in this case. It is unsworn and not subject to cross-examination or my questions. It is not "simply another medical record in the progression of medical records in this matter," as Mr. Albanese argues (Pet. br. 14) – or it would be in medical-record format and not addressed To Whom It May Concern.

> I can only comment that there are multiple well-described articles in the literature documenting risk factors for developing coronary disease….

(Ex. 33) The remaining panelist cited eight articles. (Ex. 36, p. 2)

CRB submitted medical articles and information as exhibits. (Exs. 24, 25, 39, 42, 44-52) Most of them were articles that the third panelist had cited. (Tr. 15)

At the start of the hearing, Mr. Albanese's lawyer stated that she had articles to submit, but had not submitted them as exhibits, not having considered them to be exhibits. (Tr. 14)

I expressed doubt that I could review the articles because I don't have medical expertise and panelists are given statutory authority to evaluate medical literature and other information. (Tr. 15-18) I admitted the articles, but stated that I did not plan to read them. (Tr. 17-18) I stated that my decision would not rely on medical articles to confirm or refute findings by the medical panelists. (Tr. 18-19; see also Tr. 46-47)

With his post-hearing brief, Mr. Albanese submitted medical articles and other information, such as from websites, designated Attachments A through K.

I did ask the parties to brief the significance of conduction, a term that arose during the appeal. (Tr. 47) However, in this decision, I decline to delve into and finely examine numerous medical details and their significance, as I discuss below.

Findings of Fact

Before Mr. Albanese became Chelsea Fire Chief

1. Mr. Albanese was a firefighter for the North Providence Fire Department in Rhode Island from July 18, 1986 to March 25, 2016. (Stipulation)

2. Upon being hired by the North Providence Fire Department, Mr. Albanese passed a pre-employment physical examination. (Stipulation) On July 11, 1986, Dr. David A. DiCecco

wrote a To Whom It May Concern letter stating that he had examined Mr. Albanese that day and "found [him] to be in good physical health." (Ex. 1) The short letter contained no indication of hypertension or heart disease. (Stipulation)

3. On February 9, 2016, Mr. Albanese underwent a medical evaluation, which included a cardiac component, under NFPA 1582. NFPA 1582 is a standard about firefighter medical evaluations of the National Fire Protection Association, a nonprofit with expertise in firefighter health and safety. (Tr. 21-24) The evaluation that Mr. Albanese underwent is designed to determine firefighters' risk factors and fitness for duty. (Stipulation)

4. Mr. Albanese underwent the medical evaluation as a required part of the North Providence Fire Department's annual wellness program. (Tr. 22) More specifically, Mr. Albanese did not voluntarily undergo the evaluation in anticipation that he would need it for his pending application to become Chelsea Fire Chief. (This decision discusses later his application to become fire chief.)

5. On February 16, 2016, Dr. Jay M. Burstein filled out a form for the North Providence, Rhode Island Fire Department. The form was called Firefighter Fitness and Surveillance Medical Examination Employer Clearance Letter. (Ex. 2, p. 1)

6. The clearance letter stated that Dr. Burstein had examined Mr. Albanese on February 9, 2016 and conducted a pulmonary function test, electrocardiogram, chest x-ray, and other tests. (Ex. 2, p. 1)

7. Dr. Burstein concluded that Mr. Albanese was medically qualified under NFPA 1582 and 29 Code of Federal Regulations 1910.120, an OSHA regulation about emergency response. (Ex. 2, p. 1)

8. On a section of the clearance letter headed “Non work-related medical conditions which require follow-up,” Dr. Burstein wrote, “Elevated total and LDL (bad) cholesterol level.” (Ex. 2, p. 2)

9. The electrocardiogram report noted in part, “AV conduction is normal. There is a borderline IV conduction delay.” (Ex. 2, p. 6)

10. According to the clearance letter, Mr. Albanese’s x-ray showed that “the heart is normal in size.” (Ex. 2, p. 14)

11. On April 2, 2024, eight years later, when Mr. Albanese applied for accidental disability retirement benefits, Dr. Burstein wrote about his examination on February 9, 2016, “Based on my examination, Chief Albanese did not demonstrate any evidence of pre-existing or active Heart Disease.” (Ex. 15)

Mr. Albanese as Chelsea Fire Chief

12. In December 2015, Mr. Albanese applied to be the Chelsea Fire Chief. (Stipulation)

13. On or about February 26, 2016, Mr. Albanese interviewed for the position of Chelsea Fire Chief. At the end of February 2016, Mr. Albanese met one-on-one with Chelsea’s city manager, who told Mr. Albanese that he, Mr. Albanese, did not need to take a pre-employment physical examination. (Tr. 34-35, 68-69; stipulation)

14. On April 4, 2016, Mr. Albanese became Chelsea Fire Chief. (Ex. 12, p. 3; Tr. 35)

15. On or about April 4, 2016, he gave the Firefighter Fitness and Surveillance Medical Examination Employer Clearance Letter (Ex. 2) to a human resources person for public safety employees. To his knowledge, the letter was in the city’s file when he retired. (Tr. 35, 89)

16. As fire chief, Mr. Albanese responded to approximately 30 to 32 multiple-alarm fires. He was in fire gear and went inside the buildings that were on fire to monitor conditions and ensure the safety of firefighters. (Tr. 37-39; stipulation; Ex. 5 (29 fires))

17. Mr. Albanese testified that on February 14, 2022, he responded to a fire, where he felt pain and pressure in his jaw. (Tr. 39-40)[2]

18. Mr. Albanese testified that he did not know what he was experiencing. He did not file an injury report. He went home and rested and the pain and pressure in his jaw went away. (Tr. 41)

19. During Mr. Albanese's exercise workouts in February and March 2022, he experienced pain and pressure. (Tr. 41) (He did not specify where in his body he experienced pain and pressure; it may have been in his jaw. (See Tr. 42))

20. In April 2022, Mr. Albanese saw his cardiologist. In May 2022, he took a stress test. During the stress test, he developed pain and pressure in his jaw, his blood pressure spiked, and the stress test was stopped. (Tr. 42-43)

21. Mr. Albanese testified that he continued to experience jaw pain at fires in 2022 and 2023. He did not file injury reports or keep a journal. He remembers fires on February 14, 2022 because it was Valentine's Day, and November 22, 2023 because the fire on that day was major and because it was his daughter's birthday. (Tr. 41-42)

22. Mr. Albanese testified that the November 22, 2023 fire was a dangerous, intense, and confused situation. Mr. Albanese experienced severe jaw pain. (Tr. 43-44)

[2] I put it this way here and below – "Mr. Albanese testified that" – because I do not find the substance of his testimony as fact. What he testified to may or may not have happened.

23. When he first became fire chief, Mr. Albanese worked from 7:00 a.m. to 8:00 p.m. (Tr. 90) He later worked from 8:00 a.m. to 5:00 p.m. (Tr. 91)

24. Before retiring, Mr. Albanese put himself, in effect, on light duty. He generally went to work from 8:30 a.m. to 12:30 p.m. and trained his likely successor as fire chief. (Tr. 51) It was probably in November 2023 that he put himself on light duty, although it could have been January 2024. (Tr. 83, 92)

25. Mr. Albanese did not apply for or receive benefits under G.L. c. 41, § 111F. (Tr. 82)

Miscellaneous

26. When the Chelsea Fire Department hired entry-level firefighters, it required them to have an NFPA 1582 pre-employment examination. When the department hired firefighters from other fire departments who were covered by the Massachusetts Civil Service Commission, the department did not require them to have such an examination. Mr. Albanese believes that he was treated as a transfer and therefore not required to have such an examination. (Tr. 36-37)

27. On August 15 , 2019, Mr. Albanese, as fire chief, instituted a policy on service-connected injuries, requiring injured firefighters to properly and accurately document all service-connected injuries “at the time of occurrence.” (Ex. 53; Tr. 70-71)

28. Mr. Albanese has a history of smoking tobacco. He testified that he smoked on and off for approximately 10 years and quit smoking on January 1, 2002, with slight lapses. (Tr. 53) He may have smoked for 15 years, according to medical records. (Exs. 21, 22, 26)

First application (under the Heart Law)

29. On January 10, 2024, Mr. Albanese applied for accidental disability retirement benefits. (Ex. 10)

30. When asked to state the medical conditions for which he was applying for accidental disability retirement benefits, Mr. Albanese answered, "Heart Law Presumption; qualifying severe heart disease condition." (Ex. 10, p. 4)

31. When asked when he ceased to be able to perform all essential duties of his position, Mr. Albanese did not answer, but instead stated, "Upon diagnosis and most recent follow up consultation with my physician." (Ex. 10, p. 4) Mr. Albanese did not specify which diagnosis he meant; which doctor he meant; when his most recent follow up with his doctor was; whether he meant the same or two separate dates (diagnosis and follow up); and specifically when he ceased being able to perform all essential duties of his position. Later in the same application, he stated, "I was diagnosed with a qualifying heart disease condition in the summer of 2021 (Ex. 10, p. 7), making it likely that he meant that he ceased being able to perform all essential duties in summer 2021.

32. When asked to describe his physical activities, Mr. Albanese responded in part:

> For the past year I have continued to perform most of the duties associated with my position under the supervision of my treating cardiologist. During this time frame I have noticed more restrictions to my capabilities.

(Ex. 10, p. 6) Mr. Albanese did not answer about medical rehabilitation activities, activities of daily living, or sports or other strenuous activities, although the application form specifically asked about them.

33. When asked the date(s) of his medical condition, Mr. Albanese answered, "April 4,

2016 through the present time." (Ex. 10, p. 7) In other words, Mr. Albanese stated that his medical condition began when he began work as Chelsea fire chief.

34. When asked the specific time(s) of his injury, Mr. Albanese stated, without really answering, "Responded to approximately 30 multiple alarm fire during this time frame…." (Ex. 10, p. 7)

35. When asked why he was applying under a presumption, Mr. Albanese answered,

> I was diagnosed with a qualifying heart disease condition in the summer of 2021 that I did not have at the time of my employment. I had a physical prior to starting in this position, and several annual physicals after being appointed that showed no sign of such condition. I had fatigue and other symptoms in early 2021 and sought testing….

(Ex. 10, p. 7)

36. When asked to describe his injury in his own words, Mr. Albanese stated,

> (Presumption/ Heart Law) I had no signs or symptoms of any cardiac issues or limitations prior to 2021. The presumptive injury I have sustained as a result of my job duties is heart disease.

(Ex. 10, p. 7)

37. When asked about other circumstances, events, or physical conditions that contributed or may have contributed to his disability, Mr. Albanese answered, "None." He did not mention that he had smoked tobacco. (Ex. 10, p. 7)

38. On January 8, 2024, Dr. Michael Osborne signed the Physician's Statement to accompany Mr. Albanese's application for accidental disability retirement benefits. (Ex. 9)

39. Dr. Osborne listed Mr. Albanese's medical diagnoses as coronary artery disease, hypertension, and asthma. (Ex. 9) (Dr. Osborne's diagnosis of asthma is irrelevant, because Mr. Albanese did not apply for accidental disability retirement benefits based on asthma, and

asthma is not a condition that the Heart Law covers.)

40. Dr. Osborne stated that Mr. Albanese was last able to perform his essential duties in January 2023; he did not specify a date in January. (Ex. 9, p 4)

41. Dr. Osborne stated that Mr. Albanese was incapable of performing the essential duties of his job; his disability was likely to be permanent; and his incapacity might be the natural and proximate result of the personal injury claimed. (Ex. 9)

42. When asked whether any evidence existed of a uniquely predominant non-service connected influence on Mr. Albanese's physical condition, Dr. Osborne answered no. He did not mention Mr. Albanese's history of smoking tobacco. (Ex. 9, p. 7)

43. On January 18, 2024, Mr. Albanese wrote to Chelsea's city manager to confirm their prior conversation about his intent to retire on March 8, 2024. Mr. Albanese wrote in part:

> My contract was scheduled to end on June 30. I believe this is the best time for the transition, as my successor will have the opportunity to present the FY 25 budget to the city council. I also have some personal issues that require my attention.

(Ex. 11) Mr. Albanese did not specify his personal issues or identify medical issues as among his personal issues.

44. On an unknown date, Chelsea's city manager completed the Employer's Statement to accompany Mr. Albanese's application for accidental disability retirement benefits. (Ex. 12)

45. According to the Employer's Statement, Mr. Albanese was last able to perform his essential duties on January 8, 2023. (Ex. 12, p. 3)

46. The Employer's Statement reported that Mr. Albanese was not performing in an accommodated position; he had not asked for an accommodated position; the fire department had not offered to modify his job duties or an accommodated position; and his medical

condition had not affected his attendance and job performance. (Ex. 12, pp. 3, 4) Although Mr. Albanese had, in effect, put himself on light duty, the city manager did not mention it.

47. On March 21, 2024, CRB denied Mr. Albanese's application for accidental disability retirement benefits, without having referred it to a medical panel. On March 25, 2024, it notified him of the denial. It stated in part:

> The reason for the denial stems from your submission of a disability retirement application pursuant to Massachusetts General Laws, Chapter 32, § 94: Impairment of health caused by hypertension or heart disease, resulting in disability or death of paid fire or police department member; presumption.
>
> The presumption referenced in M.G.L. c. 32, § 94 cannot be applied in your favor if a physical examination on entry into service revealed ***any evidence*** of hypertension or heart disease. Your physical examination upon entry into service with the Chelsea Fire Department revealed evidence of such conditions.

(Ex. 13)[3]

48. On April 1, 2024, Mr. Albanese timely appealed. (Ex. 14) This appeal was assigned the docket number CR-24-0240.

Second application (not under the Heart Law), original application (before amendment)

49. On April 8, 2024, Mr. Albanese again applied for accidental disability retirement benefits, this time due to a personal injury and not under the Heart Law. (Ex. 27)

50. The medical condition for which Mr. Albanese applied for accidental disability retirement benefits was heart disease. (Ex. 27, p. 4)

[3] The reference to the "physical examination upon entry into service with the Chelsea Fire Department" was to the examination of Mr. Albanese on February 9, 2016. (Ex. 2) CRB later determined that the February 9, 2016 examination was not "*upon* entry into service." (*E.g.*, Prehearing Memorandum 8, 9) I agree.

51. Mr. Albanese stated that he was

> not able to perform any of the duties of the position of fire chief due to the heart disease diagnosis and restrictions placed on me by my treating cardiologist.

(Ex. 27, p. 4)

52. Mr. Albanese stated that he ceased being able to perform all the essential duties of his job in January 2024, without specifying a date. (Ex. 27, p. 4)

53. When asked to describe his physical activities, Mr. Albanese responded in part:

> During my last year of service, I continued to perform the job duties under the supervision of my cardiologist….My capabilities have been limited progressively since my diagnosis in 2021 to the point where I could no longer safely continue[] with my job duties.

(Ex. 27, p. 6)

54. When asked the dates of this medical condition, Mr. Albanese answered, "April 4, 2016 through March 8, 2024" (Ex. 27, p. 7), the dates of his employment with the Chelsea Fire Department.

55. When asked to describe the incidents that led to his injury, Mr. Albanese answered in part:

> Managing major incidents and engaging in physical exertion at the scene of major fire operations….Also, the daily stressors of overseeing fire operations and administration of a busy fire department on a 24/7 availability schedule….

(Ex. 27, p. 7)

56. When asked to describe his injury in his own words, Mr. Albanese stated,

> I developed Heart Disease. The fire chief position in Chelsea is a high pressure, high stress, active position. I was exposed to the daily stresses of managing a very challenging work environment. I also responded to and worked at approximately 30 multiple alarm fires under extreme stress and conditions. In the command role your stress levels are very high. I was exposed to residual smoke and physical exertion that is extremely taxing on the body. Exposure to

> these stressors trigger frequent adrenaline rushes, heart racing and exertion/ exhaustion.

(Ex. 27, p. 7)

57. When asked to describe other circumstances, events, or physical conditions that contributed or may have contributed to his disability, Mr. Albanese responded in part, not entirely responsively:

> As of 2016 I had no indications of heart disease….There was no heart disease present at the time of my employment and for several years after. It was not until the spring/ summer of 2021 that I did not feel well, felt limited in my capabilities and sought testing. There are no other circumstances or events that may have contributed to my disability. The job stress and exertion is the contributing factor.

(Ex. 27, p. 7) Mr. Albanese did not mention his history of smoking tobacco.

58. Mr. Albanese stated that he was not receiving and had not received benefits, related to his claimed disability, under G.L. c. 41, § 111F. (Ex. 27, p. 9)

59. On May 22, 2024, Dr. Osborne signed a Treating Physician's Statement to accompany Mr. Albanese's second application for accidental disability retirement benefits, which was not based on the heart presumption, before the application was amended. (Ex. 27A)

60. Dr. Osborne listed "Coronary Artery Disease (heart disease)," hypertension, and asthma as Mr. Albanese's diagnoses. (Ex. 27A)

70. Dr. Osborne stated that Mr. Albanese was last able to perform the essential duties of his job in January 2024, without specifying a date. (Ex. 27A)

71. When asked if Mr. Albanese cannot perform any essential duties, Dr. Osborne did not really answer, but responded,

> He has become more fatigued and short of breath with extreme exertion, limiting his ability to safely perform this type of activity.

(Ex. 27A) He did not identify which "type of activity" he meant.

72. When asked to describe the event(s) or onset of conditions that led to Mr. Albanese's disability, Dr. Osborne wrote:

> Chronic stress, persistent surges of adrenaline, environ[]mental exposures, and exertion caused by job related activities over the course of his employment.

(Ex. 27A)

73. When asked what other life event, circumstance, or condition may have contributed to or resulted in Mr. Albanese's disability, Dr. Osborne wrote:

> Hypertension was present prior to 2021 but well controlled with medication. If this was a contributing factor it was accelerated by hazards undergone in the performance of duty.

(Ex. 27A) Dr. Osborne did not mention Mr. Albanese's history of smoking tobacco.

When asked

> Upon weighing the medical evidence, is it more likely that the disability was caused by the job-related personal injury…or the non-work related event or circumstance or condition?

Dr. Osborne answered, "It is more likely that the disability was caused by the job-related hazards." (27A)

The medical panel

74. On July 9, 10, and 18, 2024, medical panelists examined Mr. Albanese. (Exs. 35, 37, 38)

75. In sum, with more details to follow, the first medical panelist opined that Mr. Albanese was not physically incapable of performing the essential duties of his job. (Ex. 35) The second opined that he was physically incapable of performing his essential duties; his incapacity

was likely to be permanent; and his incapacity might be the natural and proximate result of his personal injury. (Ex. 37) The last opined that Mr. Albanese's incapacity was not such that it might be the natural and proximate result of his personal injury. (Ex. 38)

76. On January 6, 2025, both parties posed clarification questions to the panelists. (Ex. 26) (This decision discusses the clarification questions before discussing the panelists' reports in detail so that the decision can keep together each panelist's original report and his answer to the clarification questions.)

77. CRB asked the first set of clarification questions:

> 1. In the application for accidental disability retirement the applicant cites Heart Disease as the basis of his claim, and his treating physician cites Coronary Artery Disease, as evidenced by the applicant's high calcification score of 1168.
>
> a) What if anything, is the relationship or correlation between the patient's hypertension, for which records from Dr. Donat indicate that the member is being treated with Benicar on or before August 2012, and which condition Dr. Osborne describes on July 7, 2023 as having been known for 20-25 years, and the high calcification score?
>
> b) What if anything, is the relationship or correlation between the patient's documented family history and the high calcification score?
>
> c) The applicant self-reported a fifteen-year one pack-per-day smoking history, as documented by Dr. Alba and Dr. Lippincott. He self-reported his continued smoking "... occasionally if he is out drinking with friends" to CNP Marino on February 1, 2021, and reported that he "... continues to smoke on occasion when he is out with his friends" to Dr. Osborne on July 2, 2021, for which Dr. Osborne offers smoking cessation advice. What if anything, is the relationship or correlation between the patient's smoking history and the high calcification score?
>
> d) What if anything, is the relationship or correlation between the patient's hyperlipidemia and the high calcification score?
>
> e) What if anything, is the relationship or correlation between the patient's sleep apnea and the high calcification score?

f) What if anything, is the relationship or correlation between the patient's borderline conduction delay as evidenced in the 2016 EKG and the high calcification score?

2. If such a relationship or correlation exists, what is the mechanism by which these factors contribute?

3. What would be the likely timeline it would typically take a patient to reach a calcification score of 1168?

4. If the panel would please cite any professionally accepted sources and scholarly articles upon which they rely, it would be very helpful to the Board's assessment.

Mr. Albanese has requested that the medical panel physicians address the following questions in addition to the Retirement Board's above inquiries.

1. Did the patient's job aggravate or accelerate a pre-existing condition to the point of disability?

2. Is there any evidence that non-work factors caused Mr. Albanese's disability?

Mr. Albanese's counsel requested that documentation of incidents that Mr. Albanese responded to be appended to this letter (see below). Please be advised that no injury reports are associated with these incident reports.

(Ex. 26)

78. On July 9, 2024, Dr. Michael Johnstone, a cardiologist and medical panelist, examined Mr. Albanese. (Ex. 35)

79. Dr. Johnstone opined that Mr. Albanese was not physically incapable of performing the essential duties of his job. (Ex. 35)

80. In his narrative, Dr. Johnstone noted that Mr. Albanese had a history of hypertension, tobacco use until 2002, sleep apnea, a very high calcium score, and other conditions. (Ex. 35, pp. 1, 2)

81. Dr. Johnstone noted that Mr. Albanese had not worked since January 8, 2024. (Ex. 35, p. 2)

82. In the narrative portion of his report, Dr. Johnstone wrote, in part:

> My impression is that Mr. Albanese has hypertension, prior tobacco use, low testosterone exogenous injections, exercise-induced asthma, obstructive sleep apnea, and high coronary calcium score. He also has atypical chest discomfort with no evidence of any ischemic disease. While he has a very high calcium score, he has no evidence of coronary disease. While he has had jaw pain, prior stress tests were all normal and therefore he does not have any disability. As stated, there is no evidence that his decreased exertional tolerance is anything other than decreased training and/or a non-cardiac cause.

(Ex. 35)

83. On January 29, 2025, Dr. Johnstone generally restated the clarification questions in bold and answered them:

> **1. What, if anything, is the relationship between the patient's hypertension for which the records from [Dr. Donat] indicate that the member is being treated with Benicar on or before August 2012 for which condition [Dr.] Osborne describes on July 7, 2023, as being known for 20 to 25 years and the high calcification score?**
>
> Hypertension certainly can cause atherosclerosis or hardening of the arteries. Hardening of the arteries is manifested as calcification of the aorta and can give high scores known as the Agatston score. However, Mr. Albanese here was totally asymptomatic. 80% of us will have some degree of atherosclerosis. The evidence of atherosclerosis is not an issue here. It is whether it was limiting him from performing his duties, which it was not.
>
> **1.1. What, if anything, is the relationship or correlation between the patient's documented family history and the high calcification score?**
>
> Certainly, family history is a risk factor for atherosclerosis and therefore is a risk factor for developing high calcification scores.
>
> **1.2. The applicant self-reported a 15-year 1-pack-per-day smoking history as documented previously. He self-reported that he continued smoking occasionally if he is out drinking with friends. What, if anything, is the**

relationship or correlation between the patient's smoking history and high calcification score?

Again, smoking is a risk factor for atherosclerosis and again atherosclerosis causes calcification. Therefore, there is a direct relationship between smoking, hypertension and family history on the causes of calcification.

1.3. What, if anything, is the relationship or correlation between the patient's hyperlipidemia and the high calcification score?

Again, high cholesterol results in atherosclerosis or hardening of the arteries, which in turn causes calcification of the arteries.

1.4. What, if anything, is the relationship or correlation between the patient's sleep apnea and the high calcifications score?

Sleep apnea can cause hypertension, which in turn causes atherosclerosis, which in turn causes calcification of the vessels.

1.5. What, if anything, is the relationship between the patient's borderline conduction delay as evidenced in the 2016 EKG and the high calcification score?

High calcification score may, and the operative word here is may, cause a delay in the conduction system, but again it did not impact on Mr. Albanese's life and therefore has no clinical consequence here.

2. What is the relationship or correlation exists[4] was the mechanism by which these/actors contribute?

As stated above, all these factors result in causing atherosclerosis, which in turn causes calcification of the blood vessels.

3. What would be the likely time line it would typically take a patient to reach calcification score of 1168?

1168 is a score by the Agatston score. It is a relative score of a certain gender at a certain age, having a certain percentage of calcification. Therefore, it is a relative number and not a pure number in of itself. There is no particular time or age that such can exist, but certainly most would argue that atherosclerosis starts with calcifications at or above the age of 40.

[4] The original question was: "If such a relationship or correlation exists, what is the mechanism by which these factors contribute?"

4. If the panel would please cite any professional accepted sources of scholarly articles following which they rely, it will be very helpful to the Board[’s assessment].

I would ask that the panel refer to the American Heart Association web site to give information regarding calcium score and the importance and use of calcium score in Mr. Albanese's risk factors.

Mr. Albanese has requested the medical panel physicians address the following [questions].

1. Did the patient's job aggravate or accelerate a pre-existing condition to the point of disability?

Certainly stress may contribute, but there is no clear cause that Mr. Albanese had enough risk factors of hypertension, dyslipidemia, and smoking and a family history to cause atherosclerosis. One would be hard pressed to say what other factors may have played a role, that certainly he has atherosclerosis. Again, I want to emphasize here that he had no clinically limiting symptoms and therefore this is irrelevant as a cause of disability. There was no disability other than the knowledge of knowing that he had atherosclerosis.

2. Is there any evidence that non-work factors caused Mr. Albanese's disability?

Certainly smoking contributed to the atherosclerosis as well as family history, and his genetics would contribute to his dyslipidemia. That being said, I will end off as I have stated throughout this document, that because Mr. Albanese has a high calcium score does not cause any disability in and of itself. Mr. Albanese had no symptoms suggestive of coronary artery disease and therefore the Heart Law does not apply.

(Ex. 34)

84. On July 10, 2024, Dr. Douglas Tisdale, an oncologist and medical panelist, examined Mr. Albanese. (Ex. 37)

85. Dr. Tisdale opined that Mr. Albanese was physically incapable of performing his essential duties; his incapacity was likely to be permanent; and his incapacity might be the natural and proximate result of his personal injury. (Ex. 37)

86. Dr. Tisdale wrote:

> Mr. Albanese is a 59 year old male with a history of hypertension, incidentally-discovered severe diffuse coronary calcification, and despite good exercise tolerance, a hypertensive response with ischemic ECG changes on exertion. He is judged to have a significant risk of consequential myocardial injury with infarction (heart attack) or arrhythmia (potentially fatal) with the adrenaline surges associated with firefighting emergencies. For this reason, he is considered disabled from performing the duties of a fire chief in my opinion following the job stress and exertion of working as a fire chief between April 4, 2016 and January 8, 2023.

(Ex. 37)

87. Dr. Tisdale noted that Mr. Albanese's father had a history of idiopathic cardiomyopathy; his mother had a history of coronary artery disease (CAD). (Ex. 37, p. 4)

88. In his answer to CRB's clarification questions, Dr. Tisdale wrote:

> a) The records indicate a pre-existing long history of hypertension, which is an accepted risk factor for atherosclerosis, an underlying condition promoting coronary calcification, a feature of CAD.
>
> b) A family history of CAD is also an accepted risk factor for the development of CAD.
>
> c) Tobacco use is an accepted risk factor for the development of CAD.
>
> d) Hyperlipidemia is an accepted risk factor for the development of CAD.
>
> e) Sleep Apnea is a newer, emerging risk factor for the development of CAD.
>
> f) The borderline conduction delay noted in the record would be more likely a result of CAD or other cardiac disease, rather than a cause of CAD.
>
> 2. The common pathway to CAD includes, on a microscopic level, damage to the innermost layer of the coronary artery, called the intima. Hypertension is thought to contribute due shear stress across the intimal surface, while hyperlipidemia causes lipid deposition into the intima and coronary vessel wall, which reduces intimal structural integrity. Smoking contributes to CAD through oxidative stress, inflammation, and endothelial dysfunction, which damage artery walls, by altering lipid profiles, which promotes plaque buildup, through

> nicotine-induced vasoconstriction, and also increases blood platelet interaction with the intimal surface.
>
> 3. The speed of development of CAD varies from person to person, and is not always linear. CAD often begins at a young age and worsens without clinical events for years before symptoms arise. In this case, the exact timeline is unknowable.

(Ex. 36) (footnotes omitted)

89. On January 26, 2025, in his answer to Mr. Albanese's clarification questions, Dr. Tisdale wrote:

> 1. Mr. Albanese's cardiologist felt that the sudden and emergent nature of fire call-outs would cause a surge in adrenaline, increased blood pressure and other hemodynamic changes that were rather likely to cause coronary occlusion and myocardial infarction with potentially devastating consequences. In this way, Mr. Albanese's job appears to aggravate the CAD condition to the point of disability.
>
> 2. The pre-existing family history of CAD, hypertension, high blood cholesterol, tobacco use and sleep apnea are non-work factors that appear to have led to the underlying CAD condition.

(Ex. 36)

90. On July 18, 2024, Dr. Eric J. Ewald, a cardiologist and medical panelist, examined Mr. Albanese. (Ex. 38)

91. Dr. Ewald opined that Mr. Albanese was physically incapable of performing his essential duties; his incapacity was likely to be permanent; and his incapacity was not such that it might be the natural and proximate result of his personal injury. (Ex. 38)

92. Dr. Ewald reported that Mr. Albanese stopped working on March 8, 2024. (Ex. 38)

93. In his narrative, Dr. Ewald wrote in part:

> [I]it is my medical opinion that Mr. Albanese is not able to safely and reliably return to work as a firefighter for the City of Chelsea in his prior capacity. This opinion is based on the fact that he had an extremely elevated coronary calcium score that placed him in the 99th percentile after a screening test in June 2021.

> Although he did well after that with an unremarkable stress test in June 2021, he began developing jaw symptoms in May 2022 and his repeat exercise stress echo that year was somewhat concerning as he only achieved 72% maximum predicted heart rate, had recurrent jaw symptoms with exercise and borderline ST changes. In addition, he was noted to have a hypertensive response to exercise. His echo imaging was normal at rest and stress, but this was obtained at a non-diagnostic heart rate. However, in regard to the causality of his markedly elevated coronary calcium score/CAD, I would further opine that this finding is statistically more likely a result of his prior tobacco use and that his position did not meaningfully aggravate his coronary disease despite the recognized job related stress and physical exertion required to be a firefighter. I would certainly agree that his position results in frequent unpredictable catecholamine surges with associated physiologic increases in both heart rate and blood pressure when called to an emergency, but remain of the opinion that the more common cause of CAD in any patient remains the ongoing or prior use of cigarettes and he does ascribe to having been a smoker up until 2002.

(Ex. 38)

94. On January 20, 2025, Dr. Ewald restated the clarification questions in bold and answered them:

> **1. In the application for accidental disability retirement, the applicant cites Heart Disease as the basis of his claim, and his treating physician cites Coronary Artery Disease, as evidenced by the applicant's calcification score of 1168.**
>
> **a) What, if anything, is the relationship or correlation between the patient's hypertension for which records from Dr. Donat indicate that the member is being treated with Benicar on or before August 2012, which condition Dr. Osborn describes on July 7, 2023, as having been known for 20-25 years, and the high calcification score?**
>
> Hypertension is well recognized and accepted as a risk factor for coronary disease. Longstanding hypertension would therefore be considered contributory in regard to the high calcium score, but in conjunction with other risk factors including and arguably most importantly cigarette/tobacco use.
>
> **b) What, if anything, is the relationship or correlation between the patient's documented family history and the high calcification score?**
>
> Family history of premature coronary artery disease is recognized as a potential risk factor for developing coronary disease in first-degree relatives, and this would be inclusive of significant coronary calcifications/an increased coronary

calcium score; however, Mr. Albanese's father passed away at age 86 from a non-cardiac cause, and mother at the time of my dictation is still living, and therefore, I would opine that family history is unlikely to have contributed significantly to his very elevated coronary calcium score.

c) The applicant self-reported a 15-year 1-pack-per-day smoking history as documented by Dr. Alba and Dr. Lippincott. He self-reported continued smoking "occasionally if he is out drinking with friends" to CMP Marino on February 1, 2021, and reported that he "continues to smoke on occasion when he is out with his friends" to Dr. Osborne on July 2, 2021,[]for which Dr. Osborne offers smoking cessation advi[c]e. What, if anything, is the relationship or correlation between the patient's smoking history and the high calcification score?

Tobacco use, including intermittent or ongoing cigarette use, is well described and accepted as a significant risk factor for developing coronary artery disease and acute coronary syndromes. I would opine in Mr. Albanese's case that this is likely the most significant risk factor that predisposed him to his elevated coronary calcium score, and that all other factors, including treated hypertension, possible family history(?), and job stress, are much weaker risk factors/contributors than his cigarette use.

d) What, if anything, is the relationship or correlation between the patient's hyperlipidemia and high calcification score?

Again, hyperlipidemia is also known to be a risk factor for developing coronary artery disease. However, although Mr. Albanese's lipids may have been elevated, it would be somewhat unusual to have developed such an extreme coronary calcium score unless lipids were markedly/extremely elevated, untreated, and for a protracted timeframe as can be seen with familial hypercholesterolemia (not applicable in his case). Therefore, although his elevated lipids may have been contributory, I would still opine that the primary risk factor for his elevated coronary calcium score/calcification remains his cigarette use (past and or present).

e) What, if anything, is the relationship or correlation between the patient's sleep apnea and the high calcification score?

I do not think this has any meaningful relationship. Sleep apnea is a recognized risk factor, primarily for developing arrhythmias such as atrial fibrillation and/or PVCs/PACs, and would be considered a very weak risk factor for his development of CAD, especially given the other risk factors that are present, primarily tobacco use.

f) What, if anything, is the relationship or correlation between the patient's borderline conduction delay as evidenced in the 2016 EKG and the high calcification score?

None. There is no relationship between this EKG finding and his high coronary calcification score.

2. If such a relationship or correlation exists, what is the mechanism by which these factors contribute?

As stated above, Mr. Albanese's coronary calcium score is very elevated and suggestive of significant underlying coronary disease, although to this point he has been managed medically and not required angioplasty or bypass surgery. I would continue to opine that his coronary calcification score is most likely a result of prior and/or ongoing tobacco use, with more minor contributors of hypertension, job stress, and possibly hyperlipidemia. I suspect family history has minimal, if any, relationship to his coronary calcium score, and as stated above, do not feel sleep apnea or any conduction delay noted by EKG contributes in any meaningful way.

3. What will be the likely timeline it would typically take the patient to reach a calcification score of 1168?

It is difficult to state an exact time-frame, but it would be on the order of years. Coronary calcification is not a process that develops quickly; it is a long-standing gradual process of plaque/calcium deposition and progression, especially if there are untreated risk factors (tobacco use) or a genetic predisposition. It would be appropriate to assume that this elevation would have been developed in a gradual/progressive fashion, likely over at least a 10-year time frame and potentially longer.

4. If the panel would please cite any professionally accepted sources and scholarly articles upon which they relied, it would be very helpful to the board's assessment.

I can only comment that there are multiple well-described articles in the literature documenting risk factors for developing coronary disease. The top to recognize risk factors for coronary artery disease for many/most patients, certainly in the United States, are diabetes and a significant smoking history. However, there are other recognized contributory and/or causative risk factors including longstanding poorly treated hypertension, hyperlipidemia, family history of premature coronary artery disease, and to a lesser degree potentially some contributory component of stress, job related or otherwise.

Mr. Albanese has requested that the medical panel physicians address the following questions in addition to the retirement board's above inquiries:

1. Did the patient's job aggravate or accelerate a pre-existing condition to the point of disability?

As previously detailed, I do not dispute that stress, job related or otherwise, is potentially a risk factor for developing coronary artery disease. However, in Mr. Albanese's case, it is far more probable and statistically likely that the reason for his markedly elevated coronary calcium score remains his tobacco use, but in recognition that there may be a contributory component from his prior and ongoing history of hypertension, hyperlipidemia, and potential job stress. However, I would opine that treated hypertension, hyperlipidemia, and possible job stress are far weaker risk factors than his recognized tobacco history.

2. Is there any evidence that non-work factors caused Mr. Albanese's disability?

I remain concerned that the markedly elevated coronary calcium score has less to do with his occupation and/or job stress and is more likely related to his smoking history, past or present, with the possibility of some contribution from his known treated hypertension and hyperlipidemia.

(Ex. 33)

Second application (not under the Heart Law), amended

95. On August 5, 2024, Mr. Albanese amended his April 8, 2024 application for accidental disability retirement benefits, which was not based on the heart presumption. (Ex. 28)[5] The reason for the amendment is that Mr. Albanese had hired a lawyer. (Tr. 95)

96. The medical condition for which Mr. Albanese applied for accidental disability retirement benefits was heart disease. (Ex. 28, p. 4)

97. Mr. Albanese stated that he was

not able to perform any of the duties of the position of fire chief due to the heart disease diagnosis and restrictions placed on me by my treating cardiologist.

[5] The date is from Mr. Albanese's lawyer's cover letter to the application. The application is dated January 10, 2024. (Ex. 28, p. 7)

(Ex. 28, p. 4)

98. Mr. Albanese stated that he ceased being able to perform all the essential duties of his job on November 22, 2023. (Ex. 28, p. 4)

99. When asked the dates of this medical condition, Mr. Albanese referred to the addendum, which referred to two major fires on February 14, 2022 and November 22, 2023. (Ex. 28, pp. 7, 17; see Exs. 7 & 8 (reports of those fires))

100. When asked to describe the incidents, Mr. Albanese referred to the addendum, which stated that after the two major fires he

> experienced jaw pain. I reported this to my cardiologist, and he said it is a symptom of heart strain from stress, and shows that I was developing disabling heart disease.

(Ex. 28, pp. 4, 17)[6]

101. When asked to describe his injury in his own words, Mr. Albanese answered: coronary heart disease, hypertension, and asthma. (Ex. 28, p. 7) Mr. Albanese did not describe his injury in his own words or explain why he included hypertension and asthma on page 7 when he listed only heart disease on page 4.

102. When asked to describe other circumstances, events, or physical conditions that contributed or may have contributed to his disability, Mr. Albanese left it blank. (Ex. 28, p. 7) Mr. Albanese did not mention his history of smoking tobacco or factors such as family history.

103. Mr. Albanese stated that he was not receiving and had not received benefits, related to his claimed disability, under G.L. c. 41, § 111F. (Ex. 27, p. 9)

[6] This is the only connection between jaw pain and heart disease that is in the record and that I'm aware of.

104. On August 5, 2024, Dr. Osborne signed a Treating Physician's Statement to accompany Mr. Albanese's amended application for accidental disability retirement benefits, which was not based on the heart presumption. (Ex. 29)

105. Dr. Osborne listed February 14, 2022 and November 22, 2023 as the dates of Mr. Albanese's injuries. (Ex. 29, p. 4) Those were the dates of the two major fires. (Ex. 28, p. 17)

106. Dr. Osborne listed coronary artery disease (heart disease), hypertension, and asthma as Mr. Albanese's diagnoses. (Ex. 29, p. 4)

107. Dr. Osborne stated that Mr. Albanese was last able to perform his essential duties on November 22, 2023. (Ex. 29, p. 4)

108. When asked if Mr. Albanese cannot perform any essential duties, Dr. Osborne did not really answer, but responded,

> He has become more fatigued and short of breath with extreme exertion, limiting his ability to safely perform this type of activity.

(Ex. 29, p. 4)

109. Dr. Osborne stated that Mr. Albanese was physically incapable of performing the essential duties of his job, his condition was likely permanent, and his incapacity was the natural and proximate result of his injury. (Ex 29, p. 6)

110. When asked to describe the event(s) or onset of condition(s) that led to Mr. Albanese's disability, Dr. Osborne opined:

> Chronic stress, persistent surges of adrenaline, environmental exposure, and exertion caused by job related activities at calls on 02/14/2022 and 11/22/2023.

(Ex . 29, p. 6)

111. When asked what other life event/circumstance/condition may have contributed

or resulted in Mr. Albanese's disability, Dr. Osborne stated:

> Hypertension was present prior to 2021 but well controlled with medication. If this was a contributing factor it was accelerated by hazards undergone in the performance of duty.

(Ex. 29, p. 6) Dr. Osborne did not mention Mr. Albanese's history of smoking tobacco.

Denial of Mr. Albanese's second application (not under the Heart Law)

112. On April 17, 2025, CRB denied Mr. Albanese's second application (not under the Heart Law), presumably the amended one. (Ex. 31)

113. CRB stated in part that

> your application failed to achieve a majority medical panel indicating that you are entitled to receive an accidental disability retirement. Additionally, related documentation evidenced significant non-service-connected factors which led to the underlying claimed disability. Your long history of heavy cigarette smoking, long history of hypertension, family history of CAD, high blood cholesterol, and sleep apnea were all conditions reported as leading to your claimed disability. The time to develop a CAC score equivalent to your score was also determined to have begun far before your employment started with the Chelsea Fire Department.
>
> Additionally, there was insufficient evidence to establish the requirement that, due to your claimed disability, you were unable to perform the essential duties of your position. While the high calcification score for which you claimed disability was diagnosed in 2021, you continued to perform the essential duties of the position until your final working day, on March 8, 2024. There were no injury reports, no 111F benefits, no documentation submitted to the Fire Department, Human Resources or the City Manager evidencing any injury, or evidencing your inability to perform the essential duties of your position. There were no records requesting or receiving any light duty assignments, or duty restrictions of any kind, affecting your position as Chief of the Chelsea Fire Department.

(Ex. 31)

114. On April 24, 2025, Mr. Albanese timely appealed. (Ex. 31) This appeal was assigned the docket number CR-25-0278.

Motion to reconsider denial of second application (under the Heart Law)

115. On September 4, 2024, Mr. Albanese moved that CRB reconsider its denial of his applications for accidental disability retirement benefits with a four-and-a-half page single-spaced letter. The letter is dense and hard to summarize. Much of it entails arguing medical facts and interpretations of those facts with CRB. (Ex. 18)

116. The letter also requested that if CRB did not reconsider its denial, CRB accept an amended application, not under the Heart Law. (Ex. 18) (Mr. Albanese had already submitted an amended application.)

117. The letter also asked Dr. Ewald to reconsider his opinion, arguing medical facts and interpretations of those facts. (Ex. 18)

118. The letter also asked that Dr. Johnston's opinion be disregarded and that he be replaced. It cited four cases in which DALA had questioned Dr. Johnston's opinion. (Ex. 18)

119. On April 17, 2025, CRB denied the motion to reconsider. (Ex. 32) It stated in part:

> [T]o claim the statutory presumption, you must have *successfully passed a physical examination on entry into such service... which failed to reveal any evidence of such condition*. The Chelsea Retirement Board refuses to accept, in satisfaction of the statutory requirements of M.G.L. c. 32, § 94, either of the medical examinations you submitted which were both conducted by your prior employer, the North Providence Rhode Island Fire Department.
>
> Neither the physical examination conducted in July of 1986, when you initially entered into service with the North Providence Rhode Island Fire Department, nor the February 9, 2016 occupational medical exam satisfies the statutory requirement of Section 94.
>
> Further, the February 9, 2016 examination was an occupational medical examination, not a physical medical examination. Those are not synonymous examinations.
>
> Additionally, even if the Board were to accept the medical exams in satisfaction of the statutory requirement, which, as stated, the Board rejects, there was

> nevertheless evidence revealing conditions related to your claimed disability. Your prior employer's examination revealed evidence of high blood pressure, which was corroborated by your long history of being treated for hypertension, there was also evidence of a borderline IV conduction delay, abnormally high glucose readings, abnormally high cholesterol readings, abnormally high LDL calculation. Hypertension, high cholesterol and a borderline IV conduction delay all present evidence linked to your claimed disability.
>
> Finally, in order to apply the presumption, there cannot be competent evidence of non-work-related factors rebutting the presumption. Here, there are many non-work-related matters which establish competent evidence rebutting the presumption. All three of the panel physicians opined that there were significant non-service-connected factors which led to the underlying claimed disability. Your long history of heavy cigarette smoking, long history of hypertension, family history of CAD, high blood cholesterol, and sleep apnea were all conditions reported as leading to your claimed disability. The time to develop a CAC score equivalent to your score was also determined to have begun far before your employment started with the Chelsea Fire Department.

(Ex. 32)

120. On April 24, 2025, Mr. Albanese timely appealed the denial of the motion to reconsider. (Ex. 32) The appeal was assigned the docket number CR-25-0279.

Discussion

My declining to evaluate medical literature

Mr. Albanese's motion to reconsider to CRB, which is in front of me under appeal, and his post-hearing brief ask me, in effect, to be a doctor, which I am not. I decline to read medical literature and evaluate, and second-guess, the evaluations of medical doctors, as I told the parties at the hearing that I was disinclined to do.

Some of the many examples of when the post-hearing brief asks me to opine on medical questions follow:

• "[A] borderline conduction delay does not constitute or cause heart disease; rather, if heart disease were present, a conduction delay might be the result." (Pet. br. 17)

• "[T]he cardiac condition of a former smoker can become as healthy as that of someone who never smoked at all." (Pet. br. 18)

• "Mr. Albanese did not fast the night before the 2016 evaluation…and therefore his lipid readings from that exam are not useful." (Pet. br. 4-5, 18)

First application (under the Heart Law)

The relevant text of what is commonly called "the Heart Law" follows:

> [A]ny condition of impairment of health caused by hypertension or heart disease resulting in total or partial disability…to a uniformed member of a paid fire department…shall, if he successfully passed a physical examination on entry into such service, or subsequently successfully passed a physical examination, which examination failed to reveal any evidence of such condition, be presumed to have been suffered in the line of duty, unless the contrary be shown by competent evidence.

G.L. c. 32, § 94. The Code of Massachusetts Regulations expands on the Heart Law.

840 CMR 10.04(3)(a) states:

> The retirement board shall presume that any condition of impairment of health caused by hypertension or heart disease resulting in total or partial disability or death to a member as described in M.G.L. c. 32, § 94 was suffered in the line of duty unless the contrary is shown by competent evidence.

A retirement board determines whether the presumption applies. 840 CMR 10.04(4)(a). If a retirement board so determines, it then determines

> • [w]hether the applicant successfully passed a physical examination upon entry to service or subsequent thereto which failed to reveal any evidence of such condition

840 CMR 10.04(4)(a)(i);

• "[w]hether any contrary evidence is sufficient to overcome the applicable presumption," 840 CMR 10.04(4)(a)(v); and

• "[w]hether other causal factors related to the member's physical…condition might have contributed to the disability claimed." 840 CMR 10.04(4)(b).

Competent evidence is admissible evidence. *E.g.*, *Commonwealth v. Selesnick*, 272 Mass. 354, 357 (1930); *William Lombardo and Waltham Retirement Board v. Public Employee Retirement Administration Commission*, CR-12-159 (DALA Feb. 5, 2016).

I affirm CRB's denial of Mr. Albanese's application for accidental disability retirement benefits under the Heart Law for several reasons.

Physical examination on or upon entry

The statute refers to "a physical examination *on* entry into such service," G.L. c. 32, § 94 (emphasis added); the regulation refers to "a physical examination *upon* entry to service." 840 CMR 10.04(4)(a)(i) (emphasis added). "On" and "upon" mean the same thing in this context. *See* Marcus Thorne, GrammarSolution Hub (October 22, 2025) ("'upon' is often interchangeable with 'on'").

What does "upon" mean in this context? It does not mean, as it sometimes does, "immediately after; following on." *ProconGPS, Inc. v. Skypatrol, LLC*, No. C 11-03975 SI, 2012 WL 3276977, at *9 (N.D. Cal. Aug. 9, 2012) (quoting *Oxford English Dictionary*, 2nd ed., 1989; online version June 2012). We know that it does not mean "immediately after" here because both the statute and regulation also refer to *subsequent* physical examinations.

"Upon" may be used, and the regulation uses "upon" (the statute uses "on"), "to indicate prompt or simultaneous action," "to indicate a specific time or event," to indicate "[d]ependence or reliance: Indicating the basis of an action or decision," and "to express a condition…." Dictionary.net.

In other words, "upon" in this context indicates both temporal proximity and a relationship, such as dependence, reliance, conditionality, contingency, or cause and effect., Cambridge Dictionary. ("Upon can be used to show that something happens soon after, and often because of, something else"); Ken Adams, "The Time for Taking Action 'Upon' Something Happening," (June 8, 2015) ("upon" in contracts); Thorne, GrammarSolution Hub ("'Upon' is frequently used to express dependence or reliance," contingency, or "a cause-and-effect relationship").

Mr. Albanese introduced a one-sentence "To Whom It May Concern Letter" from 1986 as an exhibit (Ex. 1) and argued in his brief that it is relevant to the Heart Law. (Pet. br. 3, 21-22, 27) However, the Heart Law requires a physical examination "upon" entering service. Mr. Albanese entered service 30 years after that physical examination. In no way does the examination that the letter reports meet an element of the Heart Law, summed up by the word "upon."

Upon entry to service as Chelsea Fire Chief on or about April 4, 2016, Mr. Albanese gave the Firefighter Fitness and Surveillance Medical Examination Employer Clearance Letter (Ex. 2) to a Chelsea human resources person. (Tr. 35, 68-69, 89) However, that is not the significant time that the statute and regulation refer to; they refer to "physical examination." Mr. Albanese's physical examination was February 9, 2016. (Ex. 2) The two dates, February 9 and April 4, 2016 were almost two months apart. The two events, physical examination and entry into service, were temporally proximate, at least in this context. As a medical layperson, I opine that an accurate report of a physical examination is generally and probably not outdated two months later. If it had been that the Chelsea Fire Department ordered Mr. Albanese to undergo

a medical examination, he underwent an examination, and two months later, he entered service as fire chief, this element of the Heart Law would probably have been met.

However, that is not what happened. The two events, physical examination and entry into service, were temporally proximate, but not related, as the word "upon" indicates and requires. Mr. Albanese was required to undergo the examination as a firefighter in North Providence, Rhode Island, not as the incoming Chelsea Fire Chief. In fact, Chelsea's city manager told Mr. Albanese that he did *not* need a physical examination. (Tr. 34-35, 68-69; stipulation) (The record does not reveal why the city manager said so.)

It cannot be both that Mr. Albanese was not required to undergo a physical examination upon entering service, as the city manager said, and that the North Providence physical examination related to and was a condition of Mr. Albanese's entry into service in Chelsea.

Mr. Albanese argues that because the City of Chelsea accepted from Mr. Albanese the clearance letter from North Providence, CRB should have accepted the North Providence examination as Mr. Albanese's physical examination upon entry into service in Chelsea. (Pet. br. 27) The argument is unpersuasive. The Chelsea Retirement Board is a separate entity from the City of Chelsea in this regard and is not bound by the City of Chelsea's acts. And the city manager, who told Mr. Albanese that he did not need a physical examination, is a separate person from the human resources person to whom Mr. Albanese later gave the clearance letter. The record does not reveal what, if anything, Mr. Albanese said to the human resources person, despite the city manager's conversation with Mr. Albanese. The record does not reveal whether the human resources person knew that the clearance letter was not needed for Mr. Albanese's entry into service.

There was no physical examination upon, that is, related to and a condition of, Mr. Albanese's entry into service as Chelsea Fire Chief. His apparent insistence on giving a report of his North Providence physical examination to the City of Chelsea (Tr. 34-35, 68-69; stipulation), even though Chelsea did not require a physical examination and Chelsea might not have wanted the report (the record is silent on this second point), did not transform his physical examination two months earlier into an examination upon entry, related to and a condition of his entry, an element of the Heart Law.

Mr. Albanese argues that his February 9, 2016 examination was similar to the one that Chelsea *would have had him undergo* had it chosen to do so. (Pet. br. 4, 23) That misses the mark. Chelsea did not require him to take an examination and he did not undergo one upon, that is related to and a condition of, entry into service.

CRB distinguishes between an occupational medical examination and physical medical examination, and argues that Mr. Albanese's examination on February 9, 2016 did not meet the statute's and regulation's requirement. (CRB br. 4, 9-10) I can't follow CRB's argument on this point. Mr. Albanese's application under the Heart Law fails for several reasons, but not for this one.

To pass the examination

An element of the Heart Law is that a firefighter "successfully passed a physical examination." When and where did Mr. Albanese pass a physical examination? Who or what passed him?

Mr. Albanese does not explicitly answer these questions. He seems to argue that Dr. Burstein, in his clearance letter of February 16, 2016, passed him. (Pet. br. 16, 24, 28)

Dr. Burstein and North Providence may have passed Mr. Albanese for fitness as a firefighter, but that's not what the statute envisions. He didn't enter into service in North Providence.

The Commonwealth of Massachusetts Initial Hire Medical Standards for 2014 states: "Each municipal fire department shall establish and implement a pre-placement medical evaluation for candidates." Medical Standards for Municipal Fire Fighters V(2).[7] The record does not reveal that when Chelsea "establish[ed] and implement[ed] a pre-placement medical evaluation" for firefighters, it deferred to or incorporated North Providence's or any other municipality's evaluation.

The Commonwealth of Massachusetts Initial Hire Medical Standards for 2014 also contain this language:

> The physician shall inform the fire department only whether or not the candidate is medically certified to perform as a fire fighter. The specific written consent of the candidate shall be required to release confidential medical information to the fire department, following guidelines set forth under the Americans With Disabilities Act (ADA) and other relevant policies.

Medical Standards for Municipal Fire Fighters V(4). Dr. Burstein did not inform the Chelsea Fire Department whether Mr. Albanese was "medically certified to perform as a fire fighter." The record does not reveal whether Mr. Albanese gave "specific written consent…to release confidential medical information to the fire department," as required.

These gaps in the record demonstrate that Dr. Burstein's clearance letter did not constitute Mr. Albanese's "successfully pass[ing] a physical examination" under the Heart Law.

[7] That is, Roman numeral 5.

Mr. Albanese appears to gloss over the "passed a physical examination" element by arguing that he presented CRB with "not one, but two pre-employment screenings that showed no evidence of hypertension or heart disease." (Pet. br. 27) However, an element of the Heart Law is *not* that a claimant present a retirement board with evidence of the absence of those conditions. An element of the Heart Law is not that a municipality or department *receive* evidence of the absence of those conditions. Rather, an element of the Heart Law is that a claimant "successfully passed" a physical examination.

The clearance letter was in Mr. Albanese's file (Tr. 89), but not because Dr. Burstein submitted it to Chelsea and not because Chelsea requested it or wanted it. Nothing in the record demonstrates that Chelsea wanted it, even if Chelsea did not require it. Nothing in the record indicates that anyone in the Cheslea city government *even looked at it*. And certainly nothing in the record indicates that anyone in the Chelsea city government "passed" Mr. Albanese's physical examination.

The City of Chelsea said in effect to Mr. Albanese, "You are not required to pass a physical examination." With his appeal and argument, Mr. Albanese has said in effect, "Fine, I'll have North Providence pass my examination for entry into service in Providence and use that as passing an examination for entry into service in Chelsea." His apparent argument is unavailing.

I again ask: Who passed Mr. Albanese under the Heart Law? And the answer is: No one, no entity. He doesn't meet this element of the Heart Law and is not eligible for it.

Through no fault of Mr. Albanese, Chelsea did not ask him to take a physical examination and thus, an element of the Heart Law is missing here. The remedy is not to allow

Mr. Albanese to supply that element on his own in a process outside of and not envisioned by the Legislature when it enacted the Heart Law.

Mr. Albanese's argument that he passed a physical examination under the Heart Law has another flaw, a subtle one. The obvious purpose of the "passed a physical examination" requirement is to ensure that a firefighter who *began* employment with hypertension or heart disease does not benefit from the Heart Law's presumption that service as a firefighter *later caused* hypertension or heart disease.

In his second application before he amended it, Mr. Albanese stated that his medical condition was heart disease and that its dates were "April 4, 2016 through March 8, 2024." (Ex. 27, pp. 4, 7) That is, Mr. Albanese stated that he had heart disease on his first day of work.

Evidence of hypertension or heart disease

Not only must a firefighter have "successfully passed a physical examination," it must have "failed to reveal any evidence" of hypertension or heart disease. The clearance letter of February 16, 2016 was not a physical examination upon Mr. Albanese's entry into service. Nor did he successfully pass a physical examination under the Heart Law. Therefore, I do not need to examine the clearance letter for any evidence of hypertension or heart disease.

Other causal factors

"[O]ther causal factors…might have contributed to the disability claimed," 840 CMR 10.04(4)(b), namely, Mr. Albanese's smoking of tobacco, family history of heart disease, hypertension, high cholesterol, and sleep apnea. (Exs. 33, 36) Dr. Ewald opined that Mr. Albanese's heart disease

> is statistically more likely a result of his prior tobacco use and that his position did not meaningfully aggravate his coronary disease despite the recognized job related stress and physical exertion required to be a firefighter.

(Ex. 38)

CRB's denial of Mr. Albanese's application under the Heart Law was justifiable for more than one reason.

Second application (not under the Heart Law), amended

The medical panel that examined Mr. Albanese issued a so-called negative panel report. *Lynne M. Saulnier v. State Board of Retirement*, CR-98-156 (DALA 1999). A negative panel report generally precludes an applicant from receiving accidental disability retirement benefits. *Quincy Retirement Board v. Contributory Retirement Appeal Board*, 340 Mass. 56, 60 (1959) ("A certification of incapacity is a condition precedent to accidental disability retirement by the local board.") (citations omitted).

The general rule that a negative panel ends an application for accidental or involuntary disability retirement benefits has a few exceptions, namely, if: the medical panel did not "conform[] to the required procedure of physical examination"; it lacked "all the pertinent facts"; it used an erroneous legal standard; or the medical certificate was "plainly wrong." *Kelley v. Contributory Retirement Appeal Board*, 341 Mass. 611, 617 (1961). The "plainly wrong" exception does not entitle a petitioner to "an opportunity for a retrial of the medical facts." *Id*.

A medical panel's opinion is not plainly wrong simply because a petitioner disagrees with it. *Debra L. Burke v. State Board of Retirement*, CR-17-677 (DALA 2020). If a petitioner's argument on appeal is long and involved, then, in general, the medical panel may not have

been *plainly* wrong. If a petitioner's argument on appeal is unclear, then, in general, the medical panel was not plainly wrong.

Although a seminal case did mention an erroneous *medical* standard, *Malden Retirement Board v. Contributory Retirement Appeal Board*, 1 Mass. App. Ct. 420, 424 (1973), citations to this case do not discuss or refer to a medical standard. Rather, an established exception to the principle that a negative medical panel ends an application is if the panel used an erroneous *legal* standard. That makes sense. After all, if the purpose of a medical panel is to remove from a retirement board's overview medical questions that are generally "beyond [its] competence," *id*., why let laypeople on a retirement board question a medical panel's findings on the grounds that the doctors' findings are medically incorrect?

Dr. Johnstone opined that Mr. Albanese was not physically incapable of performing the essential duties of his job. (Ex. 35) Dr. Ewald opined that Mr. Albanese's incapacity was not such that it might be the natural and proximate result of his personal injury. (Ex. 38) Two of the three panelists had opinions adverse to Mr. Albanese. Thus, the panel was negative.

Mr. Albanese does not make clear which exception to a negative panel he attempts to invoke. He does not allege that medical panelists did not examine him properly or lacked all pertinent facts. The body of his brief does not seem to allege that medical panelists used an erroneous legal standard, although the last line of his post-hearing brief seems to so allege. (Pet. br. 43) Mr. Albanese may be arguing that the medical panel used an erroneous medical standard (which is not an established exception, as stated above) or that the medical panel was plainly wrong. His argument is long and involved (Pet. br. 37-41), indicating that the panel was

not *plainly* wrong. Whatever exception he is invoking, Mr. Albanese clearly seeks to retry the medical facts, which he cannot do. (Pet. br. 37-41)

CRB's denials of Mr. Albanese's applications for accidental disability retirement benefits were proper for another reason: Mr. Albanese could not specify when he became unable to perform his essential duties, as follows:

No date – but possibly summer 2021. (Ex. 10, pp. 4, 7) (first application; when asked when he ceased to be able to perform all essential duties of his position, Mr. Albanese did not answer)

January 2023. (Ex. 9, p. 4) (Treating Physician's Statement with first application)

January 8, 2023. (Ex. 12, p. 3) (employer's statement with first application)

November 23, 2023. (Ex. 28, p. 4; Ex. 29, p. 4) (second application, amended; Treating Physician's Statement with second application, amended) That was the date of the second major fire. (Ex. 7)

January 2024. (Ex. 27, p. 4, Ex. 27A) (second application, before amendment; Treating Physician's Statement with second application, before amendment)[8]

Mr. Albanese did not specify when he became unable to perform his essential duties and did not satisfactorily explain being unable to so explain. He attributes the different dates of January 8, 2024 and November 23, 2023 to an application under the Heart Law as opposed to an application not under the law, "which is filed under a different legal theory." (Pet. br. 42)

[8] Although an application for accidental disability retirement benefits cannot advance without a Treating Physician's Statement, G.L. c. 32, §8(1), 860 CMR 10.06.1.b, nothing requires a treating physician to be neutral and objective in completing the statement. Nonetheless, it is disconcerting to see Mr. Albanese's treating physician apparently rubber-stamping Mr. Albanese's different versions of an application.

The question "When did you cease to be able to perform all of the essential duties of your current position?" (Ex. 27, p. 4; Ex. 10, p. 4) seeks a factual answer. Mr. Albanese was asked the same question on his application under the Heart law and his application not under the law. An application under the Heart Law is the same application as one not under the Heart Law. That Mr. Albanese's factual answers differ supposedly because of different legal theories does not make sense.

CRB could deny Mr. Albanese's applications for accidental disability retirement benefits because he could not specify when he became unable to perform his essential duties.

CRB could deny Mr. Albanese's application not under the Heart Law for another reason: It doubted that Mr. Albanese had been injured on the job, noting that he did not file injury reports or apply for or receive benefits under G.L. c. 41, § 111F. No exhibits document that he sought medical care related to a specific fire. (CRB br. 36-38) Mr. Albanese's lack of injury reports is troublesome because as fire chief, he required injured firefighters to document on-the-job injuries when they happened (Ex. 53) – and then filed no injury reports himself. That raises the issue of whether he was injured on the job.

Mr. Albanese offers two arguments about not having filed injury reports, neither of which are compelling. One, Mr. Albanese testified that he had no intention of going out injured – leaving firefighting due to injury. (Pet. br. 35-36) That may explain why he didn't seek § 111F benefits. But it doesn't explain why he didn't file injury reports.

Two, Mr. Albanese argues that he wasn't legally required to file injury reports to successfully apply for accidental disability retirement benefits. (Pet. br. 35) But that still does not explain why he didn't file injury reports under his own policy. That argument still does not

meet CRB's point that Mr. Albanese's claim to have been injured during fires is not documented anywhere; the absence of corroboration undermines his claim.

Motion for reconsideration

CRB's denial of Mr. Albanese's motion for reconsideration was proper for two major reasons. One, the denial that Mr. Albanese wanted CRB to reconsider was proper; it did not need to be reconsidered. Two, the motion attempted to retry the medical facts of the case.

Mr. Albanese's assigning himself light duty

I did bring to the parties' attention my decision in *James Holland v. Malden Retirement Board*, CR-13-538 (DALA, April 1, 2016), about a police chief who, in effect, assigned himself light duty. However, I do not believe that *Holland* is analogous enough to this case to be elucidative.

Conclusion and Order

Mr. Albanese is not entitled to accidental disability retirement benefits, whether or not under the Heart Law. I affirm the retirement board's three decisions that he appealed.

Dated: August 21, 2026

/s/ Kenneth Bresler

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Kenneth Bresler
Administrative Magistrate
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