COMMONWEALTH OF MASSACHUSETTS
CONTRIBUTORY RETIREMENT APPEAL BOARD

ALLENA DOWNEY,

Petitioner-Appellee

v.

MIDDLESEX COUNTY RETIREMENT SYSTEM,

Respondent-Appellant.

CR-15-550

DECISION

Respondent Middlesex County Retirement Board (MCRB) appeals from a decision of an administrative magistrate of the Division of Administrative Law Appeals (DALA) granting accidental disability retirement benefits to petitioner Allena Downey pursuant to G.L. c. 32, § 94. The DALA magistrate heard the matter on February 28, 2017 and admitted thirty-one exhibits. The magistrate's decision is dated August 8, 2017. MCRB filed a timely appeal to us.

After considering the evidence in the record and the arguments presented by the parties, we adopt the magistrate's findings of fact 1 – 42 as our own with changes noted[1] and incorporate the DALA decision by reference. We reverse the DALA decision for the reasons explained below.

Background. Ms. Downey was a police officer with the Ashland Police Department from July 2002 until she ceased working in September 2013.[2] She passed an initial physical examination performed by Nicholas Phillips, D.O., on May 1, 2002. While Dr. Phillips noted

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[1] In Finding of Fact 3, the reference to Exhibit 39 should be deleted.

[2] Ms. Downey reported in her application that she ceased working in November 2013. Dr. Gange reported the same in the Treating Physician Statement. However, Ms. Downey later testified at the hearing that she ceased working on September 25, 2013. The magistrate credited this testimony.

mild mitral valve regurgitation on examination, the remainder of her examination was unremarkable.[3]

Beginning in November 2012, Ms. Downey began treating with Christopher Gange, M.D., a cardiologist, for complaints of chest pain and palpitations. She denied fainting and syncopal episodes. Holter monitors obtained between December 2012 and April 2014 confirmed the presence of premature ventricular contractions (PVC) but presented no evidence of ventricular tachycardia. Sinus rhythm was normal.[4] Echocardiograms of November 21, 2012 and April 17, 2014 demonstrated normal systolic function and negative regional wall motion abnormalities. Ejection fractions were approximately 60% - 70%.[5] Dr. Gange did not find any evidence of coronary artery disease on cardiac workup.[6] He prescribed medication therapy to address Ms. Downey's diagnosis of PVC. Although she continued to report chest pain and palpitations, Ms. Downey was able to exercise without chest discomfort and displayed no increase in PVC while exercising. She also consistently reported to Dr. Gange that she was experiencing significant stress and anxiety from psychosocial stressors relating to family and work issues, which manifested in chest pain and palpitations. In light of this and in the absence of objective diagnostic studies reflecting an underlying cardiac issue, Dr. Gange felt that Ms. Downey's complaints of chest pain and palpitations were related to her stress and anxiety. He reassured her that her symptoms were not cardiac in nature and recommended management of stress and anxiety.[7] Despite this, Dr. Gange later referred Ms. Downey for an ablation procedure because the PVCs could not be managed by medication. This procedure was performed in May 2014, but failed to resolve the PVCs.[8]

Ms. Downey also received treatment for asthma flares and migraines. Both conditions were managed with medications. During flares, Ms. Downey reported symptoms consisting of shortness of breath, palpitations, chest pain and headaches in the setting of significant anxiety and stress in her life. During the course of her treatments, diagnostic EKGs, chest x-rays and

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[3] Exhibit 14.
[4] Exhibit 16 (12/4/2012, 4/5/2013, 11/27/2013, 3/21/2014, 4/23/2014).
[5] Ex. 6, pp 38, 42.
[6] Ex. 16 (12/20/2012, 11/14/2013).
[7] Ex. 16 (1/18/2013, 11/14/2013).
[8] Ex. 16, p. 4; 17, p. 24.

cardiac enzymes obtained between April 2011 and May 2014 were unremarkable.[9] Treatment notes reflect there to be a correlation between flares of her asthma and migraine with increased levels of stress and anxiety from psychosocial stressors. In January 2013, Ms. Downey was treated for asthmatic bronchitis after presenting to the hospital with shortness of breath and palpitations. She was advised that the palpitations were due to sinus tachycardia in the setting of steroids, viral illness, and albuterol respiratory treatment. No additional cardiology evaluation was recommended.[10] During a hospitalization in April 2013 for migraines, cardiology evaluation indicated that her complaints of shortness of breath, chest pain and palpitations were driven by severe underlying anxiety. Her chest pain was determined to be from a mild flare of acute bronchitis. It was felt that Ms. Downey did not have acute coronary syndrome.[11]

Ms. Downey was treated by Joseph Cocozzella, M.D., for post traumatic stress disorder (PTSD) and ADD. She presented with complaints of depression due to several social stressors, including job, home, social, and financial issues. Dr. Cocozzella prescribed medication therapy, but her anxiety and depressive symptoms persisted. Ms. Downey began using alcohol as a means of coping with her anxiety and depressive symptoms.[12] Her alcohol consumption lead to her hospitalization at McLean Hospital from August to September 2013 and subsequent follow up treatment at Brattleboro Retreat.[13]

Ms. Downey returned to work on September 23, 2013. Two days later, Ms. Downey responded to a scene with a corpse. Because the corpse was wedged between the toilette and bathtub, she was unable to extricate the corpse to provide emergency treatment. She became significantly upset and was advised by her commanding officer to return to the police facility. She became ill and subsequently was told to go home. Ms. Downey testified that after observing the scene, she became emotionally upset and began having significant palpitations. She did not complete her workday, nor did she seek any medical treatment after this incident. She ceased working, and on July 9, 2014, applied for ordinary disability retirement benefits and accidental disability retirement benefits pursuant to G.L. c. 32, § 94, the heart law presumption. Ms. Downey claimed that she was disabled as a result of a cardiac condition, which caused her to

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[9] Ex. 17 (p. 45), 18-19.
[10] Ex. 17, pp 44-45.
[11] Ex. 17 (4/9/2013).
[12] Ex. 20.
[13] Ex. 21; FF 6; Tr. 25-26.

cease working in September 2013.[14] She explained that she was experiencing "very elevated PVCs; they are not controlled by medication and I recently had surgery which did not improve my condition." She also asserted that workplace stress may have exacerbated her heart condition.[15]

Dr. Gange completed the Treating Physician Statement in support of Ms. Downey's application. He reported that she was diagnosed with palpitations and PVCs, which became more frequent in the past year and was refractory to medication and surgical therapy. He concluded Ms. Downey was mentally and physically incapable of performing her essential duties as a patrol officer and that she ceased working around November 2013 at the time of his examination on November 14, 2013.[16]

A regional medical panel was convened to examine Ms. Downey in connection with her application for accidental disability retirement. A majority of the medical panel members rendered a positive certification, answering yes to all three statutory questions of disability, permanence and causation. Madhusadan Thakur, M.D., examined Ms. Downey on January 20, 2015 and determined she suffered from palpitations as a result of frequent PVCs. He explained that the PVCs were most likely idiopathic but concluded that Ms. Downey's disability was such as might be the natural and proximate result of the personal injury sustained or hazard undergone on account for which retirement was claimed.[17] Seth Schonwald, M.D., who examined Ms. Downey on January 29, 2015, also answered all three statutory questions in the affirmative. He stated that her incapacity was the natural and proximate result of the hazards and stresses undergone by virtue of being a police officer and on account of which her retirement was being claimed.[18] Larry Weinrauch, M.D., who examined Ms. Downey on January 6, 2015, was the only medical panel member who could not support the determination that Ms. Downey's PVCs were the causal problem in her inability to perform the duties of a police officer. Instead, he concluded that her anxiety and psychiatric conditions predominated and were disabling. He did not feel that all the symptoms she was experiencing were related to arrythmias and did not

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[14] Ms. Downey reported she ceased working in November 2013 on her application, but the magistrate credited her testimony that she ceased working in September 2013. See FN 2.
[15] Ex. 1.
[16] Ex. 2.
[17] Ex. 3; FF 27-29.
[18] Ex. 4; FF 31-35.

support total disability on this basis in light of normal functional exertional capacity and most recent inability to stimulate ectopic foci in the electrophysiology laboratory. He concluded by saying that there was no documentation in the scientific literature to suggest that police officers, firefighters or other classes of workers may develop PVC de novo as a result of their occupational exposures.[19]

The medical panel members were subsequently asked to respond to clarification questions by MCRB.[20] Dr. Thakur responded on August 27, 2015 that he could not exclude that Ms. Downey's job was a significant contributor to either the precipitation or exacerbation of her PVCs and maintained that there were no other non-job related factors that would overturn the heart law presumption. He was of the opinion that Ms. Downey's diagnoses of chronic depression, post traumatic stress disorder (PTSD) and ADD were unlikely causes of her underlying electrical abnormality, but that they may exacerbate or make more frequent the electrical abnormality. Nevertheless, Dr. Thakur expressed that these non-cardiac factors were not the primary cause of her PVCs and not the cause of her disability.[21] Dr. Schonwald responded to the clarification questions on August 3, 2015, stating that Ms. Downey did not suffer from intrinsic coronary artery disease or significant hypertension. He continued to opine Ms. Downey to be disabled by virtue of PVCs and by virtue of her mental exhaustion, ongoing stress and psychiatric diagnoses.[22]

Dr. Weinrauch, in his response to clarification questions, continued to specify that Ms. Downey's complaints were inconsistent with a cardiac cause of disability. First, he reported objective diagnostic testing failed to reveal any underlying cardiac condition or disease. He determined that there was no evidence in the record to tie Ms. Downey's reported symptoms to the presence of PVCs. Secondly, Dr. Weinrauch found it noteworthy that Ms. Downey's medication list, which consisted of Adderall, Trazadone, Zoloft, Provent, Albuterol, and Imitrex, contained several medications that provoke PVCs. While he answered yes to the questions of

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[19] Ex. 5; FF 37-39.

[20] Ex. 15. All three letters asked the panelists to

> "clarify your certification as to the basis of the applicant's incapacity to perform her police duties. Specifically, is the applicant disabled by "any condition of heart disease or hypertension?" If so, please elaborate. If not, please identify the basis for her disability. Any additional commentary on the issue would be appreciated."

[21] Ex. 7; FF 30.

[22] Ex. 6; FF 36.

disability and permanence, he could not conclude that her PVCs caused her to be disabled. Instead, he determined that her anxiety and underlying psychiatric condition to be the cause, noting "the issue is psychiatric and not cardiovascular at this time."[23]

Based on the opinions of the majority of the medical panel members and Dr. Gange's Treating Physician Statement, as well as the testimony of Ms. Downey, the magistrate determined that Ms. Downey met all the elements of the heart law presumption and concluded that there was no competent evidence to rebut this presumption. The MCRB then timely appealed this matter to us.

***Discussion*.** In order to be eligible for accidental disability retirement benefits, Ms. Downey must prove that, as of her last day of employment, she was "unable to perform the essential duties of [her] job," that "such inability is likely to be permanent," and that the disability was the result of a personal injury or hazard undergone "as a result of, and while in the performance of, [her] duties."[24] In the case of a police officer with no pre-existing heart condition, causation is generally presumed if the disability arises from a heart condition.[25]

MCRB is appealing the decision of the magistrate, who concluded that Ms. Downey met all the elements for accidental disability retirement benefits pursuant to G.L. c. 32, § 94, the heart law presumption and the determination that no competent evidence existed to rebut the presumption. MCRB argues that competent evidence exists in the record that reflects Ms. Downey (1) was not disabled by the condition for which she was seeking disability as of her last day of work and; (2) that there were other possible causes of Ms. Downey's disability. While we recognize Ms. Downey's service as a police officer, we agree with MCRB that competent evidence exists in the record to rebut the heart law presumption.

1. Application of the Heart Law Presumption.

   The "heart law," G.L. c. 32, § 94, provides in pertinent part:

   > Notwithstanding the provisions of any general or special law to the contrary affecting the non-contributory or contributory system, any condition of impairment of health caused by hypertension or heart disease resulting in total or partial disability or death to a uniformed member of a paid fire department or permanent member of a police department. . . shall, if he successfully passed a

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[23] Ex. 8; FF 40.
[24] G.L. c. 32, § 7(1) (in pertinent part); *see generally Murphy v. Contributory Retirement Appeal Bd*., 463 Mass. 333, 345 (1985).
[25] G.L. c. 32, § 94.

> 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.

Based on the statute, there are several elements of the heart law presumption: (1) the applicant must be a police officer; (2) the applicant has an impairment of health caused by heart disease disabling the individual partially or totally; (3) the applicant passed a physical examination on entry to service to becoming a police officer; (4) the physical examination failed to reveal any evidence of hypertension or heart disease; and (5) the presumption that hypertension or heart disease was suffered in the line of duty is not overcome by competent evidence. This matter involves the second, fourth and fifth elements of the heart law presumption.

Here, the record contains conflicting evidence as to whether Ms. Downey's initial physical examination failed to reveal any evidence of heart disease. Specifically, Dr. Phillips noted on initial physical examination on May 1, 2002 that Ms. Downey had mild mitral valve regurgitation.[26] Contrastingly, Dr. Gange, Ms. Downey's cardiologist, in his letter of December 8, 2016, stated that Ms. Downey did not suffer from mitral valve prolapse.[27] No concurrent supporting objective diagnostic studies were performed at the time of the initial physical examination to confirm the presence of mild mitral valve regurgitation. Because the record lacks any diagnostic testing confirming mild mitral valve regurgitation at the time of the initial physical examination and in light of Dr. Gange's opinion and expertise in the field of cardiology, we are persuaded that Ms. Downey did not suffer from mild mitral valve regurgitation. Thus, Ms. Downey's application for accidental disability retirement may be considered pursuant to the heart law presumption.

2. Causation.

The magistrate concluded that Ms. Downey met all the requirements for disability based on the heart law presumption. He determined that she was disabled by PVCs, which precluded her from performing the essential duties of a police officer. MCRB argues to the contrary. Specifically, MCRB argues that Ms. Downey was not disabled by the condition which forms the basis of her application for accidental disability retirement benefits when she ceased working.

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[26] Ex. 14.
[27] Ex. 31.

MCRB further contends that the medical panel reports do not support Ms. Downey's application for accidental disability retirement. After considering the arguments by the parties and reviewing the evidence in the record, we agree with MCRB that Ms. Downey is not entitled to accidental disability retirement benefits pursuant to the heart law presumption.

In this instance, we cannot conclude that Ms. Downey was disabled by any heart disease. Rather, we conclude that Ms. Downey was disabled as a result of an underlying psychiatric condition. While Dr. Gange opined in his Treating Physician Statement that Ms. Downey is disabled as a result of palpitations and PVCs, his treatment notes indicate Ms. Downey was disabled by stress and anxiety from psychosocial stressors. Dr. Gange noted on various occasions that the palpitations and PVCs experienced by Ms. Downey were the result of stress and anxiety. These PVCs and palpitations prevented Ms. Downey from performing the essential duties of her position as a police officer.[28] Accordingly, Ms. Downey was not disabled by any underlying heart condition as required by the heart law presumption.

Furthermore, the lack of cardiac abnormalities found on diagnostic testing and evaluations do not support Ms. Downey's application for accidental disability retirement benefits based on the heart law presumption. Holter monitor readings between December 4, 2012 and April 23, 2014 revealed normal sinus rhythm and no ventricular tachycardia.[29] On December 20, 2012, while Ms. Downey was under an inordinate amount of stress, Dr. Gange noted normal stress echocardiogram, normal baseline cardiac structure and function, and normal pulmonary artery pressure. Ms. Downey exercised for nine minutes on the treadmill and did not experience any ischemic EKG changes. Stress echocardiography was negative for ischemia. Dr. Ganges reassured her that she did not have any significant coronary artery disease.[30] When she was seen in an urgent care visit the following month on January 18, 2013, EKG showed no changes, noting normal sinus rhythm, normal axis and intervals and no acute ST or T wave abnormalities. Ms. Downey was reassured again that her complaints of shortness of breath and palpitations

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[28] Ex. 16 (12/20/2012, use of Adderall may be contributing to her cardiac symptoms); (1/18/2013, complaints of shortness of breath and palpitations were not cardiac in nature but due to increased stress and anxiety); (1/30/2013, asthmatic bronchitis was the cause of chronic chest pain and shortness of breath); (7/11/2013 asthma medications helping with palpitations and PVCs).
[29] Ex. 16 (12/4/2012, 4/5/2013, 11/27/2013, 4/23/2014).
[30] Ex. 6, pp 22-23.

were not cardiac in nature but that her increased stress and anxiety relating to loss in pay and sleep deprivation were contributing to her symptoms.[31] Here, Dr. Gange's medical records fail to establish that Ms. Downey's palpitations and PVCs were caused by an underlying heart disease. Rather, her symptoms were found to be triggered by stress and anxiety.

Similarly, treatment notes from Dr. Cocozzella, Ms. Downey's psychiatrist, reflect stress and anxiety to be predominating factors impacting her functioning. Ms. Downey reported nightmares about her work resulting in sleep problems. Because of stress and anxiety related to her work issues, she was having problems dealing with the stress and anxiety at home. She reported drinking in reaction to her stress symptoms and experiencing increased PVC symptoms with increased stress. By March 2014, Dr. Cocozzella stated that Ms. Downey had anxiety in several different settings, which were impairing, and prescribed Prozasin and Adderall.[32] Dr. Cocozzella also documented Ms. Downey's use of alcohol to manage her panic attacks and other medical conditions.[33] He recommended reducing her alcohol consumption.[34] When viewed in light of the other objective medical evidence in the record, we cannot conclude that an underlying heart disease was the cause of Ms. Downey's diagnosis of PVC and palpitations. Rather, a significant amount of PVCs occurred in the setting of stress and anxiety from psychosocial stressors.

The record also reflects that Ms. Downey experienced increased palpitations and PVCs in the setting of asthma flares and the use of stimulants. On December 20, 2012, Dr. Gange advised Ms. Downey that her use of Adderall may be contributing to her cardiac symptoms and contacted her psychiatrist to speak about reducing the dose.[35] Dr. Gange also reported during his regular follow up with her on January 30, 2013 that her diagnosis of asthmatic bronchitis to be the basis of her chronic chest pain and shortness of breath.[36] Dr. Gange reported similar findings on July 11, 2013.[37] In March 2014, Dr. Cocozzella prescribed Prozasin to manage Ms. Downey's diagnosis of PTSD. He warned her that the medication could cause arrthymias. Ms.

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[31] Ex. 6 pp 24-25.
[32] Ex. 20 (5/16/2013, 6/20/2013, 10/18/2013, 11/18/2013, 3/14/2014, 5/23/2014, 9/4/2014).
[33] Ex. 20 (10/29/2013, 5/23/2014, 6/14/2014).
[34] Ex. 20 (6/14/2014).
[35] Ex. 6, pp 22-23.
[36] Ex. 6, pp 19-20.
[37] Ex. 6, pp 16-17.

Downey was also prescribed Adderall to treat her ADHD. Dr. Cocozzella consulted with Dr. Ganges due to his concerns with its interaction with her PVC. However, Dr. Ganges reassured him that Ms. Downey's heart was normal in structure and function and recommended monitoring her condition.[38] The treatment notes from Drs. Gange and Cocozzella demonstrate that the palpitations and PVCs experienced by Ms. Downey result from conditions other than an underlying cardiac condition.

In reaching our decision, we find the opinion of Dr. Weinrauch, the minority medical panel, most consistent with the objective medical evidence in the record. Dr. Weinrauch determined Ms. Downey's disability to be psychiatric in nature, rather than based on any cardiac condition. He could not "support the suggestion that the premature contractions [were] the causal problem in her inability to perform the duties of a police officer. In this case the anxiety and psychiatric conditions predominate[d]." He failed to find any medical documentation in the record that linked the symptoms reported to the presence of a large load of PVC. Instead, he indicated, and we also found from the record, that extra beats can result from sympathetic stimulators, such as anxiety, fear, agitation, and excitement, as well as stimulators such as caffeine, alcohol and Adderall. Moreover, Dr. Weinrauch explained that all symptoms of PVCs are not felt and that all symptoms not necessarily associated with PVCs, including chest pain or anxiety, can occur in the absence of PVCs or occur with the same number of PVCs as are occurring without symptoms. General treatment to address the extra beats, including abstinence from catecolinergic stimulants and alcohol, were not followed. Accordingly, Dr. Weinrauch concluded that it was highly unlikely that symptoms complained by Ms. Downey were related to arrhythmias and could not support total disability in light of normal functional exertional capacity and inability to stimulate ectopic foci during electrophysiology testing.[39] Further, in his response to clarification questions, Dr. Weinrauch continued to maintain that Ms. Downey's complaints were not consistent with a cardiac cause of disability. He stated that he could not support the suggestion that her PVCs were the cause of Ms. Downey's inability to perform the duties of a police officer, but rather, her anxiety and psychiatric condition predominated. He could not find support in the record to link the symptoms reported by Ms. Downey to the

[38] Ex. 20 (5/16/2013, 6/20/2013, 10/18/2013, 11/18/2013, 3/14/2014, 5/23/2014, 9/4/2014).
[39] Ex. 5.

presence of a large load of PVCs.[40] Dr. Weinrauch's certification report is consistent with the treatment notes from Dr. Gange and Cocozzella and diagnostic cardiac testings and evaluations. Therefore, we find his opinion compelling.

While the magistrate found the affirmative certification reports and responses to clarification questions by Drs. Thakur and Schonwald persuasive in granting Ms. Downey's application, we conclude differently. While Dr. Thakur determined that it was possible Ms. Downey was disabled as a result of an underlying heart condition, he maintained that the diagnosis of PVC was idiopathic. That is, he concluded that the underlying cause for Ms. Downey's PVC was unknown.[41] While answering all three statutory questions in the affirmative, Dr. Schonwald concluded that Ms. Downey was disabled by both PVCs and her mental exhaustion, ongoing stress and psychiatric diagnoses. These opinions do not reflect Ms. Downey to be disabled by an underlying heart condition and therefore, do not support Ms. Downey's application for accidental disability retirement based on the heart law presumption. Accordingly, we do not find their opinions to be persuasive.

3. Disability as of last day of work.

For accidental disability retirement benefits, Ms. Downey is required to establish that the claimed injury for which her application was based must be the cause of her disability as of her last day of work. *Vest v. Contributory Retirement Appeal Bd*., 41 Mass. App. Ct. 191 (1996) (employee who has left government service without established disability may not, after termination of government service, claim accidental disability retirement status on basis of subsequently matured disability). We have consistently interpreted *Vest* to stand for the proposition that a member must establish permanent incapacity as of the date he or she last actively performed his or her essential duties based on the same disability for which the member is now seeking accidental disability retirement. *See Mathew Tinlin v. Weymouth Retirement Bd*., CR-13-361 (CRAB Aug. 9, 2016); *Lauren Forrest v. Weymouth Retirement Bd*., CR-12-690 (CRAB Apr. 13, 2015); *Myra Wolovick v. Teachers' Retirement Bd.*, CR-02-1410 (CRAB Oct. 12, 2004); *Jose Chavez v. PERAC,* CR-04-427 (CRAB Dec. 23, 2004). Said differently, when an applicant seeks accidental disability retirement, he or she must establish that the same reason he or she stopped working is the same reason for which he or she later seeks the benefit. As we

[40] Ex. 8.
[41] Ex. 3, 7.

discussed above, the objective medical evidence does not support the conclusion that an underlying heart disease is the cause of Ms. Downey's disability in light of unremarkable diagnostic cardiac testings and evaluations and no increases in PVCs with exercise. Rather, treatment notes from Dr. Gange and Dr. Cocozzella point to Ms. Downey being disabled by an underlying psychiatric condition. Increases in palpitations and PVCs were also noted by the use of stimulants and in the setting of asthma flares.

The closest treatment following her last day of work on September 25, 2013 was with Dr. Gange on November 14, 2013. While Dr. Gange determined in his Treating Physician Statement that Ms. Downey was disabled as of his examination in November 2013 based on the claimed injury,[42] we do not find support for this conclusion in his treatment notes. Dr. Gange determined that her symptoms of chest pain were likely due to her underlying anxiety and did not provide any further immediate medical treatment as of his examination in November 2013.[43] In fact, on multiple occasions, Ms. Downey's PVCs were reported as non-cardiac in nature but were triggered by her anxiety and life stressors occurring in the setting of work issues, marital discord, and problems with her son.[44] We find that Dr. Gange's treatment notes reflect Ms. Downey was not disabled from an underlying heart disease or condition as of her last day of work.

Moreover, it is noteworthy that just prior to her ceasing work, Ms. Downey presented for a planned admission to McLean Hospital on August 31, 2013 to address her heavy alcohol consumption and opioid use in the setting of multiple stressors, including work issues, her father's illness, marital difficulties and a teenage son's use of marijuana. She reported that her consumption of alcohol increased eight months prior when she went on leave from her job. Her substance use was causing difficulty functioning at work and at home. Inpatient care was provided and Ms. Downey was ultimately discharged on September 4, 2013.[45] Ms. Downey was not treated for any cardiac related issues during this hospitalization.

Ms. Downey continued treatment for stress and anxiety at Brattleboro Retreat following her discharge from McLean Hospital. She was treated from September 5-15, 2013 for chief complaints of anxiety and trauma related to her work as a police officer and history of reported

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[42] Ex. 2.
[43] Ex. 16 (11/14/2013).
[44] Ex. 6 (12/20/2013, 1/18/2013, 1/30/2013, 7/11/2013, 11/14/2013).
[45] Ex. 21, p. 184.

use of alcohol and opiates. With diagnoses of depression, anxiety, PTSD, and ADD, Ms. Downey was prescribed Adderall, Trazadone, Remeron, and Klonopin.[46] Despite admissions to McLean Hospital and Brattleboro Retreat and after she ceased working, Ms. Downey continued to exhibit opioid seeking behavior when she sought treatment for asthma and migraines in September 2014. She requested opioids despite not being in distress. She was described as eating and not nausea, sitting in a lighted room, and talking quickly – actions not typically demonstrative of having a migraine episode. EKG obtained was normal, and chest pain was reported as due to coughing. Normal course of treatment was provided for her asthma and migraine.[47] These medical reports are further support of our determination that Ms. Downey was not disabled from an underlying cardiac condition as of her last day of work. *Vest*, 41 Mass. App. Ct. 191.

Conclusion. Based on the above reasons, there is competent evidence to rebut the heart law presumption. Ms. Downey is not entitled to accidental disability retirement benefits pursuant to G.L. c. 32, § 94. The DALA decision is affirmed.

SO ORDERED.

CONTRIBUTORY RETIREMENT APPEAL BOARD

Uyen M. Tran, Esq.
Assistant Attorney General
Chair
Attorney General's Appointee

Nicolle M. Allen, Esq.
Governor's Appointee

Fariyda Mulrain, R.N., B.S.N., F.N.P.

[46] Ex. 21, p. 171-72.
[47] Ex. 21 (9/30/2014 – 10/2/2014).