COMMONWEALTH OF MASSACHUSETTS

Middlesex, ss. Division of Administrative Law Appeals

Erik Easton,
Petitioner

v. Docket No. CR-21-0566
Date Issued: Feb. 7, 2025

Middlesex County Retirement System,
Respondent

Appearance for Petitioner:

Erik Easton, *pro se*

Appearance for Respondent:

Thomas F. Gibson, Esq.
Middlesex County Retirement Board
25 Linnell Circle
P.O. Box 160
Billerica, MA 01865

Administrative Magistrate:

Kenneth J. Forton

SUMMARY

A majority of the regional medical panel concluded that the Petitioner was not incapable of performing the essential duties of his heavy machine operator job and was therefore not disabled. A certification of incapacity is a condition precedent to accidental disability retirement by the Board. The medical panel did not employ an erroneous standard, lack pertinent facts, or fail to follow proper procedures, nor was it improperly comprised, or "plainly wrong." *See Kelley v. Contributory Retirement Appeal Bd.*, 341 Mass. 611, 617 (1961).

DECISION

On November 19, 2021, Petitioner Erik Easton timely appealed under G.L. c. 32, § 16(4) the November 18, 2021 decision of the Middlesex County Retirement Board denying Mr. Easton's application for accidental disability retirement.

DALA ordered the parties to file pre-hearing memoranda. In April 2024, Mr. Easton submitted his pre-hearing memorandum, along with 14 proposed exhibits. The Board submitted its pre-hearing memorandum, along with 23 proposed exhibits.

I held a hearing on October 7, 2024, which was conducted via Webex video conference. It was digitally recorded. I admitted into evidence the 14 exhibits submitted by Mr. Easton (Exs. P1-P14) and the 24 exhibits submitted by the Board (Exs. R1-R24). Mr. Easton was the sole witness but had the assistance of his mother, June Leslie. At the conclusion of the hearing, both parties made closing arguments, whereupon the administrative record was closed.

FINDINGS OF FACT

1. Erik Easton is a 47-year-old college educated male who began working for the Town of Burlington as a Heavy Machine Operator on June 4, 2018. (Exs. P9, R4.)

2. Mr. Easton's essential duties included operating heavy machinery, paving roads, drainage maintenance, and working as part of a team. (Ex. R3.)

3. On September 10, 2018, Mr. Easton was injured after being hit in the head by a lift-gate while removing a trailer hitch in the Highway Yard. (Ex. R3.)

4. Circlehealth records indicate that Mr. Easton sought treatment for a facial contusion and neck sprain/strain shortly after the injury. Mr. Easton also filled out a Work-Related Injury Evaluation Form that was signed by his provider. He was released

to work, with the following restrictions: not lifting more than ten pounds, and no heavy machinery or driving commercial equipment. (Exs. R8, R9.)

5. A few days after the injury, Mr. Easton was seen at the Lahey Hospital Emergency Department where he was diagnosed with post-concussive syndrome. Mr. Easton followed up several times with Dr. Jay Danowitz, who wrote a note excusing him from work pending further neurologic evaluation on September 20, 2018. (Ex. R15.)

6. Medical records of the Dr. Cantu Concussion Center indicate that Mr. Easton sought treatment beginning on October 10, 2018 for "difficulty remembering, bell rung, nausea, sleeping less than usual and nervous/anxious, fatigue/low energy, trouble falling asleep, irritable, feeling more emotional, feeling in a fog, confusion, difficulty concentrating, feeling mentally slowed down, headache/head pressure, sensitivity to light sensitivity to noise, and neck pain." Nurse Practitioner Kristen McLoughlin diagnosed post-concussive syndrome, balance issues, posttraumatic headaches, memory disturbance/loss, and confusion. Dr. Cantu Concussion Center continued to treat Mr. Easton for those problems until October 24, 2019. (Exs. R12 and R13.)

7. Chiropractor Jean-Marc Slak treated Mr. Easton for headaches, as well as ongoing neck and upper back pain. Mr. Easton also engaged in physical and occupational therapy at Emerson Hospital. (Exs. R16, R20.)

8. On February 5, 2019, Dr. Robert Levine conducted an independent medical examination. He diagnosed Mr. Easton with posttraumatic cognitive difficulties. Dr. Levine opined:

> The incident on September 10, 2018 had no loss of consciousness, no amnesia, and no neurologic deficit. As such there was no concussion with the incident of September 10, 2018 . . . . Imaging with a head CT scan and

> a brain MRI scan do not describe any findings to account for his complaints. Likewise, his EEG of October 11, 2018 was a normal study. Furthermore, on today's neurological examination, there were no objective findings. On his cognitive testing, however, he had great difficulty naming the months backwards and even the days of the week backwards. He appeared anxious as well and reports that there is significant marital discord and the trauma of September 10, 2018. For this reason, in my opinion he has not reached a medical end result.
>
> In the meantime, based on the absence of any objective findings to account for his complaints from his neurologic examination as well as his imaging studies, in my opinion, from an objective neurologic perspective, he is able to return to his regular work without restrictions.

(Ex. R17.)

9. On July 9, 2019, Dr. Barry Levin performed an independent medical examination on Mr. Easton. After reviewing his records and performing an examination, Dr. Levin diagnosed Mr. Easton with concussion, post-concussive syndrome, cognitive dysfunction, post-traumatic headaches, nausea, visual disturbance, anxiety, and sleep disturbance. He concluded:

> There is a casual relationship of my diagnoses to the event of September 10, 2018 with work-related injury. The incident of September 10, 2018 was the major contributing cause of the current disability and need for ongoing treatment. Treatment to date from all sources has been necessary, reasonable, and causally related to the work-related injury of September 10, 2018. Mr. Easton has not reached maximal medical improvement.
>
> Mr. Easton is totally disabled from his usual work with the DPW and is totally disabled for any and all employment.
>
> Prognosis for his recovery is uncertain at this time.

Dr. Levin also disagreed with Dr. Levine's findings and instead stated:

> Mr. Easton did have brief loss of consciousness following his head injury. He has a patchy memory of events that occurred immediately following his injury, and has memory deficits including no memory of going to Lowell General Hospital Emergency Room, with a vague and patchy memory of events that occurred while in the hospital. The noted loss of consciousness and memory deficits are consistent with concussion. CT

> scan of patient's head showed left suboccipital soft tissue swelling consistent with head injury. The majority of individuals with head injury associated with concussion and post-concussion syndrome have a normal head CT scan and brain MRI; normal studies do not rule out these diagnoses.
>
> Dr. Levine notes that the absence of objective findings to account for his complaints indicates that from an objective neurologic perspective he is able to return to his regular work without restrictions. Mr. Easton had abnormalities on neurological examination today as described above, with abnormalities consistent with diffuse cerebral dysfunction, especially frontal and temporal lobe dysfunction, as well as vestibular dysfunction, likely involving the brainstem. Mr. Easton is totally disabled for his usual work as well as any and all types of work on the basis of his multiple and significant neurologic symptoms. His neurologic symptoms are worse with increase in cognitive and physical stimulation. His work has significant potential for injury to himself and to others and his neurologic symptoms associated with the above-noted diagnoses would present a high potential for Mr. Easton harming himself or others were he to attempt to return to work.

(Ex. R10.)

10. On October 29, 2019 another independent medical examination was performed by Dr. Vladan P. Milosavljevic. After a neurological examination, he diagnosed Mr. Easton with post-concussive syndrome and post-traumatic headaches and opined that these diagnoses were the result of his injury. He stated that Mr. Easton has been totally disabled since the injury, but he has not yet reached maximum medical improvement. Dr. Milosavljevic opined that more emphasis should be put on "prophylactic treatment of his headaches" and "on treatment of his post-concussive syndrome symptoms, mostly psychological with psychotherapy and also psychiatric treatment if necessary." He concluded the disability is temporary, but that for the time being, the patient continues to be totally disabled from his employment. (Exs. P3, R19.)

11. On August 20, 2020, Dr. David Nowell conducted an independent neuropsychological evaluation of Mr. Easton. He reviewed the Petitioner's medical

records, interviewed Mr. Easton to discuss his current functioning, social, school and work history, and symptoms. He conducted a mental status exam as well as a series of tests to evaluate Mr. Easton's general cognitive functioning, academic functioning, language functioning, memory functioning, attention and executive functioning, visual spatial functioning, and personality inventory. Dr. Nowell was asked to respond to referral questions and when asked to identify the primary impairing diagnosis(es) he concluded:

> Limitations with performance validity and symptom validity, as described above, suggest that results of today's evaluation should be interpreted cautiously. These limitations make it difficult for an independent evaluator to form impressions of capacities and limitations on the basis of these data.
>
> At the current exam, we took more frequent breaks, and longer breaks, than is typical for a neuropsychological evaluation in the clinical setting, and duration of today's examination was longer than a typical clinical evaluation or a typical medico-legal evaluation. The claimant did not present as dismissive of the tasks presented to him today, and did not refuse tasks. I do note, however, that flippant responses were noted on the MMPI-2RF in our review of "critical items." His responses suggest the claimant was not likely taking the test seriously on a consistent basis. I note that he took much longer than is typical to complete the MMPI task, taking breaks for headache and noting that the visual demands of that long true/false test were associated with increased headache. Records note that at July 1, 2020 IME, there was administration of the MoCA, with a score of 14/30. This score would be unusual outside of a population of severe dementia or acquired brain injury, and is inconsistent with presentation in interview and with mental status examinations as documented in office visit notes and with continued engagement with instrumental ADLs.

Dr. Nowell was also asked to provide a description of the claimant's neuropsychological impairments, if any, and outline how these impairments would translate into limitations and/or medically appropriate restrictions. He responded by stating:

> Due to concerns regarding symptom validity and performance validity, I am not able to form impression of capacities and limitations on the basis

> of impairment attributed to psychiatric or neurocognitive disorder. Adequate performance was noted on a measure of single word reading, receptive language, confrontation naming, with marginal performance (below expectations but not within the impaired range) on measures of reading speed, phonemic verbal fluency, story recall, immediate and delayed design recall, and performance on a speedy trial of an auditory vigilance task. Impaired performances were noted on measures of semantic verbal. Fluency, word list recall, finger-tapping, simple attention, trial one of a challenging measure of sustained auditory vigilance, and performance on a timed paper and pencil visual scanning task as well as a design copy task. Performance on an untimed nonverbal problem-solving task, the card sorting test, was variable, ranging from the impaired range to the low average range. There are performances today which would be inconsistent with stated and observed capacities with daily activities. Again, the impact of headache on capacity to sustain adequate performance across the evaluation is noted. I defer to medical regarding functional impairment attributable to medical conditions.

(Ex. R14.)

12. On August 27, 2020, Dr. Amin Sabra performed an independent medical examination of Mr. Easton. After an examination, Dr. Sabra opined:

> His neurological examination all through showed no objective abnormality, including the examination by the neurologist, Dr. Srinivasan, and my neurological examination today.
>
> Based upon my review of the medical records, as well as my interview and examination of Mr. Easton, it is my opinion with a reasonable degree of medical certainty that as a result of his injury at work dated 9/10/2018 he sustained a concussion with a post-concussive syndrome, along with a neck sprain.
>
> In this case, where there has been no loss of consciousness, and where the MRI and CT scan of his head showed no acute abnormality, patients recover within 3-6 months with regard to their post-concussive syndrome, and rarely up to one year.
>
> Mr. Easton underwent an extensive course of physical, occupational, and speech therapy for more than 1-1/2 years. Despite all of these treatments and the rest for 2 years, he states that he continues to be significantly disabled because of his post-concussive symptoms. It is quite unusual that in this case, where there has been no loss of consciousness and no acute abnormality on the CT scan of the head, that his progress is so slow, and that he has not recovered fully from his concussion and post-concussive

> syndrome . . . . Another inconsistency noted in the records is that he initially never complained of double vision for at least one year, but over the past one year he has been complaining of double vision. It is well-known that if somebody has double vision from a concussion it will appear in the first 2-3 months, and not 1-1/2 years after. Similarly, in 03/2019 he started having new symptoms related to stuttering and halting of the speech, which again is unusual as symptoms occur usually within a few weeks of months after a concussion . . . . Another inconsistency is when he was re-evaluated for speech therapy on 10/01/2019, where according to the therapist his scores now were worse on standardized testing than during his initial evaluation. This again does not make much sense as post-concussive symptoms improve with time, and do not get worse. All the above suggest symptom amplification.
>
> Mr. Easton complains of significant difficulty with memory, concentrating, and lack of stamina, where he has to lie down even during my examination because of feeling tired. Similarly, he was noted during his occupational and physical therapy to need to rest. He complained of difficulty with vision. However, he has been able to drive to all of his appointments. He was coming on time and unaccompanied, according to NP McLoughlin. He was able to drive today from New Hampshire to Boston for his visit in my office. He drives between New Hampshire and Emerson Hospital, and between Billerica and New Hampshire, where he lives. It should also be noted that he lives alone, and is able to take care of all of his daily activities. He certainly is able to plan and go to his appointments on time, which suggest good memory and planning. He has no significant problems with his vision as he is able to drive to all of his appointments. The records show that he has been helping a friend at his shop. He is able to rake and shovel his driveway. To say that someone who can do all of these activities is completely disabled does not make much medical sense.
>
> Based upon my review of the medical records, as well as my interview and examination of Mr. Easton, it is my opinion with a reasonable degree of medical certainty that by one year from the time of his concussion he would have reached a point of maximum medical improvement. It is my opinion at this time he would have been able to resume his regular job as a machine operator with no restrictions. I do not expect any residual disability or impairment as a result of his injury at work dated 9/10/2018. It is my opinion that no further treatment is reasonable or necessary with regards to his injury at work dated 9/10/2018.

(Ex. R9.)

13. On November 28, 2020, Dr. Levin submitted a Neurology Report with diagnoses that mirrored the ones in his IME on July 9, 2019. He again stated that "there is a causal relationship between these diagnoses to the event of September 10, 2018." He opined again that Mr. Easton has "reached maximal medical improvement" and is "permanently and totally disabled for all employment." (Exs. P1, R10.)

14. The Department of Industrial Accidents arranged for Dr. Terence P. Doorly to perform an impartial medical examination. Dr. Doorly reviewed Mr. Easton's history of injury, subsequent medical treatment, his current status and performed a physical examination. His prognosis for Mr. Easton was "poor" as he "has made only slight gains despite extensive evaluation and therapy over more than 2 years." It was Dr. Doorly's medical opinion that "Mr. Easton is permanently disabled with respect to working as a heavy equipment operator." Since it had been over 2 years since the injury, Dr. Doorly concluded that Mr. Easton had "reached maximum medical improvement and a medical endpoint." (Ex. P4.)

15. Mr. Easton has remained out of work since his injury. (Ex. R12.)

16. Workers' compensation payments to Mr. Easton commenced on September 27, 2018. He received weekly payments of $560.21. (Ex. R3.)

17. On February 26, 2021, Mr. Easton applied for accidental disability retirement under G.L. c. 32, § 7, citing post-concussive syndrome as a result of a work-related injury on September 10, 2018. (Ex. R3.)

18. Mr. Easton's application was supported by the Physician's Statement of Dr. Robert C. Cantu. He diagnosed Mr. Easton with "post-concussion syndrome, post-traumatic headache, convergence insufficiency, and balance issues" as a result of the

September 10, 2018 injury. Dr. Cantu opined that the injury was likely permanent and more likely than not caused by the job-related injury. (Ex. R5.)

19. On March 30, 2021, the Town of Burlington filed an Employer's Statement that listed one incident, the one on September 10, 2018. (Ex. R4.)

20. On July 23, 2021, a regional medical panel of three physicians examined and interviewed Mr. Easton and also reviewed his disability application, job description and injury report, medical treatment records, independent medical examinations, Dr. Cantu's Physician's Statement, and the Employer's Statement. The Panel comprised internist Dr. Aymen Elfiky and neurologists Drs. Julian Fisher and Daniel Vardeh. (Ex. R7.)

21. Dr. Elfiky certified in the affirmative to all certificate questions as to disability, permanence, and the medical possibility of causation to Mr. Easton's injury. He diagnosed Mr. Easton with post-concussive syndrome and concluded that it remained an impediment to his ability to perform his duties. Dr. Elfiky saw no significant improvement, despite appropriate treatment. Finally, Dr. Elfiky opined that Mr. Easton was in danger of physical injury to himself and his coworkers. (Ex. R7.)

22. Dr. Fisher certified in the negative as to disability. He concluded that there were no clear neurological findings of any import and no objective reasons why Mr. Easton could not return to work. According to Dr. Fisher, recovery from a concussion like Mr. Easton's generally takes three to six months but may take a year. Dr. Fisher relied significantly on the examinations performed by Dr. Sabra and Dr. Nowell. Dr. Fisher noted that Mr. Easton presented as clinically depressed and evasive verging on "hostil[e]," he avoided direct answers to simple questions, he "clearly pretend[ed] not to

understand the simplest questions," and he attempted to fail Romberg and heel-to-toe tests. Dr. Fisher concluded:

> Without clear neurological findings of any import, and given the depressed and evasive affect, it is not possible to find any objective reasons why from a neurological standpoint, Erik Easton cannot return to work. There appears to be profound psychological and psychiatric overlay unrelated to the accident. He is therefore not disabled and is able to return to work as before.

(Ex. R7.)

23. Dr. Vardeh also certified in the negative as to disability. He concluded:

> Extensive testing including x-rays, CTs, MRIs, EEG etc. have all been negative for objective structural injury, his initial neurological evaluations within the first weeks after injury have been negative for any neurological deficits or cognitive deficits. His neuropsychological evaluation is concerning for symptom amplification and poor effort.
>
> On today's interview and exam, there were multiple signs of symptom amplification, including discrepancies between his inability to remember the year of the accident, but remembering in detail what he was doing the night before the accident and other specific circumstances. Other signs of symptom amplification include double vision while one eye is covered, overshooting on finger-to-nose testing due to having his eyes closed, dramatic behavior including putting in earplugs during the interview, and a stumbling gait which in itself requires more coordination than walking a line.
>
> Overall, I find his presentation not compatible with a physiological/ neurological disorder.

(Ex. R7.)

24. Taken together, this means that the majority of the medical panel opined that Mr. Easton was not incapable of performing the essential functions of his position and was therefore not disabled. (Ex. R7.)

25. On November 18, 2021, the Board denied Mr. Easton's application for accidental disability retirement based upon the negative medical panel. (Ex. R7.)

26. On November 19, 2021, Mr. Easton timely appealed the Board's decision. (Ex. R 2.)

27. On November 29, 2022, Dr. Sabra performed another independent medical examination. His conclusion remained the same as his first IME on August 27, 2020. (Exs. P5, R9.)

28. On April 21, 2023, Dr. Levin performed a second independent medical examination. His diagnoses were the same save for one: he now diagnosed Mr. Easton with "concussion with loss of consciousness" rather than "concussion." Dr. Levin's conclusion remained the same as well, that Mr. Easton is permanently disabled. (Exs. P1, P2, R10.)

CONCLUSION AND ORDER

Mr. Easton appeals the Board's denial of his application for accidental disability retirement. However, as outlined below, his appeal fails because he has not demonstrated that the medical panel either lacked pertinent facts or applied an erroneous standard. The medical panel physicians' opinions were based on a thorough evaluation of the available evidence, and Mr. Easton has not shown that their opinions were flawed in a manner that warrants overturning the Board's denial.

To qualify for accidental disability retirement, a member must apply to his retirement board and undergo a medical evaluation by a regional medical panel comprising three physicians. G.L. c. 32, §§ 6(3)(a) and 7(1). The application may be approved only if a majority of the medical panel determines that the applicant is unable to perform his essential job duties, that the incapacity is permanent, and that the incapacity could reasonably result from the personal injury or hazard encountered during

employment. *See Malden Ret. Bd. v. Contributory Ret. App. Bd*., 1 Mass. App. Ct. 420, 423 (1973); *Quincy Ret. Bd. v. Contributory Ret. App. Bd.*, 340 Mass. 56, 60 (1959). If the panel answers any of the three certificate questions in the negative, as happened here, the Board must deny the application. *Id.*

The medical panelists' opinions were based on the relevant medical records, and the panel is presumed to have considered all pertinent information presented. An applicant may overcome the Board's denial by proving that the panel employed an erroneous standard, lacked pertinent facts, failed to follow proper procedures, was improperly comprised, or was "plainly wrong." *See Malden Ret. Bd.*, 1 Mass. App. Ct. at 424; *Kelley*, 341 Mass. at 617. The applicant bears the burden of proving his case by a preponderance of the evidence. *See, e.g., Lisbon v. Contributory Ret. App. Bd.*, 41 Mass. App. Ct. 246, 255 (1996). Mr. Easton has failed to meet this burden. He has not presented any evidence that would tend to show that the panel employed an erroneous standard, lacked pertinent facts, failed to follow proper procedures, was improperly comprised, or was "plainly wrong." His only arguments, which address minor issues concerning the medical records, trivial procedural matters, and differences of medical opinion lack merit. Below, I address each of the points raised in his appeal.

Mr. Easton first claims that Respondent's Exhibits 11, 14, 15, 17, 18, 20, 21, and 23 (assorted treatment records and independent medical evaluations) contain misleading or unrelated information due to inconsistencies in the page numbering of scanned records. While Mr. Easton is correct in noting that page numbers in the record may overlap or be misaligned, this does not impact the content or relevance of the documents. These records provide crucial information regarding Mr. Easton's medical history,

ongoing symptoms, and treatment plan, all of which are highly relevant to the medical panel's assessment of his disability status. Mr. Easton does not explain why these documents should be considered misleading or unrelated, and there is no basis in the record to suggest that the page numbering discrepancies had any material impact on the panel's evaluation.

Mr. Easton next argues that Respondent's Exhibit 19 (an independent medical examination report written by Dr. Vladan Milosavljevic) was presented in incorrect page order, which he claims restricted the fluidity of the medical panel's thought process. However, upon review, the documents in Respondent's Exhibit 19 are in the correct order, with the only issue being the inclusion of one page twice. This minor oversight does not constitute a significant error that would mislead the medical panel. The panel was still able to consider the relevant information in a coherent and orderly fashion. Therefore, this argument is without merit.

Mr. Easton's third example is a date discrepancy in Respondent's Exhibit 13, where one date listed on the exhibit list does not match the date in the records. However, the correct date appears in multiple other parts of the document, and there is no evidence to suggest that this minor discrepancy caused any confusion or impacted the medical panel's analysis. Mr. Easton does not explain how this issue could have materially affected the panel's decision.

Finally, Mr. Easton's fourth example is Respondent's Exhibits 12, 17, 18, 21, 22, and 23 are missing pages containing relevant medical information. Upon further review, only Respondent's Exhibits 12 and 22 are missing pages, and the total number of missing pages amounts to seven. Mr. Easton has not demonstrated how these missing pages

contain critical information that would have altered the medical panel's conclusions. The entire record, which exceeds 400 pages, provides a more than sufficient basis for the panel's evaluation. Moreover, there is no evidence to suggest that the missing seven pages were anything of concern that would have materially impacted the panel's decision.

Finally, Mr. Easton argues that Drs. Sabra and Levine held different opinions from Drs. Cantu, Doorly, Levin, and Milosavljevic but the majority medical panelists gave more weight to Dr. Sabra's and Dr. Levine's opinions, which led to a "plainly wrong" decision. However, a medical panel is not prohibited from disagreeing with other medical opinions reflected in the record. It is likewise not required to explain why it rejects those medical opinions. *Giammalvo v. Massachusetts' Teachers Ret. Sys.*, CR-12-195 (DALA June 19, 2015); *Daniele v. Worcester Reg'l Ret. Sys.*, CR-23-0003 (DALA Nov. 1, 2024). The panel is entitled to weigh the opinions before it and rely on those that it finds most persuasive. A mere difference of opinion by a treating physician does not negate medical panel results absent the use of an erroneous standard. *See Stokes-de Salvo v. State Bd. of Ret.*, CR-12-401 (DALA Jul. 29, 2016); *see also Hickney v. State Bd. of Ret.*, CR-07-511, (DALA Mar. 19, 2009) ("[T]he fact that another physician offered a contrary opinion . . . is not evidence of the use of an erroneous standard by the medical panel."); *Turner v. State Bd. of Ret.*, CR-06-27 (DALA Feb. 16, 2007) (panel did not employ an erroneous standard and was not obligated to agree with the opinions of other physicians). The panel's review of the available records was comprehensive and there is no indication that any pertinent facts were missing or that any significant errors were made in the decision-making process.

For the reasons stated above, Mr. Easton's appeal fails. He has failed to prove that the medical panel's decision was based on an erroneous standard, lacked pertinent facts, failed to follow proper procedures, was improperly comprised, or was "plainly wrong." Unless the panel applies an erroneous standard, fails to follow proper procedures, or the certificate is "plainly wrong," the local board may not ignore the panel's medical findings. *Kelley*, 341 Mass. at 617. The panel conducted an exhaustive review of the available records and made a reasonable determination that Mr. Easton did not qualify for accidental disability retirement. The Board's denial of his application for accidental disability retirement is therefore AFFIRMED.

SO ORDERED.

DIVISION OF ADMINISTRATIVE LAW APPEALS

/s/ Kenneth J. Forton

Kenneth J. Forton
Administrative Magistrate

DATED: Feb. 7, 2025