COMMONWEALTH OF MASSACHUSETTS

Suffolk, ss. Division of Administrative Law Appeals

 One Congress Street, 11th Floor

 Boston, MA 02114

**MATTHEW GALE**, (617) 626-7200

 *Petitioner* Fax: (617) 626-7220

 **www.mass.gov/dala**

*v.* Docket No: CR-13-205

**STATE BOARD OF RETIREMENT,** Date: March 3, 2017

 *Respondent*

**Appearance for Petitioner**:

Paul S. Danahy, Esq.

420 Washington Street, Suite 400

Braintree, MA 02184

**Appearance for Respondent**:

 Melinda E. Troy, Esq.

 State Board of Retirement

 One Winter Street

 Boston, MA 02108-4747

**Administrative Magistrate**:

Angela McConney Scheepers, Esq.

**SUMMARY**

The Petitioner has not proven by a preponderance of the evidence that his work was the significant contributing factor in his psychiatric incapacity. *Robinson’s Case*, [416 Mass. 454](http://sll.gvpi.net/document.php?id=sjcapp:416_mass_454), 460 (1993).

**DECISION**

Pursuant to G.L. c. 32, s. 16(4), the Petitioner, Matthew Gale, appealed the March 28, 2013 decision of the State Board of Retirement (Board) to the Contributory Retirement Appeal Board (CRAB), denying his application for accidental disability retirement benefits.

A hearing was held at the Division of Administrative Law Appeal (DALA) on January 21, 2016. The hearing was digitally recorded.

Mr. Gale testified on his own behalf. I marked Mr. Gale’s Pre-Hearing Memorandum “A” for identification and the Board’s Pre-Hearing Memorandum “B” for identification. Mr. Gale called Correction Officer Jason Cahill. The Respondent called no witnesses.

The parties proposed sixteen exhibits. Upon later examination, I found that proposed Exhibit 16 was redundant of proposed Exhibit 12. I therefore admitted proposed Exhibits 1 – 15 into evidence.

Mr. Gale submitted a Post-Hearing Brief on February 26, 2016. The Board submitted a Post-Hearing Brief on February 29, 2016, whereupon the administrative record closed.

**FINDINGS OF FACT**

Based on the documents admitted into evidence and the testimony presented at the hearing, I make the following findings of fact:

1. The Petitioner, Matthew Gale (born in 1982 and 35 years of age), was employed as a Correction Officer (CO I) for the Department of Correction (DOC) from July 5, 2009 until April 30, 2012, the date of his separation from employment. May 29, 2011 was the last day he reported for work. A March 18, 2009 pre-employment examination cleared Mr. Gale for performing the essential job functions of a correction officer. (Exhibits 3, 5 and 6; Testimony of Gale.)
2. Mr. Gale graduated from high school in 2000. He attended the DOC Academy’s twelve-week program. (Testimony of Gale.)
3. Mr. Gale was assigned to the Souza Baranowski Correctional Center (SBCC), a maximum security prison. He worked the 3:00 p.m. to 11:00 p.m. shift in the N2 housing unit. (Exhibit 6; Testimony of Gale.)
4. The following “Summary of Series” is listed within the Classification Specification for the Correction Officer Series (classification specification):

Incumbents of positions in this series maintain custodial care and control of inmates; patrol correctional facilities; observe conduct and behavior of inmates; investigate suspicious inmate activity; and perform related work as required.

The basic purpose of this work is to maintain order and security in a correctional institution.

(Exhibit 6.)

1. The following “Examples of Duties Common to all Levels in Series” lists the essential duties of the position of Correction Officer in the classification specification:
2. Maintains custodial care and control of inmates by escorting or transporting them under restraint; patrolling facilities; making periodic rounds, head counts and security checks of buildings, grounds and inmate quarters; monitoring inmates’ movements and whereabouts; and guarding and directing inmates during work assignments to maintain order and security in a correctional institution.
3. Observes conduct and behavior of inmates, noting significant behavioral patterns, to prevent disturbances, violence, escapes or other crises such as suicides.
4. Notes and investigates suspicious inmate activity relative to contraband by searching individuals, vehicles, packages, mail and inmate quarters for weapons or other forbidden devices/objects to maintain prison security.
5. Develops working relationships with inmates by referring individuals to appropriate supportive services (e.g. medical, psychiatric, vocational, etc.) as needed to aid in rehabilitation and to foster an atmosphere of cooperation between inmates and staff.
6. Prepares reports on such occurrences as fires, disturbances, accidents, security breaches, etc.; prepares monthly evaluation reports on inmates; makes entries into unit log of daily activities and reviews daily activity reports to have accurate and up-to-date information available for reference by authorized personnel.
7. Performs related duties such as screening visitors; operating two-way radios; carrying and operating firearms; inspecting fire extinguishers, sprinkler systems, alarms and other safety apparatus; serving food to inmates; and assigning housing areas to inmates.

(Exhibit 6.)

1. Mr. Gale had a history of family abuse. Both his parents were alcoholics, and his father physically and sexually assaulted him from the age of 5 to 8 years old. His father was convicted and incarcerated for the abuse, and was released from prison in 2004. Mr. Gale’s parents lost custody of him, and he was adopted and brought up by his then-nineteen year old sister. He has no contact with either birth parent. Mr. Gale underwent psychotherapy until he was fourteen years old to deal with the childhood trauma. (Exhibit 8; Testimony of Gale.)
2. While on duty, Mr. Gale sometimes observed violent situations between the inmates. Mr. Gale began to experience decreased sleep, decreased appetite and recurrent intrusive thoughts of what he had witnessed. He began to drink in order to go to sleep. He drank a thirty-pack of beer on weekends, and “quite a bit” during the week. (Exhibits 6 and 8; Testimony of Gale.)
3. On November 4, 2009 at 8:12 p.m., an inmate attacked COs Aaron Porter and Jason Cahill with a shiv. The officers were able to unlock a back room and stay there until responding staff arrived. CO Cahill sustained injuries to his neck, face and jaw after the inmate punched and stabbed him. CO Porter sustained a laceration to the right side of his cheek, a superficial laceration to the right side of his nose, an abrasion to the left side of his neck and a small contusion to his forehead. Mr. Gale arrived on the scene and observed COs Cahill and Porter bloodied. CO Cahill later filed a Notice of Injury Report form, a DOC Witness Industrial Accident Incident Report and a workers’ compensation claim. Mr. Gale’s presence was not listed on any of the three reports. (Exhibit 14; Testimony of Gale, Testimony of Cahill.)
4. On May 22, 2011 at 8:30 p.m., there was a fight on L2 where a chemical agent was used to break up the fight. The inmates were treated in the trauma center of the Health Services Unit (HSU). One inmate sustained multiple stab wounds to his head, abrasions to the chest and left shoulder and a contusion to the back of his head. Another inmate had his eyes flushed out, a 1 cm superficial laceration on his left finger, and a puncture wound to the left upper lip. The inmate refused the on-call doctor recommendation to have his lip sutured at the emergency room (ER). He also refused to have the nurse steri strip his lip as an alternative. There is no record that Mr. Gale was present on this occasion. The incident reports were submitted by nurses who treated the wounded inmates. (Exhibit 14.)
5. On May 29, 2011 at 9:30 a.m., Mr. Gale was conducting recreation and tier time in the P-2 Housing Unit when he noticed an inmate outside his cell. Because it was not the inmate’s scheduled recreational time, Mr. Gale approached the inmate to speak to him. When he went to his desk to write up the incident, Mr. Gale experienced tightness and pain in his chest area, and pain up his arm. Mr. Gale filed a Notice of Injury Report. He also reported the incident to Captain Doher, and had his blood pressure checked by a DOC nurse in the Health Services Unit (HSU). Dwayne Hannula, a CO I, submitted a DOC Witness Industrial Accident Incident Report.[[1]](#footnote-1) Mr. Gale submitted a DOC Industrial Accident Incident Report, dated May 30, 2011. (Exhibits 6 and 14.)
6. Mr. Gale telephoned his primary care physician, Perry G. Farb, M.D. of the Fallon Clinic, and described his symptoms. He was advised to go to the emergency room for an evaluation. Mr. Gale went to the Health Alliance UMass Leominster Hospital (Health Alliance), where he presented with “pressure-like, substernal chest pain with symptoms ...” and “radiation of the pain to the left shoulder, right shoulder.” He was treated by Evan C. Swayze, M.D., who diagnosed a psychiatric panic attack, and noted the risk factor of hypertension. Dr. Swayze prescribed rest, a baby aspirin daily, and advised that Mr. Gale not return to work until he had been seen by his primary care physician (PCP). (Exhibits 8, 9 and 14.)
7. Mr. Gale obtained a letter dated June 3, 2011 from Dr. Farb, excusing him from work until further notice. (Exhibit 9.)
8. On June 6, 2011, Mr. Gale saw Dr. Farb for a follow-up appointment to his emergency room visit. Dr. Farb had already diagnosed Mr. Gale with major depressive disorder on April 27, 2010, prescribing him a daily drug regimen of Lexapro 20 mg. Dr. Farb now diagnosed Mr. Gale with PTSD. When Dr. Farb recommended counseling, Mr. Gale said that the DOC had referred him to psychologists. On June 6, 2011, Dr. Farb completed a Family and Medical Leave Act (FMLA) form to excuse Mr. Gale’s absence from work.[[2]](#footnote-2) (Exhibit 9; Testimony of Gale.)
9. Mr. Gale began to see Michelle Zedalis and Ashley Doucette, licensed mental health counselors (LMHC), at Fitchburg Riverfront Counseling. He attended sessions on June 10, 13 and 17, 2011. (Exhibits 8 and 9.)
10. The LMHCs reviewed Mr. Gale’s mental health status in a diagnostic evaluation. Mr. Gale was evaluated for self-care, adequate; behavior, cooperative; thought, logical; hallucinations, none; speech, care; mood/affect, normal; impulse control, adequate; sleep, well rested; appetite, good; substance abuse, no abuse; insight, good; judgment, good; orientation, oriented to time, place, person; suicidality, none; and homicidal, none. (Exhibit 9.)
11. Ms. Doucette diagnosed Mr. Gale with Axis I adjustment disorder with PTSD. She recommended one-on-one weekly therapy sessions until February 2012 with the following goals:
12. Problem Client is experiencing nightmares, is startled easily, and feels Statement: nervous at times.

Goal 1: Help client learn cognitive and body-based processing and coping skills. Treatment modality(ies) utilized: Mindfulness and cognitive behavioral therapy (CBT).

Discharge Client will be able to apply coping skills as he adjusts to life now Goal: that he is not working at a prison.

1. Problem Client has history of phys/sexual abuse that have recently become Statement: a point of concern for him since leaving job.

Goal 2: Help client vocalize and reframe self-beliefs and emotional material related to trauma.

Discharge Client will be able to understand the effects of past trauma and Goal: redirect himself when triggered.

(Exhibit 9.)

1. On August 29, 2011, Mr. Gale contacted Dr. Farb’s office for a letter excusing his absence from work until after his November 2011 medical appointment. (Exhibit 9.)
2. On November 18, 2011, Mr. Gale returned to Dr. Farb for the follow-up to his June 2011 appointment. He reported that he had stopped seeing the LMHC because she did not relate to him; he was looking for a new one. He reported feeling pretty good, with occasional flashbacks and bad dreams. (Exhibit 9.)

*Independent Medical Examinations*

1. Mr. Gale underwent three independent medical examinations (IMEs) for his workers’ compensation claim. The first IME was conducted by Michael Rater, M.D., on October 14, 2011. Dr. Rater interviewed Mr. Gale for one hour, reviewed the petitioner’s May 30, 2011 DOC Industrial Accident Incident from and reviewed the May 29, 2011 medical records from Health Alliance, the May and June 2011 medical records from the Fallon Clinic and Ms. Zedalis’ June 17, 2011 letter. (Exhibits 9 and 14.)
2. Mr. Gale revealed that since the May 29, 2011 incident (which he described disingenuously as a “heart issue”), he had nightmares, “could not sleep right,” avoided situations that reminded him of the prison, and did not speak to anyone about the incident. Mr. Gale elaborated that it was not just one thing that happened, but it was “10 or 15 over the last 2 or 3 years that combined in my head and then after a final incident that happened, I was messed up.” Mr. Gale stated that he was escorting an inmate across the recreational yard when a rival “shanked” the inmate on the side. He also recounted incidents involving inmates seriously injuring correction officers. He described an inmate rape scene and seeing an inmate bite off and swallow another inmate’s ear. Dr. Rater found that the series of events witnessed by Mr. Gale met the definition for a traumatic event as indicated by the DSM-IV-TR.[[3]](#footnote-3) Mr. Gale also revealed that a good friend had committed suicide seven months ago, and that a correction officer had committed suicide a few days ago. (Exhibit 9.)
3. Mr. Gale reported his child abuse, but stated that he could not remember specifics of the case. He recalled that he had the “shit beaten out of me.” (Exhibit 9.)
4. At the time of the IME, Mr. Gale was not taking psychiatric meds. Dr. Rater noted that Dr. Farb diagnosed Mr. Gale with major depression back in April 2010 and prescribed Lexapro, but those records were not available for his IME. Dr. Rater wrote:

Dr. Farb’s May 3, 2011, office record, which presumably would have more contemporaneous information as to the initiation of the antidepressant information, is not available for review.

(Exhibit 9.)

1. Dr. Rater diagnosed Mr. Gale with pre-existing post-traumatic stress disorder due to childhood sexual abuse by his father, and depression related to the same childhood trauma with an exacerbation or an initiation of treatment for depression in May 2011.[[4]](#footnote-4) (Exhibit 9.)
2. For treatment, Dr. Rater opined that Mr. Gale had a medical necessity for a series of up to twelve counseling appointments for post-traumatic stress disorder causally related to his work history:

I believe it is important in Mr. Gale’s case to keep the focus of the treatment setting on his work injury to use specific treatment techniques utilizing exposure to the narrative and exposure to relaxation and stress management techniques such as is provided through EDMR (eye movement desensitization response). … it would be important to keep the treatment for his current posttraumatic stress disorder focused and limited and specific to that, since in this particular situation, there is a high risk for iatrogenic[[5]](#footnote-5) broadening and spreading of Mr. Gale’s condition if time and attention is spent in attempting to address longstanding trauma and depression-related issues that may contribute to his current situation, but are best dealt with separately, once this acute incident is addressed from a clinical perspective.

(Exhibit 9.)

1. Dr. Rater concluded that Mr. Gale was incapacitated by his post-traumatic stress disorder from working as a correction officer. His prognosis for returning to such work was poor due to the exacerbation of the pre-existing condition and the intensity of the symptoms. Dr. Rater found that Mr. Gale had the ability to work and adapt to any work other than correction work. (Exhibit 9.)
2. The second IME was conducted by Michael Braverman, M.D. on December 23, 2011. During the interview, Mr. Gale was tense, dysphoric, depressed, ill-at-ease throughout the interview, with no brightening of affect and was never fully at ease. Dr. Braverman diagnosed Mr. Gale with Axis I, post-traumatic stress disorder with associated anxiety and depression, severe, not resolved; Axis III, hypertension; Axis IV, severe; and Axis V, 50. (Exhibit 9.)
3. Dr. Braverman noted Mr. Gale’s dysfunctional family and his lack of health insurance. He noted Mr. Gale’s persistent significant signs of depression, anxiety and panic with depressed mood, anxiety, irritability, disturbance of vegetative functions with insomnia and weight fluctuations. He was aware that Mr. Gale’s PCP noted that he had symptoms of emotional distress a year ago and started him on Lexapro. Dr. Braverman noted that Mr. Gale’s significant anxiety, panic and developing PTSD continued to develop and escalate. Following the May 2011 episode, Mr. Gale was referred for psychotherapy. Dr. Braverman found that Mr. Gale had no overt symptoms related to his childhood experiences, no overt symptoms of psychiatric illness distress or disability until the traumatic experiences at work precipitated his current psychiatric conditions. He concluded:

The patient’s psychiatric conditions of posttraumatic stress disorder with associated anxiety and depression, total and permanent psychiatric disability from his previous job as a correction officer and similar types of employment, and partial disability with regards to any other forms of employment, and need for ongoing psychological and psychiatric treatment, are all directly and causally related to the multiple trauma incidents he witnessed and directly experienced during the course of his employment as a correction officer.

(Exhibit 9.)

1. Dr. Braverman noted that while performing auto body work was therapeutic for Mr. Gale, it was not clear if he could pursue other types of employment at the time. (Exhibit 9.)
2. The third and final IME was conducted by Zamir Nestelbaum, M.D. on March 29, 2012. Dr. Nestelbaum reviewed Dr. Braverman’s and Dr. Rater’s IMEs, the May 29, 2011 medical records from Health Alliance, Ms. Doucette’s records from June and July 2011, the February 5, 2007-November 20, 2011 medical records from Dr. Farb at the Fallon Clinic and Ms. Zedalis’ June 17, 2011 letter. (Exhibits 6, 9 and 14.)
3. Dr. Nestelbaum diagnosed Mr. Gale with Axis I, post-traumatic stress disorder; ruled out posttraumatic stress disorder, chronic; diagnosed depressive disorder not otherwise specified; ruled out major depressive disorder in partial remission; diagnosed history of alcohol abuse; Axis II, deferred; Axis III, hypertension, hyperlipidemia, increased blood sugar; Axis IV, moderate; and Axis V, GAF=50.
4. Mr. Gale reported his family history and that he had seen and experienced numerous violent episodes over the course of his DOC employment. He reported the suicide of two coworkers, one in 2010 and one recently. He reported seeing an inmate tying up an inmate as a set up to a rape, but had not seen the rape. Later in the same interview, he said that that he had seen the inmate anally raping the other inmate. (Exhibit 6.)
5. Mr. Gale reported that he had become increasing depressed and anxious as 2010 drew to a close. He began to have nightmares and panic attacks. He would have panic attacks while at work. He was startled by car horns, balloons popping and sirens. (Exhibit 6.)
6. According to Dr. Farb’s notes, which were reviewed by Dr. Nestelbaum, Dr. Farb wrote in his August 10, 2010 treatment notes that Mr. Gale had been on Lexapro for two years, the drug helped tremendously, and Mr. Gale had no suicidal ideation or irritability. Dr. Farb also wrote in the treatment notes that Mr. Gale had significant anxiety, but had better control as long as he took the Lexapro. Dr. Nestelbaum noted that Mr. Gale had been on a regimen of Lexapro since 2008, and that the drug helped in the prison with anxiety. (Exhibit 6.)
7. Dr. Nestelbaum noted that Mr. Gale had reduced his alcohol dependency while working at the prison from a thirty-pack on weekends and drinking during the week to a consumption of a twelve to sixteen-pack on weekends.
8. Although Mr. Gale denied a connection between his childhood and his current psychiatric condition, Dr. Nestelbaum speculated that Mr. Gale’s choice of vocation was an attempt to work his childhood trauma and his father being sent to jail. (Exhibit 6.)
9. Dr. Nestelbaum opined that Mr. Gale’s work-related stress was the major and predominant factor in his development of psychiatric disorders, including post-traumatic stress and depression. While the depressive disorder had improved and his symptoms of post-traumatic disorder had reduced, they continued to persist. Dr. Nestelbaum recommended ongoing psychiatric and psychological treatment, including a good trauma therapist. Dr. Nestelbaum noted that without ongoing treatment, he found that Mr. Gale was not at a medical endpoint. He opined that the longer Mr. Gale went without treatment, the worse his prognosis would be for a full recovery. (Exhibit 6.)

*DOC and Department of Industrial Accident Claims*

1. Mr. Gale had filed a claim with the DOC for the alleged May 29, 2011 injury. On June 6, 2011, Kelley Correia, the Director of Human Resources and Workers’ Compensation, denied the claim. Ms. Correia noted that there were no “extenuating circumstances regarding either the incident or the employee, “that there was no “satisfactory medical evidence or other documentation to substantiate a work related injury of liability.” (Exhibit 6.)
2. On June 27, 2011, Mr. Gale filed a Form 110 claim for post-traumatic stress disorder, with a date of injury of May 22, 2011. (Exhibit 6.)
3. On July 8, 2012, Ms. Correia denied Mr. Gale’s claim for the May 22, 2011 injury. She noted that Mr. Gale had never filed or reported a work injury for May 22, 2011, and that the DOC had no notice of this injury until it received the Form 110 claim on June 27, 2011. (Exhibit 6.)
4. On July 23, 2013, pursuant to G.L. c. 152, the Department of Industrial Accidents denied Mr. Gale’s claims for both the May 22 and 29, 2011 injuries. However, the partiese entered in to an agreement for redeeming liability by lump sum in the amount of $15,000.00, for the payment of Mr. Gale’s medical benefits and vocational rehabilitation. (Exhibit 15.)

*Application for Accidental Disability Retirement*

1. On March 30, 2012, Mr. Gale filed a Member’s Application for Disability Application (Application) for accidental disability. Mr. Gale claimed that the medical reason for his Application was “post traumatic stress disorder, depression and anxiety.” In the Application’s Addendum, Mr. Gale described his duties as:

… maintains custodial care and control of inmates by escorting or transporting them under restraint, patrolling facilities, making periodic rounds, head counts and security checks of buildings, grounds and inmate quarters, monitoring inmates’ movements and whereabouts, and guarding and directing inmates during work assignments to maintain order and security in a correctional institution; observes conduct and behavior of inmates, noting significant behavioral patterns, to prevent disturbances, violence, escapes or other crises such as suicides; notes and investigates suspicious inmate activity relative to contraband by searching individuals, vehicles, packages, mail and inmate quarters and physically restrains inmates when necessary.

(Exhibit 3.)

1. Mr. Gale stated that as a result of his disability, he was “unable to perform any of these functions due to my inability to handle stress” on May 29, 2011. He noted that he had pursued new employment as an automotive painter. (Exhibit 3.)
2. Under the heading “Reason for Disability,” Mr. Gale checked both the “personal injury” and “hazard” boxes on his application, and stated that May 29, 2011 was the date of the last incident at approximately 9:30 a.m. at the P2 Housing Unit. Mr. Gale wrote, “After disciplining an inmate for being out of his cell, I began having heart palpitations, high blood pressure, chest pains, numbness in my left arm.” (Exhibit 3.)
3. The Treating Physician’s Statement (Physician’s Statement) was submitted by Dr. Michael Braverman and dated May 6, 2012. In the Statement, Dr. Braverman asserted that Mr. Gale was unable to perform the essential duties of his position, his incapacity was permanent, and that the natural and proximate cause of the personal injury was sustained in the performance of his duties. (Exhibit 4.)
4. In the Physician’s Statement, Dr. Braverman wrote that Mr. Gale suffered multiple injuries through May 2011, and diagnosed him with PTSD and depression/anxiety. (Exhibit 4.)
5. Ms. Correira submitted the Employer’s Statement Pertaining to a Member’s Application for Disability Retirement (Employer’s Statement) on June 18, 2012. Ms. Correira noted that Mr. Gale could not perform the physical requirements of his essential job duties as described in the job description due to the claimed disability. She further noted that although Mr. Gale had not requested modified duty, the DOC would have been able to provide an accommodation, a temporary modified duty program, for a maximum of 180 days. (Exhibit 3.)
6. In response to the question Occurrence #1 of an Incident or Hazard Related to the Applicant’s Job Duties, Ms. Correira wrote:

Date: 05-22-11, Time: Unknown, Location: Inside SBCC-Shirley (specific area unknown)

On 06-27-11, Officer Gale’s attorney filed a From 110 claim reporting that his client suffered chest pains and stress while at work on 05-22-11. He would later be diagnosed with PTSD. The subject’s first lost day would be 05-29-11 and continuing. This IA claim would be denied by HRD-WC on 07-05-11 due to no witnesses to this alleged injury, no collaborating evidence to confirm a work related injury on 05-22-11 and the fact that CO Gale failed to notify any facility staff or supervisors of any injury sustained on 05-22-11.

(Exhibit 5.)

1. In response to the question Occurrence #2 of an Incident or Hazard Related to the Applicant’s Job Duties, Ms. Correira wrote:

Date: 05-29-11, Time: 9:30 a.m., Location: P-2 Housing Unit at SBCC-Shirley

While conducting recreation and tier time in P-2 Housing Unit, CO Gale sustained severe chest pain, high blood pressure and dizziness. He would later receive a diagnosis of anxiety and depression. This IA claim would be denied by HRD WC on 06-17-11 due to insufficient medical evidence to support a work related injury or illness. CO Gale’s first lost day would be 05-29-11 and continuing.

(Exhibit 5.)

1. In the Addendum Sheet to the Employer’s Statement, Ms. Correira noted that Mr. Gale had undergone three IMEs and gave the following summary. The October 14, 2011 IME concluded that Mr. Gale was incapacitated from his PTSD due to his work as a correction officer; that his prognosis of returning to work was poor; and that Mr. Gale’s suffered from a pre-existing history of PTSD from his childhood sexual abuse by his father and a diagnosis of depression due to that childhood trauma. The December 23, 2011 IME confirmed that Mr. Gale was totally and permanently disabled from employment as a correction officer or similar employment and partially disabled from other forms of employment. The March 29, 2012 IME concluded that Mr. Gale’s work-related stress as a correction officer was the major and predominant factor in his development of psychiatric disorder and depression, and that he had no capacity to safely work in a correctional environment. (Exhibits 5 and 6.)
2. In October 2011, the Workers’ Compensation section of the state’s Human Resources Division engaged a private investigator to conduct surveillance on Mr. Gale. The investigator reported that he arrived at Mr. Gale’s home on October 12, 2011, and saw vehicles registered to him and his girlfriend in front of the home. At 7:55 a.m., an unidentified woman left the home in one of the vehicles. There was no other activity. On October 14, 2011, the investigator returned to Mr. Gale’s home. This time, he saw vehicles registered to Mr. Gale, his girlfriend, and a person with the same last name as the girlfriend. At 7:50 a.m., an unidentified woman left the home in one of the vehicles. There was no further activity, so the investigator left Mr. Gale’s home and drove to the address of his scheduled IME. The investigator saw Mr. Gale leave his appointment at 10:52 a.m., and followed him back to his home. The investigator saw no further activity. (Exhibit 6.)
3. Pursuant to G.L. c. 32, § 6(3), PERAC convened a psychiatric medical panel comprised of Edward K. Silberman, M.D., Mark O. Cutler, M.D. and Tracy K. Mullare, M.D. The Board sent each panel physician Mr. Gale’s medical records from Dr. Farb; psychotherapists Ashley Doucette and Michelle Zedalis and Leominster Hospital; the IMEs from Dr. Rater, Dr. Braverman and Dr. Nestelbaum; the private investigator report from Summit Investigations and a CD. (Exhibits 6, 7 and 9.)
4. The panel physicians reviewed Mr. Gale’s job description and medical records and conducted separate examinations. Dr. Silberman examined Mr. Gale on September 5, 2012, Dr. Cutler examined him on September 6, 2012 and Dr. Mullare examined him on September 10, 2012. (Exhibit 8.)
5. Each panel physician answered in the affirmative on all three questions. (Exhibit 8.)
6. After reviewing the job description and medical records from Dr. Perry Farb, Ashley Doucette, Michelle Zedalis, Leominster Hospital, the IMEs from Dr. Rater, Dr. Braverman and Dr. Nestelbaum and examining Mr. Gale, Dr. Silberman diagnosed Mr. Gale with post-traumatic stress disorder, currently in remission. Dr. Silberman found that while there was no history of mental disorders in Mr. Gale’s family, there was a history of substance abuse and Mr. Gale’s father manifested severely disturbed behavior in his physical and sexual abuse of Mr. Gale. (Exhibit 8.)
7. Dr. Silberman opined that Mr. Gale was not mentally capable of performing the essential duties of his job as described in the current job description, having become symptomatic with the typical symptoms of PTSD 1½ years before leaving the job. The May 29, 2011 event had triggered an autonomic reaction accompanied by pain and dizziness. Given that routinely stressful events could trigger incapacitating symptoms, such symptoms would likely have intensified had he remained on the job and increasing interfered with his ability to perform his duties. Because he was dependent on alcohol to get through his days, he was at high risk of alcohol dependence, which would have resulted in another source of disability. (Exhibit 8.)
8. Dr. Silberman found that Mr. Gale’s trauma of abuse had been handled successfully with therapy, so there was no pre-existing condition. He was working successfully and had maintained a stable marital relationship in his recent marriage. Dr. Silberman found that Mr. Gale’s daily exposure to dangerous conditions that were potentially uncontrollable caused a stress typical of the trauma precipitating PTSD, and that his symptoms were “very typical manifestations of such a traumatic stress disorder. There was no evidence that this was a pre-existing condition, or that Mr. Gale developed PTSD as a result of other life events outside of his employment.” (Exhibit 8.)
9. Dr. Silberman opined that Mr. Gale’s incapacity was likely to be permanent:

Even in the complete absence of the precipitating stressors after May 29, 2011, Mr. Gale’s symptoms have resolved only slowly and gradually. Although he would not currently meet the criteria for active PTSD, he is aware that he is not entirely back to his previous baseline. His early history of being abused is a risk factor for PTSD and can be expected to adversely affect the prognosis if he is re-exposed to traumatic situations. It is highly likely, given his current and past history, that he would not be able to work again as a corrections officer without return of progressively more incapacitating symptoms of PTSD.

(Exhibit 8.)

1. After reviewing the job description, Mr. Gale’s Application and medical records from Dr. Perry Farb, Ashley Doucette, Michelle Zedalis, Leominster Hospital, the IMEs from Dr. Rater, Dr. Braverman and Dr. Nestelbaum and examining Mr. Gale, Dr. Cutler diagnosed Mr. Gale with Axis I, post-traumatic stress disorder and panic disorder; Axis IV, 5 work-related events and past history of physical and sexual abuse and Axis V, global assessment of functioning = 50. As Dr. Silberman had found, Dr. Cutler found that Mr. Gale’s prognosis for returning to correction work was very poor, but that his prognosis for other work was good. Mr. Gale had no contact with either parent. His sibling had no psychiatric or substance abuse disorders. Dr. Cutler noted that Mr. Gale ended his friendships with his former coworkers who remained at the correctional facility. (Exhibit 8.)
2. Dr. Cutler concluded that Mr. Gale was mentally incapable of performing the essential duties of his job, said incapacity was likely to be permanent, and was such as might be the natural and proximate result of the personal injury sustained or hazard undergone on account of which retirement claimed is warranted. (Exhibit 8.)
3. After reviewing the job description, Mr. Gale’s Application and medical records from Dr. Perry Farb, Ashley Doucette, Michelle Zedalis, Leominster Hospital, the IMEs from Dr. Rater, Dr. Braverman and Dr. Nestelbaum and examining Mr. Gale, Dr. Mullare gave him a fair to poor prognosis and diagnosed Mr. Gale with Axis I, post-traumatic stress disorder; Axis II, deferred; Axis II, hypertension, history of hyperglycemia; Axis IV, moderate-severe; and Axis V, current GAF #49. (Exhibit 8.)
4. Dr. Mullare noted that Mr. Gale denied family psychiatric history, but revealed that both parents abused alcohol. Mr. Gale reported that he had developed an alcohol habit in order to go to sleep, but had now reduced his drinking to weekends. He avoided anything that reminded him of his former work. He avoided former coworkers, which included the best man at his wedding. (Exhibit 8.)
5. Dr. Mullare opined that Mr. Gale was exposed to multiple traumatic events that caused significant emotional distress, resulting in PTSD. Because of his trauma, he experienced panic and avoids situations that remind him of these traumatic events. Dr. Mullare opined that if Mr. Gale returned to his duties, they would trigger his emotional distress. (Exhibit 8.)
6. Dr. Mullare found that after the counseling for his childhood trauma, Mr. Gale went on to graduate from high school, work full-time, and maintain relationships without evidence of significant psychiatric symptoms. Given the severity of Mr. Gale’s symptoms and their persistence despite treatment of medications and therapy, it was Dr. Mullare’s opinion that his incapacity is permanent. Dr. Mullare wrote:

Mr. Gale’s experiences while performing his job duties as a Corrections Officer predisposed him to development of a Post Traumatic Stress Disorder, which accounts for his emotional impairment for which he applies for disability.

(Exhibit 8.)

1. By letter dated December 27, 2012, the Board informed Mr. Gale that it would table his request until it could obtain further information. (Exhibit 10.)
2. On February 22, 2013, the DOC forwarded the Board a report of its investigation into Mr. Gale’s complaints. The DOC investigation concluded that even if Mr. Gale had been present at those instances of violent inmate behavior that he relied upon in his claim, he had failed to notify his superiors of an injury and he had failed to file a formal workmen’s compensation claim for those incidents. The DOC found that Mr. Gale failed to provide specific dates of injury due to inmate violence; and in the case of allegations of injury to other officers, he could not provide dates or the names of the officers assaulted. The report stated that in some cases, Mr. Gale claimed to suffer from stress not due to actually witnessing inmate violence, but due to the violence some of his fellow officers incurred from inmates. (Exhibits 11 and 14.)
3. Mr. Gale attended a hearing before the Board on March 28, 2013. In a notice dated March 29, 2013, the Board informed him that it had voted to deny his application for accidental disability retirement, stating:

… based on its review of the medical and non-medical evidence in the record, the Board determined that Mr. Gale had failed to meet his burden to show that he had sustained a compensable injury pursuant to G.L. c. 32, §7. …

(Exhibits 1 and 13.)

1. On April 8, 2013, Mr. Gale filed a timely appeal at DALA. (Exhibit 2.)
2. Mr. Gale has been employed full-time painting cars since June 2011. (Exhibits 8 and 11; Testimony of Gale.)

**CONCLUSION AND ORDER**

 After careful consideration of the evidence presented in this case, the Board's denial of Mr. Gale’s application for disability retirement benefits is affirmed.

An applicant bears the burden of proving his entitlement to accidental disability retirement by a preponderance of the evidence. *Lisbon v. Contributory Retirement Appeal Bd*., [41 Mass. App. Ct. 246](http://sll.gvpi.net/document.php?id=sjcapp:41_mass_app_ct_246), 255 (1996). To qualify for accidental disability retirement, an applicant must prove total and permanent disability by reason of a personal injury sustained or a hazard undergone as a result of, and while in the performance of, his duties at some definite place and at some definite time. G. L. c. 32, § 7. Accidental disability benefits are awarded only when a regional medical panel majority concludes that the applicant is incapable of performing the essential duties of the job, that the incapacity is permanent, and that the incapacity might be the natural and proximate result of the personal injury sustained or hazard undergone in the course of employment. *See Malden Retirement Bd. v. Contributory Retirement Appeal Bd*., [1 Mass. App. Ct. 420](http://sll.gvpi.net/document.php?id=sjcapp:1_mass_app_ct_420), 423 (1973). A certification of incapacity is a condition precedent to accidental disability retirement by the local board. *Quincy Retirement Bd. v. Contributory Retirement Appeal Bd*., [340 Mass. 56](http://sll.gvpi.net/document.php?id=sjcapp:340_mass_56), 60 (1959).

Aggravation of a pre-existing condition to the point of total and permanent disability satisfies the “natural and proximate” cause requirement. *Baruffaldi v. Contributory Retirement Appeal Bd*., [337 Mass. 495](http://sll.gvpi.net/document.php?id=sjcapp:337_mass_495), 499 (1958). Massachusetts courts have held that in order to meet the “natural and proximate cause” standard, the applicant’s work-related incident must be more than a “contributing” or “aggravating” factor to a pre-existing condition. *Blanchette*, 20 Mass. App. Ct. at 485; *Campbell v. Contributory Retirement Appeal Bd*., [17 Mass. App. Ct. 1018](http://sll.gvpi.net/document.php?id=sjcapp:17_mass_app_ct_1018), 1019 (1984). The Supreme Judicial Court has noted that in order for an event of employment to be more than a “contributing cause,” it must be found to be “a significant contributing cause to [the] employee’s disability.” *Robinson’s Case*, [416 Mass. 454](http://sll.gvpi.net/document.php?id=sjcapp:416_mass_454), 460 (1993).

 Mr. Gale was examined by a psychiatric medical panel. That panel unanimously concluded that he was psychiatrically disabled, and was unable to perform as a Correction Officer I or similar occupation. However, while an affirmative medical panel certificate is a condition precedent to an award of a disability pension, it is not conclusive, and the retirement board or CRAB must make the ultimate determination based on the record as a whole. *See Blanchette v. Contributory Retirement Appeal Bd.*, [20 Mass. App. Ct. 479](http://sll.gvpi.net/document.php?id=sjcapp:20_mass_app_ct_479), 482 (1985).

 In order to meet the burden of proof with regards to causation, a member must prove one of two hypotheses: that the disability was caused by a single or series of work-related events, or that the applicant’s employment exposed his to an “identifiable condition … that is not common and necessary to all or a great many occupations.” *Blanchette*, 20 Mass. App. Ct. at 485, quoting *Zerofski’s Case*, [385 Mass. 590](http://sll.gvpi.net/document.php?id=sjcapp:385_mass_590), 595 (1982). It is the applicant’s burden to prove that he has a permanent and total disability that is the natural and proximate result of a personal injury sustained as a result of the performance of his duties. *Fairbairn v. Contributory Retirement Appeal Bd*., [54 Mass. App. Ct. 353](http://sll.gvpi.net/document.php?id=sjcapp:54_mass_app_ct_353), 357 (2002), citing *Blanchette*, 20 Mass. App. Ct. at 483.

Mr. Gale was trained at the twelve-week DOC Academy to perform the essential job duties of a correction officer. Mr. Gale testified that he worked in a violent environment at the SBCC, a maximum security prison. It is presumable that the inmates at SBCC were individuals who had committed serious crimes and were sentenced to lengthy terms. Mr. Gale related that in his first week on the job, he saw an inmate stab another inmate more than twenty-five times. Mr. Gale was sometimes assigned to the “North Can,” where the worse prisoners at SBCC were housed. He testified that the prisoners there were kept in their cells twenty-three hours a day, had no recreational time, and ate meals in their cells. He stated that the “North Can” prisoners would cut themselves during the correction officers shift changes, sometimes squirting blood at the ceiling. Mr. Gale stated that he had seen an inmate put batteries and a pencil in his penis.

The types of incidents that Mr. Gale recounted, while troubling, are included on the job description or within the scope of the job description. They are the types of situations common to a prison. According to the “Examples of Duties Common to all Levels in Series,” incumbents must maintain custodial care and control of inmates by escorting or transporting them under restraint, patrolling facilities, making periodic rounds, head counts and security checks of buildings, grounds and inmate quarters, monitoring inmates’ movements and whereabouts, and guarding and directing inmates during work assignments to maintain order and security in a correctional institution. A correction officer must observe conduct and behavior of inmates, noting significant behavioral patterns in order to prevent disturbances, violence, escapes or other crises such as suicides. From the training and job description, it was evident that Mr. Gale would be working in a violent environment that was the home of offenders.

According to the job description, correction officers must also prepare reports on such occurrences as fires, disturbances, accidents and security breaches. Mr. Gale testified that he was assigned to various housing units during approximately two years with the DOC, was witness to many violent situations, but only completed an incident report once. He testified that he did not file incident reports for all the incidents claimed because he had not been advised to do so.

Mr. Gale described suicides and suicide attempts among the DOC correction officers. However, injuries to third parties do not suffice to establish that one has sustained a compensable injury. *Fender v. Contributory Ret. Appeal Bd*., 72 Mass. App. Ct., 755, 759 (2008) (two deaths and one suicide attempt may not amount to a “personal injury” to the applicant) CR-08-736 (DALA on remand); *See also Calnan v. Cambridge Retirement Bd. & PERAC*, CR-08-589 (DALA 2012) (in order to be compensable, applicant must show that coworker’s suicide occurred both “as a result of” and “while in the performance of” the applicant’s duties).

Mr. Gale was not a reliable historian, and this affected his credibility. His recollections were redolent with alleged violence at the SBCC. Mr. Gale also appeared to conflate his memories with alleged reports from his coworkers. The discrepancies in his narratives were documented in Dr. Nestelbaum’s IME report. In the March 29, 2012 interview with Dr. Nestelbaum, Mr. Gale said that he did not see an actual rape – but an inmate tying up another as a prelude to the rape. In the same interview, he reported walking by a cell and seeing an inmate anally raping another. At the October 14, 2011 IME interview with Dr. Rater, he said that he was walking in the tiers when he saw an inmate raping an inmate tied to a bed. There were also discrepancies in the number of times he was assaulted and how many of his fellow correction officers had committed suicide or attempted to do so.

In his IME interviews and his medical panel single separate interviews, Mr. Gale refused to elaborate on his childhood trauma. The psychiatrists did not press him.

In his IME interviews and in his testimony at DALA, Mr. Gale related seeing an inmate bite off another’s ear and swallow it. He related fights with over one hundred inmates in the chow hall while only ten to twelve correction officers were at hand. He described breaking up fights among inmates, and having a frog – a combination of urine, feces and semen – thrown on him by inmates. He described a frog landing in a correction officer’s eye.

Mr. Gale’s Application alleges that he suffered from PTSD, anxiety and depression from and after the May 29, 2011 incident. In support thereof, Mr. Gale submitted claims for work-related incidents on November 4, 2009 and May 22, 2011, using contemporaneous incident reports which omit any reference to Mr. Gale. Those reports do not document what Mr. Gale was doing at the time of these incidents or if he were even on duty. Thus the evidence in the record is insufficient to establish specific events on November 4, 2009 and May 22, 2011 that could serve as the basis for his application. *See Zajac v. State Bd. of Retirement,* CR-12-444 (DALA 2014); *aff’d* (CRAB 2015) (complaint pending in Hampden County Sup. Ct.) (application for accidental disability retirement benefits may not be amended retroactively to include new injuries or new incidents; events upon which a member relies must be stated in the application). *See Azevedo v. State Bd. of Retirement & Contributory Ret. Appeal Bd.,* (Bristol Sup. Ct. April 30, 2010) No. 2009-1126 (employee who alleged inappropriate conduct by superiors failed to prove that the events occurred as he testified as there was no corroborating evidence in the record). *See also Barbati v. State Bd. of Retirement,* CR-10-590 (DALA), *aff’d* (CRAB 2012), *aff’d* Norfolk Sup. Ct. Nov. 24, 2014).

Based on his past history of anxiety and depression, Mr. Gale had been suffering for some time. According to Dr. Farb’s (the PCP) medical records, he was diagnosed with major depression in April 2010, and was prescribed Lexapro. According to Dr. Nestelbaum’s IME, which relied partly on records from Dr. Farb not in evidence, Mr. Gale was taking Lexapro upon Dr. Farb’s direction as early as 2008 – before he became a correction officer.

The psychiatric panel unanimously found that Mr. Gale suffered from PTSD, causally linked to his employment as a correction officer. Dr. Silberman opined that Mr. Gale had developed PTSD 1½ years before leaving the job (he reported for work for less than two years), but now the disorder was in remission. He found that there was no pre-existing condition. The entire panel agreed that a return to the DOC or similar type of work would cause significant emotional distress, and that the incapacity was permanent.

When Mr. Gale became a correction officer in July 2009, he had the work environment common to the other correction officers. He was not subject to outrageous working conditions in comparison with the work the other correction officers were doing. Based on the evidence presented, I conclude that the May 29, 2011 work incident did not “significantly contribute” to Mr. Gale’s disability by aggravating his underlying anxiety and depression. Mr. Gale’s anxiety, rather than the conditions of the job, was the contributing factor. To reiterate, Gale’s underlying anxieties caused his incapacity, not the conditions of the job or the responsibilities of the duties themselves. Given Mr. Gale’s history of physical and sexual abuse by his father, and that fact that his father was incarcerated for a long time, working in a prison may not have been the optimal employment environment for him, but that does not mean the work incidents were contributing factors of his disability.

Mr. Gale had successfully treated for his childhood trauma with psychotherapy from the time he was 8 to about 14 years old. It is possible that his condition had become quiescent from a clinical perspective by the time of his employment. However, he did not follow through with the PCP’s recommendation for psychotherapy after the May 29, 2011 incident. Dr. Farb referred Mr. Gale to licensed mental health therapists for care. Ms. Doucette, the LMHC, evaluated him and recommended one-on-one weekly sessions from July 2011 to February 2012. However, Mr. Gale only attended three appointments. In fact, in his October 14, 2011 IME, Dr. Rater concluded that Mr. Gale had a medical necessity for a series of up to twelve counseling appointments for post-traumatic stress disorder. Dr. Rater’s recommended coping mechanisms were similar to those in Ms. Doucette’s proposed course of treatment. In the March 29, 2013 IME, Dr. Nestelbaum concurred, noting that Mr. Gale would benefit from a good trauma therapist. Because Mr. Gale did not complete the recommended psychotherapy regimen, it is possible that he was not at a medical end point when he filed his Application. With the lessening of his symptoms after he left his job, including a reduction in drinking, it is probable that a complete regimen of psychotherapy could have resolved his anxiety, depression and PTSD.

Mr. Gale was performing the essential duties of his job as was expected of him in the position of a Correction Officer I in a correctional institution. As such, he has failed to establish that he sustained a personal injury. *See Sheilah Knowles v. State Bd. of Retirement,* CR-09-1087 (DALA) *aff’d* (CRAB 2013) (Petitioner’s claim that contact with probationers daily exacerbated her condition rejected because everyday contact with probationers was part of the duties of that position).

While Mr. Gale did not receive Worker’s Compensation benefits for any of the alleged work-related incidents, he settled a claim in 2013 by way of lump sum agreement. The receipt of either temporary or lump sum benefits has been properly held to demonstrate that the parties engaged in legal compromise, rather than a resolution of a claim for entitlement to benefits. *Zajac,* *supra.*

 For the foregoing reasons, Mr. Gale’s claim fails because of the lack of causation related to the claimed date of injury for the alleged disabling condition. Accordingly, the State Board of Retirement’s denial of Matthew Gale’s application for accidental disability retirement is affirmed.

SO ORDERED.

DIVISION OF ADMINISTRATIVE LAW APPEALS

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Angela McConney Scheepers

Administrative Magistrate

DATED:

1. CO Hannula wrote in his report:

Approximately 11:00 a.m. on Sunday May 29th [,]I CO Hannula, witnessed CO Matt Gale complain of a rapid heartbeat and express his concerns of his health. CO Gale told me that he felt angry and was having trouble controlling his anger and his state of mind. Gale informed me that he was stepping out to see the nurse in the nurses pod area and that was the last I heard from him. (Exhibit 6.) [↑](#footnote-ref-1)
2. Dr. Farb also completed a letter dated June 21, 2011 at the behest of Mr. Gale’s counsel, noting that the Petitioner suffered from post-traumatic stress disorder, the disorder appeared to be work-related and Mr. Gale was referred to a mental health specialist. (Exhibit 9.) [↑](#footnote-ref-2)
3. Dr. Rater wrote:

All of these incidents separately and collectively are consistent with traumatic events and in particular, given Mr. Gale’s own personal history, the event of walking by the inmate who was sexually assaulting the other inmate was certainly traumatic and a dangerous incident for Mr. Gale to witness with regard to his own mental stability. (Exhibit 9.) [↑](#footnote-ref-3)
4. Dr. Farb’s treatment notes in evidence indicate that the onset of Mr. Gale’s most recent depression was April 2010. (*See* Findings of Fact 13 and 33; Exhibit 9.) [↑](#footnote-ref-4)
5. Denoting response to medical or surgical treatment, usually denotes unfavorable response. *Stedman’s Medical Dictionary*, (28th ed. 2006.) [↑](#footnote-ref-5)