COMMONWEALTH OF MASSACHUSETTS

Middlesex, ss. **Division of Administrative Law Appeals**

Robert Rowley, Jr.,
Petitioner,

v.

Everett Retirement Board,
Respondent.

No. CR-19-579

Dated: June 10, 2022

Appearance for Petitioner:
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Appearance for Respondent:
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Administrative Magistrate:
Yakov Malkiel

SUMMARY OF DECISION

The petitioner applied for accidental disability retirement, having suffered a concussion in a work-related car accident. A medical panel comprised of neurologists returned a negative certificate, reasoning that proper psychiatric treatment might alleviate the petitioner's symptoms. The retirement board possessed, but declined to give the panelists, a psychiatrist's report concluding that psychiatric treatment is unlikely to resolve the petitioner's disability. In these circumstances, the panel's certificate was issued without the benefit of pertinent facts. The case is therefore remanded to the board for further proceedings.

DECISION

Petitioner Robert Rowley, Jr.[1] appeals from a decision of the Everett Retirement Board denying his application for accidental disability retirement. The appeal was submitted on the

[1] The petitioner is so designated in the pleadings, though various record documents identify his first name as Ralph.

papers. 801 C.M.R. § 1.01(10)(c).[2] I admit into evidence stipulations numbered 1-29 and exhibits marked 1-35 and A-I.[3]

Findings of Fact

I find the following facts.

1. Mr. Rowley served as a City of Everett parking officer beginning in 2010. He worked in shifts from midnight to 8 AM, patrolling the city in a work-provided vehicle. (Stipulation 1; Exhibit 1.)

2. On June 27, 2016, while Mr. Rowley was on duty, another car crossed a yellow line and collided head-on with Mr. Rowley's vehicle. Mr. Rowley's vehicle was destroyed. Debris from both cars littered the road. Mr. Rowley's face and hands were covered with blood. (Stipulation 2; Exhibits 1, 26.)

3. Mr. Rowley was ambulanced to the hospital. He was diagnosed with a head injury, a nose fracture, a neck sprain, and PCS (post-concussion syndrome). He was kept in the hospital overnight. A CT scan taken at the hospital and an MRI performed several days later showed no acute abnormalities. (Stipulations 2, 3; Exhibits 16, 25.)

4. One month after his accident, Mr. Rowley was examined by Dr. Michael Alexander, a neurologist. He complained of headaches, anxiety, and insomnia. To Dr. Alexander, it was "not immediately apparent" whether Mr. Rowley had suffered a TBI (traumatic brain injury). After a follow-up visit, Dr. Alexander wrote: "[B]rain injury is not the

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[2] The board purported to request an evidentiary hearing, but did not name any potential witnesses. Mr. Rowley initially identified himself and his wife as witnesses, but later agreed that their testimony was unlikely to illuminate the issues determinative of a negative-panel case. *See Manning v. Plymouth Cty. Ret. Bd.*, No. CR-15-557, at 2-3 (DALA May 12, 2017).

[3] The latter set of exhibits was submitted separately by the board, originally marked 1-9, and re-marked (as A-I) in DALA's case file.

likely source of his current complaints. Chronic sleep difficulties and significant anxiety are much more likely." Dr. Alexander prescribed Gabapentin, emphasizing in his notes the importance of Mr. Rowley's compliance. (Exhibit 23.)

5. Mr. Rowley was referred for evaluation and treatment to Dr. Ron Calvanio, a psychiatrist. Dr. Calvanio's testing indicated a severely impaired ability to form new memories, a common symptom (he wrote) among PCS patients. Dr. Calvanio was "absolutely certain that Mr. Rowley's impairments are due to brain injury and not to a psychiatric disturbance or malingering." He explained that, upon an extensive evaluation, "Mr. Rowley produced a classic, textbook TBI test profile." (Exhibit 22.)

6. In May 2018, Mr. Rowley saw neurologist Dr. Ferdinando S. Buonanno, who ordered a new MRI. The radiologist performing the scan noted no evidence of "hemorrhage, acute infarction, intracranial mass lesion or hydrocephalus." But when Dr. Buonanno reviewed the images, he saw "some foci of leukoaraiosis . . . more atrophy than expected for age, and reduced ASL signal (blood flow) bilaterally in the temporal lobes." In Dr. Buonanno's view, the MRI provided "clear evidence" of "reduced blood flow bilaterally in the anterior temporal region." This finding was "consistent with the dynamics of Mr. Rowley's [car accident]." (Exhibits 16, 21.)

7. Mr. Rowley was seen on various occasions by Dr. Walter Panis, a concussion expert. Dr. Panis believed that Mr. Rowley was suffering from PCS. He suspected that anxiety was hindering Mr. Rowley's recovery. Nevertheless, Dr. Panis confirmed repeatedly that Mr.

Rowley "is totally and permanently disabled as the result of the work-related car accident." (Exhibits 16, 20.)[4]

8. Mr. Rowley visited his primary care physician at regular intervals. In November 2016, he was referred to counseling, "did not develop a good rapport" with the psychologist, and asked for a new provider. For a time, Mr. Rowley also received treatment for anxiety from Dr. Calvanio. Mr. Rowley would "sometimes forget" to take his Gabapentin, and he discontinued that medication altogether in February 2017. (Exhibit 16.)

9. Several records dated before and soon after Mr. Rowley's accident recite his medical history. His pre-accident issues included reflux, high cholesterol, prediabetes, and varicose veins. The histories do not mention anxiety or insomnia. (Exhibits 16, 20, 23.)

10. Mr. Rowley obtained workers' compensation through vigorously contested proceedings. Several of his medical evaluations, all performed by neurologists, were adverse to him. In April 2017, Dr. Julian Fisher opined that Mr. Rowley's headaches and memory problems "appear to be related to both the anxiety and a chronic sleep disorder . . . neither related to the motor vehicle accident." In December 2017, Dr. Paul Chervin agreed, stating that the "symptoms which have prevented Mr. Rowley's return to employment are those of anxiety and unrelated to his head injury."[5] In September 2018, Dr. Robert A. Levine concluded less specifically that, based on the absence of "objective findings," Mr. Rowley was fit to return to work. (Stipulations 4-18; Exhibits 3, 4, 6, 10-15, 33, 34.)

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[4] While the medical panel was at work, Dr. Panis attempted to start Mr. Rowley on a "trial" course of Celexa. Mr. Rowley resisted. Dr. Panis subsequently reconfirmed Mr. Rowley's total, permanent disability resulting from the car accident. (Exhibits 16, 20.)

[5] It is not obvious from the record why Dr. Fisher and Dr. Chervin viewed Mr. Rowley's anxiety and insomnia as unconnected to his accident.

11. Another report prepared in connection with the workers' compensation proceedings was authored in March 2018 by psychiatrist Dr. Michael Braverman. Dr. Braverman diagnosed impairments of attention, memory, and ability to deal with stress. He believed that these conditions were "directly causally related to the head injury." Dr. Braverman wrote that Mr. Rowley needs intensive treatment in a "head injury treatment program," to be supplemented by "supportive psychotherapy" and potentially psychiatric medication. But Dr. Braverman described his prognosis as "guarded" in any event, stating that Mr. Rowley's disability is "likely to be permanent." (Exhibit 19.)

12. On September 12, 2018, Mr. Rowley applied for accidental disability retirement. His application complained of a TBI, specifying problems with memory, concentration, and confusion. PERAC convened a panel of neurologists to evaluate the application. The panelists performed separate examinations. In their original reports (later modified as discussed *infra*), the panelists certified unanimously that Mr. Rowley is permanently disabled; two panelists also certified that the disability is such as might be the natural and proximate result of Mr. Rowley's accident. (Exhibits 1, 5.)

13. Dr. Judy Fine-Edelstein described Mr. Rowley's symptoms as "cognitive deficits, with distractibility, short-term memory, getting lost, anxiety, depression, poor sleep, and chronic headaches." She noted that "there may be sleep disturbances, anxiety, and other additional reasons for his cognitive dysfunction and persistent symptoms." Even so, Dr. Fine-Edelstein found Mr. Rowley to be "disabled from his job due to the motor vehicle accident." (Exhibit 5.)

14. Dr. Francis Rockett reported that Mr. Rowley suffers from dizziness, headaches, sensitivity to noise, memory issues, and an attention deficit. He interpreted Mr. Rowley's cognitive testing as revealing "a severe and permanent new memory formation impairment," and

the MRI as showing that Mr. Rowley's "blood flow was significantly reduced in the anterior temporal region." Dr. Rockett wrote: "These findings are consistent with bilateral pre-frontal brain injury . . . . There is no doubt that Mr. Rowley's post-concussion syndrome resulted from the [car accident]." (Exhibit 5.)

15. Dr. Rachel Nardin stated that the evidence supports a diagnosis of PCS with significant cognitive deficits. But she added that "anxiety and other psychological symptoms, as well as poor sleep and ongoing headache, may be contributing to Mr. Rowley's ongoing cognitive difficulties." In Dr. Nardin's assessment, these issues "have not been adequately treated." She explained that Mr. Rowley "has declined to engage in psychotherapy after a single visit and has not tried medications to treat his posttraumatic tension headaches at adequate doses or with sufficient regularity." Dr. Nardin therefore would not certify that Mr. Rowley's injury might be the natural and proximate result of his accident. (Exhibit 5.)

16. After receiving the panel's reports, the board at first voted to deny Mr. Rowley's application. Thereafter, the board decided instead to transmit a follow-up question to the panel (via PERAC). The question read: "According to the medical records, Mr. Rowley has medical symptoms [of] chronic insomnia, headaches, and anxiety. If Mr. Rowley was treated properly for these conditions, and particularly for the anxiety which seems to stem from his lack of sleep, would he be disabled?" Along with its question, the board provided the panelists with copies of the reports of Dr. Chervin, Dr. Fisher, and Dr. Levine. The board declined to add Dr. Braverman's report to this compilation over protests from Mr. Rowley's counsel. (Exhibits 5-8.)

17. The panelists responded to the board's question separately during 2019. Dr. Nardin stated that "if Mr. Rowley's anxiety, chronic insomnia and headaches were appropriately treated, he would not be disabled." Dr. Rockett wrote elliptically that Mr. Rowley would cease

to be disabled if he "had been treated properly . . . and he had responded well to these treatments." Dr. Fine-Edelstein's reaction was more elaborately ambivalent:

> [T]he PERAC panel can reevaluate him . . . if he indeed has not had sufficient treatment for his chronic headaches, and in particular his anxiety. . . . I would suggest Mr. Rowley be evaluated by a psychiatrist/psychologist . . . . [A]lthough he appeared to have many different complaints . . . I agree that addressing these medical issues would be important before determining that [Mr. Rowley] is totally disabled.

(Exhibit 8.)

18. Promptly upon receiving the panel's letters, the board denied Mr. Rowley's application, stating that "the denial was based on the medical panel reports and the clarification reports." Mr. Rowley timely appealed. He has since continued to undergo treatment and evaluations, including an extended course of psychotherapy and multiple psychiatric exams. (Exhibits 2, 9, 16, 17, 19, 29.)

Analysis

The standard governing applications for accidental disability retirement is stated in G.L. c. 32, § 7(1). The member must show that he "is unable to perform the essential duties of his job," that the disability "is likely to be permanent," and that the disability arose "by reason of a personal injury sustained . . . as a result of, and while in the performance of, his duties." *Id.*

A medical panel evaluating an accidental disability retirement application must consider "[w]hether the nature of the condition or injury is such that it could be expected to improve if the member were willing to undergo reasonable medical treatment." 840 C.M.R. § 10.04(2). This consideration may impact the analyses of both permanence and causation: A disability is not permanent if reasonable treatment would alleviate it. And it is not causally linked to the workplace accident if the member's obstinance is the more immediate reason for his continued

incapacity. *See Retirement Bd. of Revere v. Contributory Ret. Appeal Bd.* (*DiDonato*), 36 Mass. App. Ct. 99, 107-12 (1994).

Important caveats are built into the foregoing principle. Permanence and causation are undermined only where the rejected course of treatment "would probably successfully eliminate the disabling condition." *DiDonato*, 36 Mass. App. Ct. at 108. *See Boston Ret. Bd. v. Contributory Ret. Appeal Bd.*, 95 Mass. App. Ct. 1102, slip op. at 9-10 (2019) (unpublished memorandum opinion); *Church v. Marblehead Ret. Bd.*, No. CR-10-38, at 19-21 (DALA July 26, 2013). Also, a member's refusal to undergo treatment is significant only if it was "unreasonable" in light of the attendant risks. *DiDonato*, 36 Mass. App. Ct. at 109-11. *See Zechella v. Marlborough Ret. Bd.*, No. CR-08-456, at 13 (DALA Dec. 3, 2010).

A medical panel's affirmative certificate of disability, permanence, and causation is typically a condition precedent to accidental disability retirement. *Blanchette v. Contributory Ret. Appeal Bd.*, 20 Mass. App. Ct. 479, 483 (1985). Here the panel majority initially provided the necessary certificate. But in response to the board's follow-up question, Dr. Fine-Edelstein effectively changed her vote, concluding that a disability determination would be premature. *Cf. Silva v. Plymouth Ret. Bd.*, No. CR-11-393, at 2-3 (CRAB Nov. 29, 2018). Now lacking a supportive majority, Mr. Rowley's application is doomed unless the panel applied an "erroneous standard" or failed to review "pertinent facts." *See Foresta v. Contributory Ret. Appeal Bd.*, 453 Mass. 669, 684 (2009).

It is clear as day that Dr. Braverman's evaluation of March 2018 consisted of "pertinent facts" that the medical panel received no opportunity to review. Mr. Rowley neither zealously obeyed nor wholly rejected his providers' recommendations. But Dr. Nardin and Dr. Fine-Edelstein's negative certificates rested largely on the theory that not-yet-administered psychiatric

treatment might cure Mr. Rowley. Dr. Nardin specifically cited Mr. Rowley's November 2016 discontinuation of psychotherapy. Dr. Fine-Edelstein highlighted his anxiety as a condition that may not have been treated adequately.

Dr. Braverman was the only psychiatrist to have methodically analyzed the probability that psychotherapy and psychiatric drugs would resolve Mr. Rowley's disability. His conclusion was that a successful outcome, though possible, was not likely. This analysis was exceedingly germane to the majority panelists' line of reasoning. Indeed, Dr. Fine-Edelstein's follow-up note called out for Mr. Rowley to be "evaluated by a psychiatrist/psychologist." By proceeding to a swift decision, as if the type of evaluation requested by Dr. Fine-Edelstein were not already available, the board strayed from its regulatory mission. *See* 840 C.M.R. § 10.02 (requiring the board "to assist retirement system members to . . . obtain all benefits to which entitled").[6]

The board claimed in correspondence with Mr. Rowley's attorney that, given Dr. Braverman's psychiatric specialty, his opinion was irrelevant to Mr. Rowley's neurology-based application. This explanation was groundless. The board was required to give the panelists "any pertinent information known to exist." 840 C.M.R. §§ 10.08(6), 10.09(1). Mr. Rowley's symptoms have drawn overlapping interventions from both neurologists and psychiatrists. The panel had already reviewed records from psychiatrist Dr. Calvanio. Dr. Nardin's certificate

[6] The board's follow-up question to the panelists reflected a similarly off-track attitude. It is very appropriate for a board to inquire about the risks and benefits of potential courses of treatment. *See DiDonato*, 36 Mass. App. Ct. at 102. But here the assertions and premises of the board's question betrayed premature adverseness to Mr. Rowley's still-pending application. *Cf. Chaves v. Taunton Ret. Bd.*, No. CR-18-204, at 68 (DALA Dec. 3, 2021). PERAC's transmittal of the board's question to the panel implied no endorsement of the board's approach, given that the transmittal was not discretionary. *See* 840 C.M.R. § 10.11(2).

raised questions specifically about Mr. Rowley's psychiatric care. And the board's own follow-up letter was easily interpretable as inquiring about the impact of potential psychiatric treatment.

Conclusion and Order

For the foregoing reasons, the board's denial of Mr. Rowley's application is VACATED. The matter is remanded to the board for further proceedings, with the following guidance:

1. In view of the arc of the proceedings to date, PERAC is asked to assemble a new medical panel rather than reconvening the original panelists.

2. The potential impact of psychiatric treatment on Mr. Rowley's condition appears to be a key medical issue. PERAC is therefore asked to consider appointing a psychiatrist to the new panel. *See* 840 C.M.R. § 10.08(3).

3. The pertinent information to be provided to the new panel may include records prepared by non-neurologists, as well as documentation of events postdating the original panel's decision. *See* 840 C.M.R. §§ 10.08(6), 10.09(1).

4. It is possible that the new panel's certificate will again implicate Mr. Rowley's failure to follow his providers' advice. In that event, the board must ascertain before making its decision that it has received an adequate analysis of the risks and benefits associated with any unfollowed recommendations. *See DiDonato*, 36 Mass. App. Ct. at 111; *Church*, *supra*, at 21.

SO ORDERED.

Division of Administrative Law Appeals

/s/ Yakov Malkiel
Yakov Malkiel
Administrative Magistrate