

Matter of Goodacre v Kelly

2010 NY Slip Op 33262(U)

November 19, 2010

Supreme Court, New York County

Docket Number: 106093/10

Judge: Alice Schlesinger

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Index Number : 106093/2010
GOODACRE, CHARLES
vs.
KELLY, RAYMOND
SEQUENCE NUMBER : 001
ARTICLE 78

INDEX NO. _____
MOTION DATE _____
MOTION SEQ. NO. _____
MOTION CAL. NO. _____

The following papers, numbered 1 to _____ were read on this motion to/for _____

Notice of Motion/ Order to Show Cause — Affidavits — Exhibits ...
Answering Affidavits — Exhibits _____
Replying Affidavits _____

PAPERS NUMBERED

Cross-Motion: Yes No

Upon the foregoing papers, it is ordered that this motion *Article 78* proceeding is determined in accordance with the accompanying memorandum decision, and the petition is granted.

UNFILED JUDGMENT
This judgment has not been entered by the County Clerk and notice of entry cannot be served based hereon. To obtain entry, counsel or authorized representative must appear in person at the Judgment Clerk's Desk (Room 141B).

Dated: NOV 19 2010

Alice Schlesinger
ALICE SCHLESINGER S.C.

Check one: FINAL DISPOSITION NON-FINAL DISPOSITION
Check if appropriate: DO NOT POST REFERENCE

MOTION/CASE IS RESPECTFULLY REFERRED TO JUSTICE FOR THE FOLLOWING REASON(S):

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK: IAS PART 16

-----X
In the Matter of the Application of

CHARLES GOODACRE,

Petitioner,

For a Judgment under Article 78 of the Civil
Practice Law and Rules,

-against -

Index No. 106093/10
Motion Seq. No. 001

RAYMOND KELLY, as the Police Commissioner of
the City of New York, and as Chairman of the Board
of Trustees of the Police Pension fund, Article II,
THE BOARD OF TRUSTEES, of the Police Pension
Fund, Article II, NEW YORK CITY POLICE
DEPARTMENT and THE CITY OF NEW YORK,

Respondents.
-----X

SCHLESINGER, J:

Between May 2, 2003 and August 7, 2009, the Medical Board of the Police Pension Fund examined and reviewed Charles Goodacre's case eleven times. All of these evaluations were focused on whether Goodacre's very complex medical history entitled him to the approval of Accident Disability Retirement (ADR) benefits under the Heart Bill (General Municipal Law §207-k).

During this period, Goodacre also commenced three separate Article 78 petitions, including the instant one now before this Court. The first, in April 2006, was settled pursuant to a stipulation between the parties wherein the petition would be withdrawn and the ADR application would be remanded to the Medical Board for reconsideration of certain designated questions.

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But since the result was two denials that were ultimately accepted by the Pension Board, the second of which included new evidence by the Medical Board, Goodacre brought a second Article 78 proceeding (Index No. 103789/08). This proceeding was commenced on March 18, 2008 and it came before this Court. On November 18, 2008, I found that the Heart Bill presumption had not been rebutted by the respondent and, after reviewing what I believed to be the relevant medical history, found that Goodacre was, in fact, suffering from a stress-related condition.

In this regard I stated:

While it may be the case that his ischemia and coronary artery disease are not disabling in and by themselves, and while the myocardial bridging may not be related to either one, his unrelenting hypertension together with the above, all documented in countless invasive tests, together with his clinical appearance and intake of serious heart medications, create an irresistible conclusion that he is suffering from a disabling condition of the heart.

Therefore, I found as a matter of law that the Heart Bill had not been rebutted and that Goodacre was entitled to Accident Disability Retirement benefits. But then, on March 26, 2009, I altered my decision, pursuant to a motion to reargue brought by respondent. There I said that "the original decision, taking issue with the methodology and findings of the Medical Board, stands" but I agreed with moving counsel that a remand was appropriate. As to the remand, I advised the Medical Board to focus on what I deemed to be its parameters; that is, "petitioner's long-standing hypertension and how it, along with coronary heart disease and mild ischemia, does not lead to the conclusion that stress-

related pathologies exist, whether or not they are directly related to the bridging.”¹ In other words, the Medical Board was asked to explain why the totality of the circumstances, including the hypertension, the mild ischemia, and evidence of hypertrophy, did not constitute sufficient evidence of a disability caused by job-related stress.

On August 7, 2009, the final and eleventh review, the Medical Board responded to the judicial remand. In reviewing the case, the Board noted its “complexity” and the fact that the officer had tests relating to his cardiovascular system going as far back as 2000. He had retired from the Police Department in June 2003. The Board acknowledged that “the multiplicity and the number of times tests were repeated reflects the fact that definitive conclusions were difficult to draw from their results”. The Board then referred to the rare and uncertain significance of “bridging”, which is not relevant here. Finally, the “third issue related to cardiovascular system is the officer’s history of hypertension”. This was the issue I had directed the Board to focus on.

The Board then comments that: “Hypertension per se is not considered a disabling condition as far as the Heart Bill unless it is associated with evidence of left ventricular hypertrophy or other complications”. This Court certainly does not dispute this point since a number of appellate opinions hold precisely that. However, contrary to the Medical Board’s conclusion, the specifics of Goodacre’s medical history and the evidence do indicate that the hypertension is indeed associated with evidence of hypertrophy and other

¹On May 21, 2004, the Medical Board did recommend approval of Ordinary Disability, their diagnosis being Myocardial Bridging involving the left Anterior Descending Artery. Whereas a finding of a disability is all that is required for Ordinary Disability benefits, Accident Disability is awarded only if the disability is caused by job-related stress.

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complications.

I had used the term "unrelenting hypertension" in my earlier decision. The Board clearly did not like that description. Nor did the members agree with it. But what it appears they did was cherry-pick the data supporting their conclusion and ignore significant evidence in favor of petitioner. As an example, the Board says in their paragraph 5 that the highest blood pressure reading that I quoted was 170/90. But in fact, I also cited to a reading at Staten Island Hospital on June 4, 2003 which was 195/94. This reading is referred to in the Medical Board's determination of September 19, 2003. Also, in its determination that followed, dated April 23, 2004, the Board relates that Goodacre and a family member, who is a physician's assistant, regularly check his blood pressure at home and it "runs around 180/90".

Further, despite the Medical Board's finding in its May 25, 2007 recommendation, that petitioner's hypertension was "well controlled" with medication, on November 17, 2006 for example, upon examination his blood pressure was recorded as 160/80 in each arm. This high reading is not even mentioned in the August 2009 remand, much less explained.

This Court certainly does not profess to have any medical expertise, much less in the rarified area of cardiology, but would respectfully suggest that the medical community at large would not characterize a reading of "160/80 in each arm" in a person on therapeutic blood pressure medication as evidence of "well controlled" hypertension. See, *Taber's Cyclopedic Medical Dictionary* (FA Davis Company 2005) (defining hypertension as a condition reflected by at least three readings higher than 140/90). Yet this certainly required, at the least, an explanation or some minimal discussion. But there was none.

Finally, the Board's relatively brief review concludes with the statement that: "A standard criterion for hypertensive heart disease which is used, is the presence of left ventricular hypertrophy on echocardiography".² But here, the Board seems to again cherry-pick. It only refers to "the most current echocardiogram" performed on June 4, 2003. This report quoted the interventricular septum to be 1.2 cm. and the left ventricular posterior wall to be 1.30 cm. The Board states that a finding of significant left ventricular hypertrophy is diagnosed when the thickness of the interventricular septum and posterior wall of the left ventricle exceed 1.4 cm. The June 4 readings fail to meet that standard.

However, in an earlier Board determination, two other echo readings are discussed which do meet the standard. Specifically, in its May 2, 2003 report, reference is made to a 2-D echocardiogram of November 21, 2000 that shows a left ventricle septal thickness of 1.8 cm. and a posterior wall thickness of 1.6 cm. (though there was an additional finding of "normal left ventricular systolic function and no evidence of any doppler abnormalities"). Also discussed is a 2-D echo of January 14, 2003, where the septal thickness was reported as 1.4 cm. and posterior wall thickness as 1.3 cm. (There the final interpretation is also reported as "normal left ventricular systolic function, hypertensive heart disease, mild aortic sclerosis...") But the Board in August 2009 does not even mention these two earlier echocardiograms and their readings, even though at least the November 21, 2000 one would seem to meet the criteria specified by the Board for a finding of left ventricular

²Hypertrophy is evident when an organ increases in size to meet increased functional demands, such as the hypertrophy of the heart that accompanies certain cardiovascular disorders, such as the hypertension here. See *Taber's, supra*.

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hypertrophy.³

I have discussed these measurements in the body of this decision and in a footnote because I believe the echo results are significant. Yet, they are given only a cursory and/or incomplete and/or inaccurate review by this Board. Nevertheless, the echocardiogram readings are the major factor that they rely upon.

Frankly, I am at a loss as to what to do now. I had urged the Board to focus on petitioner's longstanding hypertension, which if it is serious enough to cause other complications such as hypertrophy, can be stress-related and can qualify an officer for ADR under the Heart Bill. In my earlier decisions, I had referred to Mr. Goodacre's consistently high blood pressure readings despite continuous medication for it, the opinion of his cardiologist Dr. Thomas Costantino, and the multiple invasive tests he had undergone, together with his clinical appearance.

The Board, in its latest decision, takes on the role of adversary to this Court rather than the role of independent medical examiners searching the truth in a highly complex case. Under the circumstances, I fail to see what would be served by a further remand.

³There is some confusion here. In the report at issue here, the Board describes the June 4, 2003 echo (the one reported in its July 11, 2003 determination) as the most recent. Yet, in a later determination dated May 21, 2004, the Board states it reviewed two echos, one from January 14, 2003 and the second from July 7, 2003, the latter of which is more recent than the previously referenced June 4, 2003 one. In the May 2004 report, the Board further characterizes the January 14 echo as "good quality." Nevertheless, it describes the results in an inconsistent manner at two different times. In the determination at issue here, it describes the measurements as "both below one centimeter", which is within normal limits. However, in the May 2, 2003 report, those measurements were stated to be 1.4 and 1.3 cm, which is evidence of hypertrophy. Another inconsistency exists with respect to the intraventricular septal measurement. In its May 21, 2004 report the measurement is given as 1.28 and the posterior wall measurement is given as 1.21, which is a little higher than the 1.2 cm reported on June 4, 2003.

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While counsel for the respondent argues that I must defer to the Board's determination as long as it is based on some credible evidence, it is hard to find such here. As pointed out, the Board either ignores readings it does not like, or fails to discuss the significance of the numbers it alludes to.

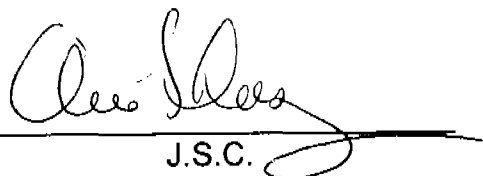
Therefore, I believe this Court's earlier decision that Officer Goodacre does suffer from unrelenting hypertension is correct. That hypertension may well have led to left ventricular⁴ hypertrophy as evidenced by some of the echo test readings. Further, under these circumstances it is a stress-related condition. Since I conclude that nothing would be served by a further remand to the Medical Board in light of how the Board treated the last one, I am determining once again that petitioner is entitled to ADR benefits as a matter of law.

Accordingly, it is hereby

ADJUDGED that the petition is granted, and the proceeding is remanded to the respondents for further processing and an award to petitioner of ADR benefits consistent with this decision.

Dated: November 19, 2010

NOV 19 2010



J.S.C.

ALICE SCHLESINGER

⁴The Board's November 17, 2006 Determination comments on the results of some of the echos and says that: "Results of these tests were somewhat inconsistent and not always of a technical quality which made them reliable. (This refers particularly to the echocardiographic measurements which form the basis for determining whether the officer has hypertensive heart disease)." Nevertheless, the Board did not explicitly reject any of the readings on this ground. Thus, the comment is no justification for its cherry-picking.

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