

# ***Dep't of Correction v. A. S.***

OATH Index No. 2448/09 (Sept. 30, 2009)

ALJ recommended dismissal of medical separation charge under section 73, finding officer currently fit to work. Respondent was guilty of misconduct separately charged under section 75 for which ALJ recommended a 20-day suspension.

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## **NEW YORK CITY OFFICE OF ADMINISTRATIVE TRIALS AND HEARINGS**

*In the Matter of*  
**DEPARTMENT OF CORRECTION**  
*Petitioner*  
*- against -*  
**A. S.<sup>1</sup>**  
*Respondent*

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### **REPORT AND RECOMMENDATION**

**TYNIA D. RICHARD**, *Administrative Law Judge*

This proceeding was referred by petitioner, the Department of Correction (the "Department"), pursuant to sections 73 and 75 of the Civil Service Law. Petitioner charges respondent, a correction officer, with misconduct under section 75 for being out of residence and for driving while ability impaired on January 3, 2008. Petitioner also seeks to terminate respondent under the provisions for medical separation in section 73 for being continuously absent for more than one year due to a non work-related disability.<sup>2</sup> Respondent denies the allegations.

On May 27, 2008, respondent was served with a letter advising him that the Department would pursue a medical separation/termination of his employment based on

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<sup>1</sup> Respondent's full name is being withheld for purposes of publication in order to protect his privacy because this decision discusses his medical records which include matters of a personal nature. This accommodation is being made *sua sponte* as the parties have not requested it. See *Dep't of Citywide Admin. Services v. H. M.*, OATH Index No. 1670/04 at 1 n. 1 (July 26, 2004).

<sup>2</sup> Originally, petitioner asserted that respondent's absences were separate violations of both sections 73 and 75 and sought a finding under both sections of the Civil Service Law. Finding it inappropriate to make two separate findings of fault, and offer two penalties, on the same set of facts, I asked petitioner to choose under which section it wished to proceed. Petitioner opted to seek medical separation under section 73 rather than incompetence under section 75. Thus, petitioner withdrew its section 75 claim without prejudice (Tr. II 8).

his absence since “on or about June 18, 2007 . . . because of [his] inability to perform the full duties of [his] position with the Department by reason of a non work-related disability” (ALJ Ex. 1). The letter detailed respondent’s right to a hearing “if there is a triable issue of fact concerning [his] fitness for full duty.” Respondent contends that he is able to perform the duties of a correction officer and seeks to return to service.

The hearing was conducted before me on July 17 and 24, 2009.<sup>3</sup> Petitioner supplemented the record with additional Department directives on August 17, 2008, at which time the record was closed. Petitioner presented eight Department witnesses, including one of its staff psychologists who was qualified as an expert. Respondent testified on his own behalf and presented the testimony of his therapist, who testified by telephone.<sup>4</sup>

For the reasons stated below, I find that a preponderance of the evidence establishes that respondent has been continuously absent from his position as a correction officer in excess of one year due to a non work-related disability and that respondent is *not* unfit to perform the duties of his position. Therefore, medical separation is not warranted.

For the further reasons set forth below, I find that petitioner proved respondent committed misconduct under section 75 by being out of residence on January 3, 2008, and by engaging in unbecoming conduct when he became involved in a motor vehicle accident while driving under the influence of alcohol, a traffic infraction for which he entered a plea of guilty. For the misconduct, I recommend 20 days’ suspension.

## ANALYSIS

### *Section 73 medical separation*

Respondent has been absent from work for more than a calendar year stemming from a severe depression apparently triggered by marital problems and alcoholism. Events reached a crescendo on January 3, 2008, when he was arrested for DWAI and attempted suicide while in police custody. His illness took some time to resolve and

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<sup>3</sup> Citations to transcripts for the two days’ proceedings conducted on July 17 or July 24 are denoted “Tr. I” and “Tr. II,” respectively, followed by the page of the transcript.

<sup>4</sup> The tribunal has allowed witness testimony to be given by telephone due to physical unavailability and did so in this case because respondent’s therapist, Mr. DiDomenico, was the only supervisor available to staff his office in Goshen, New York. *See Matter of Live Centre Tenants Ass’n*, OATH Index No. 834/05, mem. dec. at 2 (Dec. 1, 2005); 48 RCNY §1-46(b).

respondent does not contest that he was for some period of time unfit to work. He does dispute that he is presently unfit to work and claims that the Department has unjustly refused his return to work which has been recommended by his personal physician. He also claims that the Department was on the verge of returning him to work when it suddenly changed course and denied his requests.

Section 73 of the Civil Service Law provides that “When an employee has been continuously absent from and unable to perform the duties of his position for one year or more by reason of a disability . . . , his employment status may be terminated and his position may be filled by a permanent appointment.” Thus, to separate a member of service because of a continuous one year absence from work under this section, the Department must show that his yearlong absence was caused by a non work-related disability and that he is currently unfit to work because of the disability. *See Dep’t of Correction v. Stevenson*, OATH Index No. 1296/07 (Oct. 24, 2007); *Dep’t of Correction v. Shepherd*, OATH Index No. 965/03 (Nov. 6, 2003).

*Dr. Theo, petitioner’s monitoring psychologist*

Peter Theo, Ph.D., is a licensed psychologist and full time employee of the Department’s Health Management Division (“HMD”) where he has worked for 17 years (Tr. I 232). He evaluates Department employees for fitness for duty and monitors officers while on sick leave to assess their ability to perform full duty work. He has a bachelor’s degree in psychology from City College in New York and a master’s degree from California State University in Los Angeles. He obtained a doctorate from New York University in 1989. In all, he has 20 years of clinical work experience. At the hearing, he was qualified as an expert in psychology with a specialty in evaluating military or paramilitary employees who work in stressful environments, and he offered his opinion that respondent was not fit to work full duty as a correction officer (Tr. I 237).

Dr. Theo first met respondent on June 28, 2007, when he interviewed him after his discharge from Arden Hill Hospital (Tr. II 16). Respondent first visited HMD on June 18, 2007, and was interviewed by Dr. Petroski who saw clear signs of depression and referred him for inpatient evaluation at Arden Hill Hospital because of the severity of his symptoms (Tr. II 15-16, 56-59). Respondent spent a week there in inpatient care.

During his initial visit to HMD, respondent was extremely depressed and suicidal, though unwilling to make a specific statement; he asked desperately for help, and he reported issues of anger management, poor appetite, and insomnia. He said he had been having marital problems and was living in his car. He reported a history of alcohol problems. Upon discharge, Arden Hill referred respondent for outpatient psychiatric treatment and prescribed medication. On June 28, respondent reported feeling better to Dr. Theo who noted that he was within the normal range of affect and was motivated to return to duty (Tr. II 60-61). Dr. Theo did not diagnose him but noted that his return to duty was anticipated (Pet. Ex. 18). Thereafter, he saw respondent regularly, approximately monthly, for ongoing monitoring of his condition. The routine monthly interviews with Dr. Theo tended to last 10 to 20 minutes (Tr. II 41). Dr. Theo said respondent was compliant, did not miss appointments, and brought documentation when requested (Tr. II 62). Respondent had no reported history of mental health issues prior to this.

Dr. Theo testified that respondent has “done very well for himself” given the level of depression he experienced over an extended period of time (Tr. II 17). He has responded to treatment and he has “mostly stabilized.” Nevertheless, throughout his illness he evidenced “very severe symptoms,” and Dr. Theo opined that there is “no possibility of him going to full duty given what he was presenting to us consistently for over a year” (Tr. II 17). Dr. Theo has never conducted his own psychological evaluation of respondent (Tr. II 44). Besides his brief “impressionistic” mental status exams of respondent, Dr. Theo based his opinions on the diagnoses and evaluations contained in treating physician summary reports prepared and submitted by respondent’s treating physician, psychiatrist Stavros Sarantakos, M.D. (Tr. II 26, 45, 77). Dr. Sarantakos, who did not testify at the hearing, believes that respondent is fit to return to full duty as a correction officer.

Dr. Sarantakos, respondent’s treating physician

According to Dr. Sarantakos’s treating physician summary reports (“TPSRs”) (Pet. Ex. 19), respondent was initially diagnosed with major depressive disorder in partial remission. During his first visit with Dr. Sarantakos on July 13, 2007, respondent complained of depression, anxiety and insomnia, and the doctor prescribed an anti-depressant and another medication. Over time, respondent would report to his doctor

depression, anxiety, insomnia, irritability, loss of appetite, panic attacks, a phobia of driving, and alcohol dependence. In addition to regular monthly visits to his psychiatrist, respondent began seeing a therapist on March 18, 2008, who he visited five days per week for individual and group sessions (Tr. II 167). Ultimately, Dr. Sarantakos refined his diagnoses to include major depressive disorder, panic disorder, and alcohol abuse (Pet. Ex. 19). By June 2008, all three conditions were in remission. In May 2008, Dr. Sarantakos first recommended respondent's return to full duty. To date, he has not been allowed by HMD to return to work.

According to the doctor's notes, during his early treatment through December 19, 2007, respondent struggled with panic attacks while driving, withdrawal from alcohol dependency, adjustment to medications, sleeplessness and depression (Resp. Ex. D). Dr. Sarantakos increased the medications he prescribed to address the symptoms. Then, respondent was admitted to Arden Hill Hospital for psychiatric evaluation and treatment for his depression from January 3 through January 28, 2008, and again from February 22 to February 27, 2008. Dr. Sarantakos submitted TPSR's on April 1 and April 29, 2008, noting that respondent's alcohol abuse was in remission, though he continued to experience symptoms of depression, anxiety, panic attacks, and phobic behavior. Although he believed respondent's prognosis was good, he recommended that he be continued on sick leave through April 2008.

On May 22, 2008, Dr. Sarantakos recommended that respondent be "returned to full duty with no restrictions" on May 30. HMD asked that he provide a thorough review of respondent's condition which Dr. Sarantakos conducted on June 4, 2008 (Pet. Ex. 19). In his evaluation, the physician reported three Axis I diagnoses: major depressive disorder, panic disorder, and alcohol abuse, and that all were in remission. He wrote: "Pt is 40 yr old married male with 3 children who works for the corrections department. Pt came to our facility on 7-13-2007 complaining of anxiety, panic attacks, and irritability. Pt had stopped drinking a week before his admission. He was also complaining of phobic behavior around driving. He has now responded to medication and he is asymptomatic." With regard to his alcohol abuse, Dr. Sarantakos noted that respondent "has been sober for at least 7 months. Attends A.A." He wrote that respondent's "prognosis is good

although relapse cannot be excluded. He is to continue with psychotherapy and medications.” Respondent did continue with his therapy and medications.

In the succeeding months, Dr. Sarantakos continued to submit TPSR’s to HMD. He noted on June 3, 2008 that respondent’s panic disorder was in remission and, on June 12, 2008, that his major depressive disorder was in remission. On August 5, 2008, respondent was reduced to a single medication for depression, Lexapro, and Dr. Sarantakos indicated that he had recovered from major depressive disorder and panic disorder. He noted his prognosis was “good,” and said he was capable of returning to full duty. In March 2009, respondent was off all medications and Dr. Sarantakos wrote that respondent’s major depressive disorder, along with his panic disorder and alcohol abuse, were in “complete remission.” His remaining TPSR’s, submitted on April 10, May 5, and June 3, 2009, are unremarkable in that they continue to report that respondent has a history of depressive illness that is in remission, has an “excellent” prognosis, and is capable of returning to full duty.

Respondent’s therapist Ralph DiDomenico, a certified alcohol and substance abuse counselor at Catholic Charities, testified that respondent is in “sustained remission” which means he has maintained his sobriety for more than 12 months (Tr. II 185). Subject to weekly and random breathalyzers and occasional urine or oral swabs since he started in March 2008, respondent has always tested negative (Tr. II 170, 174).

*Dr. Theo’s recommendation against fitness*

Despite Dr. Sarantakos’s positive recommendation, Dr. Theo identified “red flags” that he said, cumulatively, prevented respondent from work as a correction officer: he had multiple diagnoses (major depressive disorder, panic disorder, and alcohol abuse), his diagnosis of major depression was “very severe,” and he was hospitalized three times during the course of his illness (Tr. II 17-18). He said that respondent had experienced a “lethal combination” of symptoms, including depression, suicidal ideation and alcohol abuse (Tr. II 108).

Major depressive disorder is characterized by an episode of depressed mood that lasts for a period of at least two weeks (Tr. II 67). A person with the disorder may suffer from one episode or many over a period of time. If a person has more than one episode, the disorder is considered recurrent. Dr. Sarantakos diagnosed respondent with recurrent

major depressive disorder, a fact that Dr. Theo believed to be significant (Tr. II 19). He stated that Dr. Sarantakos had diagnosed bipolar disorder, which is characterized by fluctuating emotions, but this was not true.<sup>5</sup> All of this clinical data, he said, pointed to someone who has difficulty controlling their emotions and poor impulse control. He said the severity of respondent's depression is a predictor of the persistence of symptoms and the possibility of relapse, and that respondent was one of the most severely depressed people he has ever seen in his tenure with the Department (Tr. II 49). The combination of severity of illness and multiple diagnoses "would preclude him from this job," reported Dr. Theo (Tr. II 18). By contrast, respondent's therapist, Mr. DiDomenico, testified that depression and alcoholism are often related, as in respondent's case, and that, if a person is able to stay clean and sober, their mental health issues typically fade (Tr. II 172-73).

To draw an example of his lack of fitness, Dr. Theo noted in particular that respondent had manifested symptoms of "irritability" in a recent visit to HMD on June 3, 2009 (Tr. II 19). That day, respondent reported being under stress because he had been unable to return to work for so long, despite his doctor's recommendations that he was fit (Tr. II 24-25). Although it was understandable to be upset, Dr. Theo acknowledged, it is how one reacts to this stressor that is significant:

The person might still be angry but they're not going to show any kind of irritability. On the other hand, if somebody responds with irritability to this type of stress, it's a whole different situation. The irritability that I perceived that day was major in the sense that I felt that the officer could not be calmed down, even if I talked to him, tried to reason with him, he would not lose his irritability. He was just irritable and that's the difference when somebody is upset from a clinical feature of irritability. The person cannot control himself.

(Tr. II 25). Although he stated that respondent would not "calm down," he did not indicate what if anything he did during their meeting that required calming. He did not say that respondent argued with him, shouted at him, or was curt or disrespectful or sarcastic to him. He read from his progress notes and stated that "what was significant

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<sup>5</sup> He first stated that respondent was diagnosed with bipolar disorder (Tr. II 18) but later admitted that Dr. Sarantakos had never made a definitive diagnosis, although he had once noted that he had not ruled out the disorder (Tr. II 89-90).

about this presentation was that as I note he presented – ‘C.O. presents with irritable, sad mood’” (Tr. II 24). Dr. Theo also stated that he had “very poor frustration tolerance” and had exhibited it on “a couple of occasions” without giving a single example of what in respondent’s conduct or demeanor caused the observation (Tr. II 25-26). Further, he testified that respondent did not lose control that day. He noted, however, that he did not provoke the officer but that an inmate might provoke him. Thus, he concluded respondent might in the future lose control if faced with a major stressor on his job. He opined that respondent could act out of his anger or hit someone “given his history” (Tr. II 26).

I found his conclusion to be at odds with the record. Dr. Theo acknowledged that respondent was confronting a significant stressor that day (*i.e.*, the possibility of losing his livelihood, which would explain his “irritable, sad mood”) and that respondent did not engage in any behavior to “act out” his understandable anxiety and anger. But, rather than seeing this as a demonstration of self-control, Dr. Theo made it a prognosis for disability, suggesting that respondent *might* display less control in the future and lash out at an inmate “given his history.” I should note that the record contains no such history. There was no evidence of respondent lashing out at Dr. Theo, inmates, or others in his workplace; none of the evidence indicates that he lashed out at anyone besides himself during his prolonged depressive illness. I should also note that Dr. Theo and HMD could reasonably be seen as a direct cause of respondent’s stress and anxiety on that particular day since it was HMD’s determination and Dr. Theo’s recommendations that prevented him from returning to work. I would surmise that respondent’s “stressors” were significant during his encounters with Dr. Theo. I might also note that respondent seemed in control of any anxiety he may have had during the two-day trial. Although he could have been on his best behavior to favorably impress the tribunal, I have observed many who either would not or could not exercise that amount of discipline.

When asked on cross examination if it was reasonable for respondent to be irritated because he had been refused a return to work for a whole year after his doctor thought he was fit, Dr. Theo tried to distinguish commonplace irritability from what he called “clinical” irritability (Tr. II 126). According to Dr. Theo, respondent had a clinical symptom “far and beyond what ordinarily would be someone being upset over a

situation” (Tr. II 127). Yet, he admitted that respondent did not act out in a destructive way during the visit, and he failed to describe any conduct of respondent’s that manifested the *clinical* irritability he spoke of (Tr. II 128). Aside from his observation of respondent’s “irritability” on the June 2009 visit, Dr. Theo acknowledged that respondent’s condition has remained stable from June 2008 to the present (Tr. II 126).

I noted the concerns expressed by Dr. Theo that this officer would not be able to withstand the stress of a jail environment, which is characterized by the provocative and unruly conduct of its residents. The question is whether those concerns were sufficient to establish that respondent is medically unfit for work as a correction officer.

*The medical evidence*

According to Dr. Theo’s testimony, petitioner offered two primary bases for respondent’s unfitness: the severity of his illness, which is presently remitted, and his continued irritability.

Dr. Theo asserted that the number and severity of symptoms observed during his illness (major depressive disorder, panic disorder, and alcoholism) precluded respondent’s return to full duty. He referred to red flags and a lethal combination of symptoms to dramatize the risk of retaining respondent in his position. These symptoms are no longer present but are capable of recurring which, in his opinion, is enough to determine respondent unfit to return to work. I did not find the possibility of recurrence in this case a sufficient basis for concluding that respondent is presently unfit to work. However, the risk of recurrence is a valid basis for determining fitness. *See Dep’t of Correction v. Stevenson*, OATH Index No. 1296/07 (Oct. 24, 2007); *Housing Auth. v. Caballero*, OATH Index No. 699/96 (Mar. 13, 1996); *Human Resources Admin. v. Bartolo*, OATH Index No. 1211/94 (Nov. 3, 1994).

The fact that an employee’s illness may recur in the future is a factor to consider, but it must be weighed alongside the employee’s demonstrated interest in maintaining wellness. *See Caballero*, OATH 699/96. Any possibility of recurrence of illness cannot be the sole factor in determining fitness. “The focus in a disability case is not on the employee’s past conduct, but on his present condition and future conduct.” *Housing Auth. v. Dave*, OATH Index No. 138/95 at 3 (Aug. 12, 1994), *aff’d*, NYC Civ. Serv. Comm’n Item No. C-95-72-4 (Dec. 11, 1995); *see also Housing Auth. v. Turetsky*, OATH

Index No. 716/91 (May 1, 1991), *aff'd*, NYC Civ. Serv. Comm'n Item No. C 92-72-1 (July 15, 1992). "Past incidents are relevant only insofar as they are probative of the employee's present condition and future conduct." *Dave*, OATH 138/95 at 4.

In cases where an employee may foreseeably become unfit because he or she has suffered from episodic or chronic conditions or disabilities (*e.g.*, drug use, alcoholism, depression or bipolar disorder) for which a recurrence or relapse is always a potentiality, this tribunal has held that a proper assessment of current unfitness must include an evaluation of "the probability that such recurrence or relapse will take place, and the consequences for the employer if it does." *Caballero*, OATH 699/96 at 22.

In *Human Resources Administration v. Bartolo*, in which Judge McFaul considered whether an employee diagnosed with bipolar disorder was fit to be reinstated to his position after an involuntary leave, the tribunal stated:

There are many disabilities, both mental and physical, which are episodic or might recur unpredictably. In such cases, the employer faces a degree of risk that the disabling condition might reappear and manifest itself in the workplace. Among the considerations relevant to assessing the level of risk involved are the probability of a recurrence, the frequency or intervals between episodes, and the severity or consequences of a recurrence in the workplace. In certain circumstances, the risk of a recurrence is so great that the employer should not have to assume it. In cases of high probability of frequent and severely disruptive recurrences, a significant risk is presented, making reinstatement inappropriate. However, where the risk of recurrence and the severity are less significant, reinstatement should be granted.

*Bartolo*, OATH 1211/94 at 9 (citations omitted). Here, the risk of a recurrence of respondent's major depression and panic disorder, according to respondent's treating physician, exists but is "minimal." Dr. Theo appeared to regard that opinion with some skepticism but did not contend that the risk was any greater (Tr. II 139-40). Nor did he attempt to speak to Dr. Sarantakos to discuss his hesitation about returning respondent to full duty (Tr. II 124).

There was no evidence here that a recurrence would create a significant risk to the Department. Dr. Theo testified that respondent was referred to HMD because of his

behavior at work, but he offered no details (Tr. II 140). Respondent testified that, on June 18, 2007, he arrived at work sweating and disoriented. He went to Deputy Director Brantley and told her about his condition and his marital problems, and she referred him to HMD (Tr. II 239-41). At the time, his relationship with his wife was so difficult that he had been sleeping in his car and at the office. There is no record that respondent was a disciplinary problem in his unit, or that he ever became a danger to himself or others at work. His attempts at suicide in January 2008, discussed more fully below, appear to be a singular aberration. Petitioner did not prove by a preponderance of the evidence that there is a high degree of probability that he would become such a danger in the future.

In *Housing Authority v. Caballero*, Judge Kramer upheld the general rule that an employee may be found to be fit despite the existence of a future potential for relapse or recurrence “where it is apparent at the time of the hearing that the employee's condition or disability is in check or remission, or otherwise under control, because the employee recognizes the problem and/or is taking medication or steps to treat it.” OATH 699/96 at 23. See also *Human Resources Admin. v. Estevez*, OATH Index No. 1085/94 (Dec. 14, 1994) (employee with bipolar disorder not currently unfit where employee was taking prescribed medication as required and was found trustworthy enough to continue to do so); *Bartolo*, OATH 1211/94 (employee not currently unfit where bipolar disorder was in remission); *Employees Retirement System v. Bosco*, OATH Index No. 505/93 (Mar. 31, 1993) (the potential risk of a relapse for a recovering drug abuser, who also suffered from periodic depression due to post-traumatic stress syndrome related to his Vietnam war experiences, was insufficient to establish current unfitness, where the employee was receiving treatment for his disabilities and appeared to have them under control at the time of trial); *Human Resources Admin. v. Middleton*, OATH Index No. 564/91 (Jan. 29, 1991) (employee not currently unfit where alcohol abuse and periodic depression were under control). An employee who “denies the existence of the disability, or refuses to properly treat it or make efforts to bring it under control” is far more likely to be unfit within the meaning of the statute because such an employee is at far greater risk of recurrence. *Caballero*, OATH 699/96 at 23. See also *Admin. for Children's Services v. Desir*, OATH Index No. 202/03 (Oct. 18, 2002), *aff'd in part*, Comm'r Dec. (Dec. 4, 2002) (respondent who lacked insight into her illness, refused to acknowledge need for

treatment, refused medication and did not believe she had a psychiatric problem all weighed in favor of finding respondent unfit); *Dave*, OATH 138/95 (untreated alcoholic with bipolar disorder currently unfit due to probability that he would not take his medication without alcohol which negated the effects).

Not only is respondent's illness in remission but the record shows that he conscientiously participates in his own treatment and recovery. Respondent's testimony was extremely lucid. He appeared upbeat and ready for the challenge of work. He said that it has been several months since he felt depressed and he no longer has anxiety while driving (Tr. II 227-30). His full privileges have been restored for him to renew his drivers license. He takes medications to regulate his blood pressure and diabetes but no psychiatric medication (Tr. II 219). He sleeps well, is able to concentrate, and has improved his diet since he has reduced his intake of sugar. He feels he has recovered from his depression and anxiety (Tr. II 243). With respect to alcohol, he was understandably circumspect and said that he is "recovering every single day." He described his process of recovery with appropriate self-reflection and clarity.

When questioned about his ability to handle stress in the jail environment, he stated that he has dealt with inmates since 1994 when he worked for the state Department of Correctional Services. He compared monitoring 50 inmates in the New York City system as opposed to 150 to 300 at a time in the state system and called it a "cakewalk" (Tr. II 223-25). He said he did not experience much job related stress. His stress related problems had been 99% personal, particularly stemming from the deterioration of his marriage. He noted the extensive counseling he has received and the coping mechanisms he has developed to manage stress. He described the process of handling a combative inmate in detail (take a step back, speak calmly, use your interpersonal skills to calm down an irrational inmate, show them respect and listen and they will calm down) (Tr. II 226). He said he is used to the outbursts of violence, aggression, and provocation that occur in jail and has never had a problem. He has never had a use of force or a situation that he could not control. He proudly stated that his record "speaks for itself" (Tr. II 245). This testimony was unrebutted.

Respondent denied having any problem losing control of himself and believes that he should have an opportunity to return to work (Tr. II 226). "Everybody gets sick. You

go to the doctor, . . . you get your medication, [you get better] and you go back to work” (Tr. II 222). He eagerly anticipates a return to work and noted how difficult it has been to be confined to his home because of departmental sick leave rules. He longs to be able to travel freely to visit friends and family (Tr. II 223).

The facts of this case are very different from another case in which an officer suffering from depression and other mental conditions was found unfit by the tribunal. In *Department of Correction v. Stevenson*, the officer who was diagnosed with bipolar and depressive disorders had suffered at least six to eight relapses requiring hospitalizations over the course of a 16-year period and she continued to be symptomatic at the time of the hearing. She had a “history of noncompliance with treatment and [a] propensity to relapse.” OATH 1296/07 at 7. The latter two factors were connected because her medications balanced her mood; thus, her failure to take her medication led to her tendency to relapse. In addition, the doctors were concerned that she lacked a range of emotion, was lethargic (which could hinder her ability to observe the activity around her in the jail), and lacked judgment and the ability to plan (as demonstrated by her taking three hours to drive from Long Island to Queens). OATH 1296/07 at 8-9. None of these observations have been made about respondent.

Respondent is asymptomatic and has been medication-free since March 2009. Respondent’s treating physician and therapist both represent that he no longer experiences symptoms of the depression, panic disorder or alcoholism that disabled him. Dr. Theo did not dispute these findings as a matter of fact. Respondent was compliant throughout his treatment, acknowledges his illnesses, and has embraced his treatment; thus, he is at a far lesser risk of recurrence.

Although Dr. Sarantakos found that respondent’s depression, alcoholism and panic disorder were in remission, Dr. Theo testified that “remission” is different from “recovery” in that recovery indicates a return of the illness is unanticipated, whereas remission makes no claim of whether there may be a recurrence (Tr. II 143). The possibility of recurrence concerned him (Tr. II 106). His conclusions at times appeared exaggerated, however. For example, Dr. Theo initially noted that respondent’s depression was diagnosed as “recurrent” which he said meant “by definition” “that it’s due to recur” (Tr. II 19), but under cross examination he admitted that the “recurrent”

diagnosis is not necessarily predictive of another episode because one never knows if there might be another episode, and it is possible with a recurrent diagnosis to go one's entire life without a recurrence (Tr. II 69-70).

With respect to his alcohol treatment, respondent's therapist Mr. DiDomenico testified about the "relapse prevention" techniques they have spent months cultivating in therapy sessions and respondent's successful development of coping skills to handle stress (Tr. II 177). He said that respondent has a demonstrated ability to manage his frustration (Tr. II 170, 174, 177). He has also benefitted from regularly scheduled activities with his children. He has shared with respondent his philosophy that alcoholism is a chronic disease which means it is never cured. He listed the stress reduction techniques he teaches and said that respondent has all the skills necessary to maintain his sobriety and that he uses them regularly (Tr. II 180, 186). He described respondent as insightful, extremely high functioning with above average intelligence, and highly motivated to get back into the mainstream of society and return to work (Tr. II 177). Such motivation helps reduce the chance of relapse. Moreover, as this tribunal has noted, should a relapse occur, the agency has a remedy under section 72. *Caballero*, OATH 699/96 at 29.

Significantly, Judge Rodriguez in *Stevenson* noted a history of "excessive" relapse which was due in part to the stress of the job. OATH 1296/07 at 13. Here, respondent has had a single incidence of illness, albeit a prolonged one. There is no history of relapse. The fact that he had several hospitalizations during his illness does not establish a history of relapse since he had not yet recovered; he was not deemed suitable for work by his private physician until May 2008, months after his final hospitalization. Moreover, there is no strong indication that job stress would lead to relapse for respondent since his depression was triggered by personal rather than job stress.

The trier of fact is not bound to accept the opinion or theory of any given medical expert, but instead should weigh the medical evidence and draw her own inferences. *See Peabody Coal Co. v. Benefits Review Bd.*, 560 F.2d 797, 802 (7th Cir. 1977); *Finn v. Cassidy*, 165 N.Y. 584 (1901). In this case, I find that the possibility of a future recurrence of illness is insufficient to warrant a finding that respondent is unfit to return to full duty work as a correction officer.

Next, Dr. Theo used his observation of respondent's irritability during a recent office visit as support for why he is unfit to work. As discussed above, Dr. Theo's notes and testimony made no reference to actions or demeanor that were so inappropriate as to arouse alarm and it was unclear what he meant by "clinical" irritability. He provided no foundation for his conclusion that the irritability he observed made respondent unable to perform the duties of his position. Although Dr. Theo conceded that some irritability was understandable, he failed to explain how respondent's irritability was abnormal or excessive under the circumstances. I therefore found his allusion to respondent's irritability conclusory and exaggerated. This evidence failed to establish that respondent is unfit to perform the duties of his position.

*Other considerations*

There is reason to believe that Dr. Theo's opinion of respondent's fitness was inappropriately influenced by a separate administrative decision to medically separate respondent. In evidence not offered by petitioner, it appears that Dr. Theo had actually authorized respondent to return to work on medically monitored (light duty) status in June 2008, shortly after Dr. Sarantakos's initial recommendation that he be returned to full duty (Resp. Ex. B, Tr. II 111). Dr. Theo conceded that he authorized the return and then rescinded it on the same day.

On June 6, 2008, Dr. Theo filled out HMD's medically monitored return restriction form ("MMR form") and gave it to respondent during his office visit that day (Tr. II 111). The purpose stated on the form for returning respondent to light duty under medically monitored status was "readjustment," presumably meaning a readjustment to work. Respondent would have no physical limitations, and no psychological limitations were noted (Resp. Ex. B). No impairments due to medication were noted, although respondent would be restricted from operating a Department vehicle. Under "prognosis for rtd (return to full duty)," Dr. Theo wrote "1 mo." Respondent understood the form to mean that he was being authorized to return to work on light duty and that his return to full duty was anticipated by the Department in a month (Tr. II 217). It would be hard to quarrel with this interpretation. Respondent testified that Dr. Theo seemed happy for him when they met that day.

Dr. Theo admitted that on June 6 he had determined that respondent was ready to return to work on light duty, in spite of the red flags and the “lethal combination” of symptoms that he emphasized in his direct testimony ruined the officer’s chances of ever returning to work full duty (Tr. II 113). He explained “well, you know, the officer was motivated to work, . . . he was not totally disabled at that time . . . and he could do light duties, so we assigned him light duty. Or I assigned him light duty” (Tr. II 113). He said he later decided that it was unlikely that respondent would ever be capable of full duty work and reversed his decision to return him on MMR status. A couple of hours after he met with respondent, Dr. Theo filled out HMD’s case disposition form withdrawing his prior light duty authorization and returned respondent to the sick list (Resp. Ex. C). He had a staff member notify respondent about the reversal by phone (Tr. II 125).

Dr. Theo’s explanations about the reversal were somewhat contradictory and contained an admission that the reversal also was influenced by a meeting he had later that day with HMD’s chief medical doctor, Dr. Leinhardt (Tr. II 115-16).

There was no new medical information uncovered in the meeting. He and Dr. Leinhardt discussed the history of respondent’s illness and decided it was too risky to allow him back to work. Dr. Theo wrote an addendum in his medical notes reflecting that conclusion: “Due to documented history of suicidal ideation and gesture in the past, relapse cannot be excluded per private medical doctor. Return to duty is considered a risk at this time. Although CO is currently stable and out of danger to self or others, he is considered unsuitable for inherent work of correction occupation” (Tr. II 117, Pet. Ex. 18 at 9).

In light of these events, Dr. Theo had difficulty explaining his notation on the MMR form, where he wrote “1 mo.” under “prognosis for [return to full duty]”. He denied that it meant that respondent would indeed return to full duty in a month, or that he had made the determination that respondent was capable of returning to full duty. He explained “that’s what we write down there, but that doesn’t really indicate that he can do full duty” (Tr. II 112). As if to unring the bell sounded by his earlier authorization of light duty and issuance of the MMR form, Dr. Theo insisted the notation was merely “a projection” (Tr. II 119). He admitted that, although he had believed when he signed the MMR form earlier that day that it was “certainly possible” for respondent to return to

work full duty at some time in the future (Tr. II 112), after the meeting with Dr. Leinhardt he was convinced his return to full duty was “unlikely” (Tr. II 117-18). Thus, the decision was made to keep respondent on sick leave.

I tend to disagree that Dr. Theo’s explanation offers a logical or reasonable interpretation of the notation or adequately explains what changed his mind about the likelihood of respondent qualifying for full duty. The notation does imply that respondent could be ready to work full duty in a month. When it was pointed out that the next line on the MMR form reads, “If no date for rtd, please explain” and that he could have written in that space that respondent’s return to full duty was not anticipated, if indeed it were true, he stated “we don’t really fill out that bottom part” (Tr. II 124). His responses were not believable.

I concluded that Dr. Theo believed when he completed the MMR form that respondent was likely to return to full duty in the near future, perhaps in a month, because if he thought at the time that it was “unlikely” that respondent could ever return to full duty, he would not have written “1 mo.” on the form. Since he was fully familiar with respondent’s history of illness and the severity of his symptoms at the height of his illness, I also concluded that some new information introduced in the meeting with Dr. Leinhardt must have caused him to change his mind.

In fact, Dr. Theo revealed that he and Dr. Leinhardt also discussed the fact that the Department had already commenced processing respondent’s medical separation, and that returning respondent to duty, even light duty, would toll the running of the one-year period required for medical separation.<sup>6</sup> He testified that, when they realized “that [returning him to work on MMR status] would block the whole separation process, it was determined that he should be on sick leave” (Tr. II 123). He stated “this is an administrative issue that comes . . . into play here. The officer was being pressed for separation. Administratively, once you go back to light duty, the process stops and starts all over again” (Tr. II 118). “So in all honesty, there was because of the administration

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<sup>6</sup> See *Shepherd*, OATH 965/03 at 6-7 (citing ALJ analysis in *Dep’t of Sanitation v. Troy*, OATH Index No. 842/95 at 6-8 (Feb. 1, 1995), which found that days employee worked on “light duty” assignment were not includable in calculation of absences under section 73, whose legislative history referred repeatedly to “employees who are wholly absent” from their duties for one year). In *Troy*, the Sanitation commissioner rejected the ALJ’s legal analysis and, initially, decided to terminate the employee under section 73, but then reconsidered and agreed to a settlement in which the employee was to complete a probationary period, during which he was not assigned driving duties. I find the legal analysis in *Troy* unassailable.

since the officer was not going to go full duty at that time, that placing him on light duty, which I determined he was able to do would eradicate that process so it was determined to maintain [him] on sick leave so he could be separated” (Tr. II 118-19).

Dr. Theo credibly testified that he was not aware that the Department had commenced a medical separation proceeding when he assessed respondent that day and approved him for light duty (Tr. II 101), but the description of his conversation with Dr. Leinhardt indicates that Leinhardt was aware of it. The medical separation notice is dated May 7, 2008, and was served on respondent on May 27, 2008 (ALJ Ex. 1).<sup>7</sup>

The testimony appears to describe a process in which Dr. Theo’s medical determination about respondent’s fitness was upended, or at least influenced, by an administrative one (the tail wagging the dog). The doctor’s stark change in opinion cannot be reconciled with any medical evidence, and Dr. Theo’s duty as the Department’s psychologist is to make a medical determination about respondent’s fitness for work, not an administrative one. *See Dep’t of Sanitation v. Troy*, OATH Index No. 842/95 at 6 (Feb. 1, 1995), *rev’d on other grounds*, Comm’r Dec. (Feb. 10, 1995), *reconsidered, modified on penalty*, Comm’r Dec. (Mar. 2, 1995) (“Fitness under section 73 of the Civil Service Law is a medical matter to be determined by the Department.”). If respondent was fit to return to duty, then that determination should have been the final word, untainted by an administrative decision about medical separation. *See Bodnar v. NYS Thruway Auth.*, 52 A.D.2d 345 (3d Dep’t 1976) (continuous one-year absence from work was not caused by continuing disability but was forced upon employee by employer’s misuse of section 73 in imposing an involuntary leave of absence and refusal to allow employee return to work).

After Dr. Theo’s testimony about red flags and a lethal combination of symptoms, the fact that he had in fact come to a different initial conclusion about respondent’s ability to work as a correction officer (even on light duty) was troubling. If his expressed concern that respondent might lose control with inmates were genuine, the wisdom of assigning him to light duty could be questioned since there is no reason to believe he

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<sup>7</sup> It should also be noted that the Department submitted an application on April 14, 2008, with the New York City Employees’ Retirement System (“NYCERS”) seeking a disability retirement for respondent, which was denied by the NYCERS medical board on June 20, 2008, which found that respondent was not disabled (Resp. Ex. A). Dr. Theo disparaged the finding, stating that the board does not like to award its significant benefits (75% of full salary) to eligible applicants (Tr. II 96).

would not be subject to inmate provocation while on light duty. The MMR form did not indicate that he should be kept from inmate contact. The explanation was not credible.

Qualification to carry a firearm

As a separate basis for finding respondent unfit for full duty, petitioner asserts that he is not currently qualified to carry a firearm which is a condition of his employment. Based upon his interview conducted on June 18, 2007, an HMD doctor found respondent psychologically unfit to carry a firearm (Pet. Ex. 18, at 19). Respondent has not been re-qualified to carry his firearm since then.

The Notice of Examination for correction officers states that every officer must “remain qualified” to carry a firearm (Pet. Exs. 13, 15).<sup>8</sup> Depending upon their particular work assignment, correction officers who are not psychologically qualified to carry a firearm may be limited in their ability to carry out their duties because some functions of a correction officer require officers to carry a firearm (*e.g.*, escorting an inmate to a hospital or entering the arsenal where personal protection firearms are kept) (Tr. II 12, 13, 63). There was no evidence indicating whether it was necessary for respondent to carry a firearm to conduct his duties in the Investigations Division, where he was assigned. Typically, an officer found to be psychologically unqualified is reevaluated at a later date to determine his fitness. That is, officers are not automatically terminated once determined to be psychologically unfit to carry a gun.

Dr. Theo testified that “under no circumstances would [respondent] ever be found fit for a firearm” by him or anyone else in the Department (Tr. II 146, 149-50). “It’s just that it’s too risky given the history.” He claimed that he had this belief even when he completed the MMR form allowing respondent to work light duty and that light duty assignments were available without a firearm qualification. Even if true, the MMR form did not mention that respondent was psychologically unfit to carry a firearm (Resp. Ex. B).

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<sup>8</sup> Petitioner offered Directive 4511R-A (“Firearms Policy and Procedures” (eff. June 12, 2006)) in support of its contention that respondent is not fit to be a correction officer because he is not currently qualified to carry a firearm. The directive provides that all new correction officer candidates are to be advised that “failure to satisfy all firearm requisites” is grounds for termination (section II (B)(4)). It also provides that an officer who is “authorized to handle/possess a handgun” shall report for annual requalification (section V (D)(1)). Respondent is not presently authorized by the Department to handle or possess a firearm.

Petitioner makes a circular argument here (that respondent is unfit to be an officer because he is not authorized to carry a firearm) because it is petitioner's determination that he is not psychologically fit that prevents respondent from qualifying to carry the gun. This is not a separate claim upon which a lack of fitness might be established. If HMD found respondent psychologically fit, he could take the necessary tests that would allow him to qualify. Moreover, I have already found that petitioner's determination that respondent lacks fitness is unsubstantiated.

Not only did Dr. Theo base his opinion of respondent's lack of fitness predominantly on respondent's past symptoms of mental illness, but he also admitted that his concern, at least in part, stemmed from the fact that the Department could be sued if respondent ever lost control at work and harmed someone – a concern never shown to be likely (Tr. II 145, 149). Nevertheless, Dr. Theo again gives the impression that he was distracted from making a medical determination by considerations administrative and legal. Even more concerning are the numerous broad pronouncements he made about respondent's illness, perhaps intended to add heft that would persuade the tribunal, but that instead seemed to be overreaching to the extent that they suggest that an officer in good health has no hope of ever returning to full time employment with the Department if he formerly suffered from a serious mental disability. His pronouncements, which I found conclusory and mired in a strong aversion toward symptoms that respondent no longer displayed, included the following:

- that there was “no possibility” of respondent working full duty again “given what he was presenting to us consistently for over a year” (Tr. II 17);
- that the combination of severity of illness and multiple diagnoses “would preclude him” from the position (Tr. II 18);
- that, despite being “currently stable and out of danger to self or others,” he is “unsuitable for inherent work of correction occupation” (Tr. II 117); and
- that “under no circumstances” would he “ever be found fit for a firearm” by Dr. Theo “or anyone else” in the Department (Tr. II 146).

These pronouncements focus entirely on symptoms that are no longer present and suggest a policy determination that members of service who had suffered with depression and/or suicidal ideation could never be trusted again to perform in the position of correction

officer. The final pronouncement is the most disturbing in that it states with some certitude what all other qualified mental health professionals employed by the Department would do. Dr. Theo also testified that, in January 2009, when Dr. Sarantakos was reporting that respondent's prognosis was "very good," that "no matter what his doctor said at that point, I was not going to return him to full duty" (Tr. II 130-31), when in fact he had no contrary evidence suggesting that respondent was more sick than Dr. Sarantakos indicated, and it is his duty to thoroughly review and consider Dr. Sarantakos's recommendations. This kind of preclusion from qualification based on prior disability suggests a kind of discrimination that is contrary to law and is the reason for the passage of the Americans with Disabilities Act and other state and local laws that prohibit discrimination based on disability. *See NYC Transit Auth. v. Beazer*, 440 U.S. 568 (1979) (Authority's blanket policy under which it refused to employ methadone users violated federal Rehabilitation Act); *NYS Dep't of Correctional Services v. NYS Division of Human Rights*, 868 N.Y.S.2d 387 (3d Dep't 2008) (state department of corrections unlawfully discriminated against correction officer on the basis of a disability by terminating his employment under section 73 on the speculative possibility that he could not perform his duties after suffering a heart attack because a physical confrontation with an inmate could damage his defibrillator, where treating cardiologist found the officer able to work without restriction).

Dr. Theo pointed to his greater familiarity with the jail environment to distinguish his opinion of respondent's prognosis and to suggest it was superior to that of Dr. Sarantakos. Dr. Theo noted several times in his testimony that Dr. Sarantakos's role as the treating physician is to "treat the patient, to help them recover, and to offer support" but he is "not trained or authorized to make a specific assessment regarding a specific job" (Tr. II 38, 147), suggesting that Dr. Sarantakos did not know enough about the duties of a correction officer to make a compelling assessment or that he might do so without considering the nature of respondent's work. Dr. Theo emphasized that he has the "expertise" necessary to assess whether someone "is suitable for a specific job, *not his doctor*" (Tr. II 39) (emphasis added). However, there is no basis for crediting Dr. Theo's opinion over Dr. Sarantakos's opinion simply because Dr. Theo is the Department's in-house physician.

The opinion of the agency doctor is not to “be given preclusive effect or greater weight than evidence offered by respondent.” *Employees Retirement System v. Bosco*, OATH 505/93 at 8. The constitutionality of section 73 relies upon an employee’s ability to challenge the opinion of the agency doctor. *See Prue v. Hunt*, 78 N.Y.2d 364 (1991) (section 73 is not facially unconstitutional provided that there is pre-termination notification of the grounds for discharge and opportunity to respond and a post-termination adversarial hearing); *cf. Laurido v. Simon*, 489 F. Supp. 1169 (S.D.N.Y. 1980) (declaring section 72 facially unconstitutional for its failure to provide minimal procedural safeguards, such as notice of the facts on which the employer finds an employee unfit and an adversarial-type hearing, prior to imposing the unpaid leave); *Snead v. Dep’t of Social Services*, 355 F. Supp. 764 (S.D.N.Y. 1973) (declaring section 72 unconstitutional for its failure to provide employees an opportunity to challenge a proposed involuntary leave at a meaningful time or in a meaningful manner); *Bosco*, OATH 505/93 at 9 (foremost among the due process procedures required to assure constitutionality of section 72 is “the right to an adversarial hearing where the employee may present medical experts and other witnesses and evidence and where the burden of proof is on the employer”). The court in *Snead* noted that “[o]ur jurisprudence does not recognize the opinion of any individual expert as infallible; professional judgments concerning mental fitness are just as likely to differ as the observations of laymen regarding simple issues of fact.” *Snead*, 355 F. Supp. at 772. Thus, I would reject any view that Dr. Theo’s opinion should be given deference over that of a doctor not affiliated with the Department simply because of that affiliation. The Department would certainly reject the opposing contention, that an agency-employed doctor is inherently too close to the Department to render an objective opinion about respondent’s competence in this adversarial proceeding. Neither is the appropriate view.

Given his long association with respondent through two years of counseling, there was no basis for believing that Dr. Sarantakos was unfamiliar with respondent’s job responsibilities or that he failed to take them into account in his evaluation. He specifically noted his awareness in the notes of his meetings with respondent. While Dr. Theo may in fact have more intimate knowledge of the conditions of respondent’s job, his knowledge does not necessarily extend to superior knowledge of respondent’s

individual capacity to perform the job. Dr. Sarantakos and Mr. DiDomenico are far more familiar with respondent's mental and emotional capacity as they have regularly treated him for the better part of two years. By contrast, Dr. Theo has no professional experience in full time counseling of patients, which is the context in which patients arrive at therapeutic healing. The sheer difference in the amount of time spent with respondent is notable. Dr. Theo conducts abbreviated 10- to 20-minute monthly examinations of the employee in a context that cannot be considered therapeutic. Respondent's therapist has seen him as many as five times a week during his illness and can offer quite a bit of detail in the progressive changes in respondent's coping abilities. I found his assertion that his intimate knowledge of departmental job functions made him uniquely qualified to render an opinion about respondent's capacity beside the point. Moreover, Dr. Theo's abrupt about face after learning of the decision to proceed with medical separation calls into question his ability to dispassionately evaluate respondent's mental health based on objective criteria.

According to the criteria outlined in the cases above, petitioner has failed to prove respondent's current unfitness. Respondent's symptoms are in remission and his condition under control without the assistance of medication. He has embraced treatment and has completed his alcohol treatment counseling according to his therapist, and has become a mentor to other patients. In his testimony, respondent demonstrated a clear understanding of his illness and the modes of thinking that are likely to create problems for him and those that will continue to foster his healing. He credibly articulated that he wants to return to work and is committed to doing what is necessary to maintain his mental health and prolong his remission in order to maintain full productivity.

***Section 75 discipline***

Respondent is charged with misconduct for being out of residence without authorization and without logging out at HMD on January 3, 2008, and for driving while ability impaired, a traffic infraction under the Vehicle and Traffic Law. The facts concerning his DWAI arrest were recounted by two New York State troopers who arrested respondent after finding him at the scene of an accident on State Road 17 in Goshen, New York.

It is not disputed that respondent was on sick leave and was not authorized to be away from home on January 3, 2008, when he was arrested on State Road 17 just after midnight. The arresting officers found him standing outside his car which had struck a guardrail headed westbound (Tr. I 58-60). Trooper Rothbaum testified at the hearing that respondent smelled of alcohol and he asked him to perform field sobriety tests. After determining respondent was impaired, the trooper arrested him and transported him to the barracks where he refused to take a breathalyzer (Tr. I 62). Later that day, around 10:45 hours, respondent personally notified his command of his arrest (Pet. Ex. 3).

The arresting officers, Lewis and Rothbaum, testified that respondent made a number of attempts to harm himself while in custody (Tr. I 63-64, 70-71). Trooper Rothbaum, whose credibility was tested by his selective memory, testified that respondent became belligerent at the barracks and started cursing. After allowing him to use the restroom, the troopers found him lying on the floor near the toilet with a belt around his throat dangling from the toilet paper holder. Respondent said something about trying to "end it" and complained of family problems. The troopers handcuffed him to a bench, where he eventually used his available hand to wrap a shoe lace from his boot around his neck in another unsuccessful attempt to hurt himself (Tr. I 121). The troopers then secured both his hands and legs to the bench. When they later drove respondent to the Goshen Town Court for his arraignment, he became loud and obnoxious in the car, threw himself against the door and threw his head toward the window in another attempt to hurt himself (Tr. I 70). He stated he would end it for them all. Trooper Rothbaum got in the back seat to restrain him. After arraignment, the troopers transported respondent to the Orange County jail which later had him transported to Arden Hill Hospital for psychiatric evaluation (Tr. I 71, 122-23).

Although the troopers said they were trained in suicide prevention techniques, they appeared not to use any specialized conflict prevention methods to deal with respondent, nor did they call EMS for assistance, or even make note of his suicidal ideation in the arrest papers they filed (Pet. Ex. 6, Tr. I 129).

Respondent testified that he was very depressed that day and that he woke up in the late afternoon wanting to kill himself (Tr. II 203-05). The holidays had been difficult for him ever since his mother died in 1998 and they were made worse by his marital

problems and the fact that he was restricted to home and could not be with family. Around the time of his mother's death, he started a regular habit of drinking heavily and, by 2008, was up to a bottle of Vodka every day (Tr. II 202). He had spent New Years alone and he felt worthless. He felt that no one cared and that his wife had discarded him "like a piece of garbage." He drank alcohol and took a handful of pills before leaving the house that day. When he was arrested, he told the troopers that he wanted to kill himself.

On March 26, 2008, respondent pled guilty to driving while ability impaired under section 1192(1) of the Vehicle and Traffic Law ("No person shall operate a motor vehicle while the person's ability to operate such motor vehicle is impaired by the consumption of alcohol") (Pet. Ex. 1). He was sentenced to pay a \$300 fine.

The evidence shows that respondent has suffered over the past two years from depression, panic disorder and alcohol abuse and that he was suffering from depression and alcoholism at the time he committed these acts, which is relevant to a review of the misconduct charges. The effect of the Human Rights Law on the administration of discipline to an employee who is a recovering alcoholic was the subject of the Court of Appeals decision in *McEniry v. Landi*, 84 N.Y.2d 554 (1994), where a civil service employee who was alcohol-dependent was charged for time and attendance violations that occurred after the onset of his disability. In *McEniry*, a unanimous Court of Appeals concluded that alcoholism is a mental disability that had caused the employee's attendance problems and that the employee's termination, based solely on his alcohol-related absenteeism, was improper. *Id.* at 559. After a prima facie case for discrimination was established, the burden rested with the employer to establish that the employee's disability rendered him "incapable of 'performing in a reasonable manner the activities involved in the job'." *Id.* (quoting Exec. Law § 292(21)). In this individualized inquiry, the employer "must demonstrate that [the employee's] alcoholism prevents him from performing the duties of the job, failing which, his alcohol dependency may not serve as the basis for his termination." *Id.* The employer failed to do so inasmuch as the evidence showed that the employee had completed his rehabilitation, had not relapsed, and was performing his job satisfactorily at the time he was discharged. The court was careful to note that its holding was not intended to create a "safe haven" for individuals "who resort to recovery programs as a pretext for avoiding otherwise legitimate

disciplinary action.” *Id.* at 560. Nor did the court mean to suggest that all disciplinary action is prohibited in every case where an alcoholic is purportedly rehabilitated. Rather, the court was making an individualized assessment of the facts before it. “Thus, in the appropriate case, an alcoholic who is found not to be actually rehabilitated, or who is shown to have an established propensity to relapse may be found unable to perform the job in a reasonable manner.” *Id.* at 561.

The holding of *McEniry* is relevant here because respondent was disabled by depression and alcoholism when he violated Department rules on January 3, 2008, and I find that his misconduct was causally related to his disabilities. His depression caused him to want to harm himself and the alcohol and pills he ingested before leaving home that day were his modus operandi to accomplishing that. I have also found that, due to treatment and alcohol rehabilitation, his illnesses have since abated and no longer hinder him from satisfactorily performing the duties of a correction officer.

In concert with the individualized review urged in *McEniry*, I also find that, despite the fact of his disability at the time of the misconduct, respondent’s conduct may be disciplined though he cannot be terminated for it. Therefore, the question of penalty is addressed below.

### **FINDINGS AND CONCLUSIONS**

1. Respondent has been continuously absent from his position as a correction officer in excess of one year due to one or more disabilities, including major depression disorder, panic disorder, and alcoholism.
2. Respondent is not currently unfit to perform the duties of a correction officer, as set forth under section 73.
3. Respondent was out of residence without authorization and without logging out at HMD on January 3, 2008, and his actions were caused by his depression and alcoholism.<sup>9</sup>
4. Respondent is guilty of driving while ability impaired on January 3, 2008, and his actions were caused by his depression and alcoholism.

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<sup>9</sup> Specifications 1 and 2 are combined here into one finding of misconduct since they allege essentially the same conduct which is respondent’s failure to obtain authorization to leave home (Tr. II 277).

### **RECOMMENDATION**

Upon making these findings, I obtained and reviewed an abstract of respondent's employee performance service report (Form 22R) for purposes of recommending an appropriate penalty. His record is exemplary. He was appointed to his position as a correction officer on January 30, 2003, and has no prior infractions. He had not taken any sick days prior to this incident.

For the misconduct alleged, petitioner seeks a penalty of 20 days for the sick leave violations and 45 days for the DWAI (Tr. II 274-77). Respondent asks for mitigation of any penalty assessed, because of the medical disabilities he suffered at the time he committed these acts.

The decision in *McEniry* has come to stand for a rule against administering discipline for pre-rehabilitation time and attendance violations when they have been causally related to a disability. Consequently, this tribunal has in many such cases dismissed time and attendance charges. See *Health & Hospitals Corp. (Harlem Hospital Ctr.) v. Sealey*, OATH Index No. 1738/06 (Sept. 25, 2006) (ALJ recommended dismissal of charges for more than six-month AWOL caused by respondent's mental disorder); *Admin. for Children's Services v. Solomon*, OATH Index No. 1797/05 (Sept. 27, 2005) (ALJ recommended dismissal of charges for six-month AWOL caused by respondent's drug addiction); *Dep't of Correction v. Mason*, OATH Index No. 2162/96 (Nov. 17, 1996) (time and attendance charges dismissed as not subject to discipline under section 75, although they could be addressed under section 72). In other such cases, however, the tribunal has imposed moderate penalties. See *Health & Hospitals Corp. (Health and Home Care) v. Smith*, OATH Index No. 315/05 (Nov. 30, 2004) (ALJ recommended 10-day suspension after finding that AWOL, excessive absenteeism, and lateness were caused by alcoholism); *Dep't of Sanitation v. Lockhart*, OATH Index No. 1591/03 (Sept. 17, 2003) (ALJ recommended 30-day suspension for employee who had been AWOL for two months due to a substance abuse problem).

According to *McEniry's* individualized review, all disciplinary action is not prohibited where an employee has demonstrated rehabilitation, for *McEniry* held that such employees may not be terminated. 84 N.Y.2d at 560-61. For more serious acts of

misconduct caused by a disability, this tribunal has followed the central holding of *McEniry* by mitigating the penalty imposed, rather than dismissing the charges. *See, e.g., Dep't of Sanitation v. Linehan*, OATH Index No. 1508/04 (Aug. 23, 2004) (ALJ considered evidence that sanitation worker's violation of sick leave regulations was caused by his addiction to painkillers and heroin and, due to successful rehabilitation, termination was an inappropriate sanction and recommended 30-day suspension; the parties later agreed to a settlement in which respondent accepted one year's probation and a 30-day suspension); *Dep't of Health v. Protzel*, OATH Index No. 613/98 (July 15, 1998) (ALJ recommended 30-day suspension after finding that respondent's adjustment disorder, for which he was treated and had recovered, caused him to file a false tax statement and his failure to file a state tax return for three consecutive taxable years, one year with intent to evade).

In cases where the employee is unable to show a causal connection between the misconduct and their alcoholism (or other disability), however, mitigation has been denied and termination imposed. *See, e.g., Murolo v. Safir*, 246 A.D.2d 653 (2d Dep't 1998) (court upheld termination of firefighter who called in a false alarm and stole items from the Department, acts that were unconnected to his alcoholism); *Dep't of Correction v. Lynch*, OATH Index No. 1538/98 (Jan. 15, 1999) (no basis to mitigate penalty where officer's refusal to submit a specimen for drug testing and to surrender his shield and ID following that refusal were unrelated to his alcoholism and where he "concocted" defense of mistaken identity at trial; termination was recommended); *Bd. of Education v. Manchaca*, OATH Index No. 1094/96 (July 12, 1996), *aff'd*, NYC Civ. Serv. Comm'n Item No. CD 98-56-SA (May 6, 1998) (respondent terminated where ALJ found alcoholism insufficiently linked to respondent's submission of fraudulent time cards); *Transit Auth. v. Camacho*, OATH Index No. 108/95 (Oct. 13, 1994) (ALJ recommended termination after noting "tenuous link" between respondent's alcoholism and misconduct where employee had been off post on several occasions and made false entries in a memo book); *Police Dep't v. Combs*, OATH Index Nos. 1073/91 & 422/92 (July 7, 1992), *modified on penalty*, Comm'r Dec. (Oct. 5, 1992), *aff'd*, 210 A.D.2d 12 (1<sup>st</sup> Dep't 1994) (termination warranted where alcoholism did not explain police officer's repeated failure

to pay bridge tolls or his false statements to assistant district attorney). These cases demonstrate that causation is essential to the disability analysis in *McEniry*.

A similar analysis was applied even before *McEniry*. For example, in *Department of Correction v. Brown*, OATH Index No. 200/88 (July 28, 1988), the tribunal noted that it would have awarded mitigation for the two alcohol-related charges sustained at the hearing which included a DWI. However, respondent failed to assert a causal relationship between his alcoholism and his violation of sick leave regulations on 24 occasions and made related false statements to the Department. Respondent was terminated on the basis of the latter charges, taking into account his lack of candor about his alcoholism.

Termination has also been imposed where intentionally false statements, made at the hearing or during the course of investigating the misconduct, suggest that the employee has not taken responsibility for his behavior or his alcoholism. In *Department of Correction v. Ortiz*, OATH Index No. 986/07 (June 25, 2007), *aff'd*, NYC Civ. Serv. Comm'n Item No. CD 08-22-A (May 9, 2008), an officer was terminated for his second alcohol-related act of misconduct where the first act had resulted in a 45-day suspension. Importantly, respondent discredited himself at trial by accusing a companion officer of driving his vehicle and by blaming, alternately, a concussion and a reaction to the medicine Motrin for his reckless driving rather than alcohol. Respondent's denials indicate a refusal to take responsibility for his conduct and, thus, disprove any possible claim that he was "actually rehabilitated." *McEniry*, 84 N.Y.2d at 561. Such dishonesty reflects a failure to accept responsibility which is the hallmark of rehabilitation and sobriety, which is critical to the *McEniry* analysis.

The misconduct here is distinguishable from the DWI and other cases cited above, most particularly because of respondent's major depression and alcoholism and the fact that he has taken responsibility for his actions, his treatment, and his sobriety. In addition, his case presents no aggravating circumstances. His refusal to take the breathalyzer did not suggest a different conclusion since his behavior can hardly be considered intentional under the weight of his mental state at the time. Respondent was suffering from two illnesses that disabled him when he committed the misconduct here, major depression and alcoholism, and it is evident that his depression propelled his

actions even more than the alcohol. Respondent credibly testified that his depression worsened during the holiday season because he could not be with family and had been rejected by his wife, and when he woke up that day he wanted to kill himself, so he drank and took pills to further his goal. Eventually, he left the house and drove while impaired, intending to harm himself. The state troopers who arrested him on the highway confirmed that he was suicidal at the time of his arrest and that he made overt suicidal gestures in their presence, which eventually led police to refer him to a psychiatric facility. There can be no doubt that he was ill, because he was already on sick leave and in the midst of treatment when the misconduct occurred. Under these circumstances, he cannot be accused of opportunistically resorting to a recovery program “as a pretext for avoiding otherwise legitimate disciplinary action.” *McEniry v. Landi*, 84 N.Y.2d at 560. I find that respondent’s misconduct is clearly causally related to the depression and alcoholism he suffered and the facts are compelling in support of mitigation.

In consideration of the foregoing, I recommend a penalty that is moderated by the substantial mitigation presented in this case but that also reflects respondent’s position as a peace officer, which holds a weightier responsibility to act in accordance with law. I therefore recommend a suspension of 20 days’ duration for all the misconduct proven, with credit for any pre-suspension penalty served.

Additionally, having concluded that respondent is not unfit to perform the duties of a correction officer, I find that his employment with the Department may not be terminated under section 73 of the Civil Service Law.

Tynia D. Richard  
Administrative Law Judge

September 30, 2009

SUBMITTED TO:

**DORA SCHIRO**  
*Commissioner*

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**BY: BRANDI HAWKINS, ESQ.**