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IN THE
APPELLATE COURT OF ILLINOIS
SECOND DISTRICT

ROBERT MALUSKA,)	Appeal from the Circuit Court
)	of Lake County.
Plaintiff-Appellee,)	
)	
v.)	No. 10-MR-2076
)	
THE BOARD OF TRUSTEES OF THE)	
NORTH CHICAGO POLICE PENSION)	
FUND and TIM CLARK, VALIZA NASH,)	
CURTIS BRAME, GERALD PEDRIN, and)	
THERESA McSEE-ODOMS, as Trustees of)	
the North Chicago Police Pension Fund,)	Honorable
)	Christopher C. Starck,
Defendants-Appellants.)	Judge, Presiding.

JUSTICE SCHOSTOK delivered the judgment of the court.
Justices Bowman and Hudson concurred in the judgment.

ORDER

Held: The Board's ruling that plaintiff's disability was not caused by an act of duty was against the manifest weight of the evidence: although plaintiff was kicked in the knee and was disabled by foot and ankle pain, all the evidence indicated a causal connection, specifically complex regional pain syndrome.

¶ 1 The Board of Trustees of the North Chicago Police Pension Fund (Board) denied the application of plaintiff, Robert Maluska, for a line-of-duty disability pension, awarding him a

nonduty pension instead. Plaintiff then filed a complaint in the circuit court of Lake County, seeking administrative review of the decision. The trial court reversed the Board's decision to deny a line-of-duty pension and the Board brought this appeal. We affirm.

¶2 At the hearing on plaintiff's application for a line-of-duty disability pension, plaintiff testified that on April 20, 2007, while on duty as a North Chicago police officer, he responded to a domestic disturbance call. At the scene, he encountered an individual named Henry Waters who was holding a woman in a bear hug. Plaintiff forced Waters to release the woman and later placed Waters under arrest. As Waters was being placed in a squad car, he lay down on the seat and extended his legs, preventing the door from being closed. When plaintiff tried to push Waters's legs into the vehicle, Waters kicked plaintiff in the face and the left knee. Plaintiff believed that Waters kicked his knee only once, and he did not recall being kicked in the foot or the ankle.

¶3 Plaintiff went to the emergency room at Lake Forest Hospital and returned to the same hospital at some point in the next few days. He was then referred to Dr. Roger Chams. Plaintiff reported to Chams that his knee was in severe pain and that his foot hurt. Chams wanted to address the knee first. Chams performed surgery on plaintiff's knee and the knee pain was relieved. However, plaintiff continued to experience constant pain in his left foot. Chams administered a cortisone injection and released plaintiff to work in September 2007. While working, plaintiff experienced severe, continuous foot pain. Chams referred plaintiff to Dr. Christopher Amann, who administered a second cortisone injection in November 2007. Amann referred plaintiff to Dr. Amy Jo Ptaszek, who performed two operations on his ankle. The procedures did not relieve plaintiff's pain and he stopped working as a police officer in May 2008. While he was undergoing treatment, plaintiff was taking prescription medication for pain. Ptaszek referred plaintiff to Dr. Axel Vargas

for pain management. Vargas diagnosed plaintiff with complex regional pain syndrome (CRPS). Vargas changed plaintiff's medication, but plaintiff experienced no improvement. Plaintiff achieved temporary relief with two spinal injections, but the second caused unpleasant side effects, and plaintiff refused to continue with that treatment. Plaintiff rated the pain he felt on a day-to-day basis at 7 on a scale of 0 to 10. Plaintiff had no problems with his left foot or ankle prior to the April 20, 2007, incident.

¶ 4 Records from Lake Forest Hospital show that plaintiff reported suffering knee pain. His treating physician's impression was that he had sustained a contusion. The records do not indicate whether plaintiff reported any foot or ankle pain. Upon being discharged from the emergency room, plaintiff was restricted to a "sitting job" until cleared for more strenuous work by the hospital's occupational health service. When plaintiff visited the occupational health service on April 23, 2007, he reported arch pain in his left foot. An X-ray was taken, and plaintiff was diagnosed with a strained foot.

¶ 5 Chams examined plaintiff on April 26, 2007. According to Chams's records, plaintiff complained of medial left knee and foot pain. Plaintiff exhibited tenderness of the medial aspect of his ankle, extending to the arch of the foot and the medial aspect of the plantar fascia. It was Chams's impression at that time that plaintiff was suffering from a left knee contusion, a possible meniscal tear, and a sprained foot. Plaintiff saw Chams again on May 10, 2007, complaining that the posterior tibialis was painful and tender. Chams noted tenderness near the insertion of the posterior tibialis into the navicular bone of the foot. Chams observed weakness with inversion and plantar flexion of the ankle.

¶ 6 On June 13, 2007, Chams performed an arthroscopic procedure on plaintiff's knee. On a followup visit on July 11, 2007, plaintiff reported marked improvement with his knee. However, he continued to suffer from medial ankle and foot discomfort, with palpable tenderness of the posterior tibialis tendon. Chams ordered an MRI of plaintiff's foot. Chams next examined plaintiff on July 26, 2007. On palpation, plaintiff exhibited tenderness of the plantar fascia and the arch of the foot. Plaintiff demonstrated no loss of strength and a full range of motion with inversion, eversion, dorsiflexion, and plantarflexion. It was Chams's impression that plaintiff was suffering from plantar fasciitis and osteochondritis desiccans. In subsequent examinations on August 16, 2007, and September 6, 2007, Chams formed the impression that plaintiff was suffering from osteochondritis desiccans and from a plantar strain. During August 2007, plaintiff evidently obtained some relief through physical therapy and was able to bike and jog relatively short distances without pain. Plaintiff continued to show no deficit in strength or range of motion. On September 6, 2007, Chams released plaintiff to full duty.

¶ 7 On November 21, 2007, plaintiff was examined by Amann. Plaintiff reported occasional pain and numbness of the plantar aspect of the foot and the big toe. Amann indicated a differential diagnosis of "posterior tibial tendinitis versus a tarsal tunnel syndrome versus plantar fasciitis." Aman added, however, that plaintiff's symptoms were atypical of plantar fasciitis. Amman ordered an electromyogram (EMG), which was negative for tarsal tunnel syndrome. Plaintiff visited Amman again on December 6, 2007. At that time, despite the results of the EMG, Amman believed that plaintiff was suffering from tarsal tunnel syndrome and he administered a corticosteroid injection.

¶ 8 Plaintiff continued to report arch pain and Amman referred him to Ptaszek for a surgical consultation. Plaintiff saw Ptaszek on January 14, 2008. He reported swelling and relatively

constant burning arch pain exacerbated by activity. It was Ptaszek's impression that plaintiff suffered from stage 1 posterior tibial tendon insufficiency. Plaintiff visited Ptaszek again on February 4, 2008, at which time she noted that he was experiencing focal and radiating arch pain. In her notes, Ptaszek expressed concern that injections plaintiff had received "may have affected his overall symptomatology." She also observed that his MRI showed no evidence of lesions in the plantar fascia or the posterior tibial tendon. Ptaszek ordered an additional MRI. She saw plaintiff again on February 18, 2008. Her notes from that visit indicate that a posterior talar osteochondral defect was responsible for some of plaintiff's ankle pain and that he was suffering from "plantar-based heel pain, which is likely more of a chronic phenomenon." On May 20, 2008, Ptaszek performed arthroscopic surgery to correct the osteochondral defect and administered shock wave therapy to treat plaintiff's heel pain.

¶9 Plaintiff reported no subjective improvement with the surgery and conservative postoperative therapy. Plaintiff saw Ptaszek on January 5, 2009. Her notes from that appointment state that plaintiff "feels the epicenter of his discomfort is anterolateral about his ankle" with some medial pain. Ptaszek felt that the osteochondral defect had been successfully corrected with surgery and that the pain did not originate in the medial aspect of the ankle joint. She recommended lateral ligament reconstruction surgery. She performed that procedure on February 25, 2009. She later referred plaintiff to Vargas, who examined plaintiff in May 2009. According to Vargas's notes, plaintiff related that, when he was kicked in the leg, his left ankle was "anchored between the police cruiser and the curb." Plaintiff reported "constant, unremitting, 'burning intense pain' localized throughout the medial and lateral aspect of his left ankle" and described experiencing "intermittent allodynia,

mild dysesthesia and ‘electrical-like shooting pain’ into his foot.”¹ Vargas ordered a bone scan study and concluded that, along with plaintiff’s history and clinical presentation, the results of that study were consistent with CRPS.

¶ 10 Ptaszek and two other physicians, Drs. Jay L. Levin and Joseph A. Meis, performed independent medical examinations. All three found that plaintiff was disabled from service as a police officer. Noting that plaintiff had denied any prior history of left foot or ankle problems, Levin opined, “Assuming that information to be accurate [plaintiff’s] current disability has been caused by the work related injury of April 20, 2007.” Levin and Meis opined that it was “medically possible” that plaintiff’s condition was the result of the April 20, 2007, incident. Ptaszek did not offer an opinion on causation.

¶ 11 The Board found that plaintiff was disabled from service as a police officer. The Board further found that: (1) plaintiff suffered “an on duty injury on April 20, 2007 to his left knee, ankle, and face”; (2) the on-duty injury was resolved and plaintiff returned to work in September 2007; and (3) “[t]he injury to [plaintiff’s] left ankle and foot which prevents [his] return to full police duties was not the product of an on duty injury.”

¹Allodynia has been defined as “ ‘pain resulting from a non-noxious stimulus to normal skin.’ ” *Shannon v. Astrue*, No. 4:11-CV-00289, 2012 WL 1205816, at *6 n.16 (M.D. Pa. April 1, 2012) (quoting Dorland’s Illustrated Medical Dictionary 50 (27th ed. 1988)). “Dysesthesia is defined as: ‘an unpleasant abnormal sensation produced by normal stimuli.’ ” *Garza v. Astrue*, No. ED CV 11-685-PLA, 2012 WL 589985, at *3 n.4 (C.D. Cal. Feb. 22, 2012) (quoting Dorland’s Illustrated Medical Dictionary 553 (29th ed. 2000)).

¶ 12 In an appeal from a judgment in an administrative review proceeding, the appellate court reviews the administrative agency's decision, not the trial court's. *Harroun v. Addison Police Pension Board*, 372 Ill. App. 3d 260, 261-62 (2007). Although the agency's rulings on questions of law are reviewed *de novo*, findings of fact will be disturbed only if they are against the manifest weight of the evidence. *Id.* at 262. " 'An administrative agency decision is against the manifest weight of the evidence only if the opposite conclusion is clearly evident.' " *Wade v. City of North Chicago Police Pension Board*, 226 Ill. 2d 485, 504 (2007) (quoting *Abrahamson v. Illinois Department of Professional Regulation*, 153 Ill. 2d 76, 88 (1992)).

¶ 13 Pursuant to section 3-114.1(a) of the Illinois Pension Code (Code), a police officer found to be disabled from service in the police department "as the result of sickness, accident or injury incurred in or resulting from the performance of an act of duty *** shall be entitled to a disability retirement pension equal to *** 65% of the salary attached to the rank on the police force held by the officer at the date of suspension of duty or retirement ***." 40 ILCS 5/3-114.1(a) (West 2006). Where a disability results from any cause other than an act of duty, the officer is entitled to a pension equal to 50% of the salary attached to the officer's rank at the date of suspension of duty or retirement. 40 ILCS 5/3-114.2 (West 2006). In order to receive a line-of-duty pension, an applicant must establish a causal connection between his or her disability and an act of duty. *Ryndak v. River Grove Police Pension Board*, 248 Ill. App. 3d 486, 489 (1993).

¶ 14 There is no dispute here that (1) plaintiff was performing an act of duty while trying to place an arrestee in a squad car and (2) plaintiff is disabled from service. At issue is whether there was a causal connection between the former and the latter. The Board found that there was not. The Board's finding on the question of causation will not be disturbed unless that finding is against the

manifest weight of the evidence. Despite the deference we owe to the Board's finding, we conclude that that finding is, indeed, against the manifest weight of the evidence.

¶ 15 We note that medical evidence is not always necessary to establish causation. With respect to workers' compensation claims, it has been noted that "[a] chain of events which demonstrates a previous condition of good health, an accident, and a subsequent injury resulting in disability can be sufficient circumstantial evidence to prove a causal nexus between the accident and the employee's injury." *Gano Electrical Contracting v. Industrial Comm'n*, 260 Ill. App. 3d 92, 96-97 (1994). Here, plaintiff testified that he was kicked in the knee. Although he was not aware of being kicked in the foot or ankle, plaintiff told one of his treating physicians that, when the blow to his knee occurred, his ankle was "anchored between the police cruiser and the curb." This explains how the blow could result in foot or ankle trauma. The same physician formed the impression that plaintiff was suffering from CRPS—also known as reflex sympathetic dystrophy syndrome (RSDS)—which the Social Security Administration (SSA) has described in a policy interpretation ruling as "a chronic pain syndrome most often resulting from trauma to a single extremity." SSR 03-2p, 68 Fed. Reg. 59972 (Oct. 20, 2003). According to the SSA ruling, "[e]ven a minor injury can trigger RSDS/CRPS," and "[w]hen left untreated, the signs and symptoms of the disorder may worsen over time." *Id.* These features of CRPS are consistent with the history of the injury plaintiff sustained. Plaintiff reported foot pain not long after the incident in which he was kicked in the knee. At first, however, the foot pain was overshadowed by the more serious knee injury. With time the knee improved, while plaintiff's foot and ankle pain became more severe and disabling. Three physicians performed independent medical examinations. Two concluded either that plaintiff's

disabling condition was causally connected to an act of duty or that a causal connection was medically possible. None ruled out a causal connection.

¶ 16 Although the Board found that plaintiff's ankle was injured in the April 20, 2007, incident, it further found that that injury had fully healed and that plaintiff's disabling condition was not the result of an injury suffered in the line of duty. The only evidence supporting that finding is that plaintiff experienced some temporary relief while receiving physical therapy and was released to full duty in September 2007. However, plaintiff's condition deteriorated after he returned to work, even though there is no evidence of any other injury to his foot. This course of events is consistent with the diagnosis of CRPS. Notably, plaintiff was released to full duty before being diagnosed with CRPS.

¶ 17 The Board cites *Demski v. Mundelein Police Pension Board*, 358 Ill. App. 3d 499 (2005), as authority that it is not bound by a physician's opinion on the question of causation. In that case, we upheld a police pension board's decision to deny a line-of-duty pension to an officer who claimed that she injured her back during a routine physical agility examination. Specifically, she claimed that she felt a "pull" across her lower back while performing sit-ups. *Id.* at 501. Two physicians certified that the officer was disabled as a result of the performance of an act of duty and a third physician testified that it was possible that the disability was duty-related. However, we concluded that there was evidence to support the board's decision in *Demski*, inasmuch as, at the time of the agility examination, the officer did not report her injury; she carried heavy objects the following day; and she had a history of back problems, including two prior injuries that occurred after she lifted books. *Id.* at 504-05. Here, in contrast, the Board's rejection of a physician's medical opinion was evidently based on a finding that plaintiff's "on duty injury" (the Board's words) had healed and that his

disability was the result of a new injury. As discussed, the record simply does not support the finding that the original injury had healed.

¶ 18 For the foregoing reasons, the judgment of the circuit court of Lake County is affirmed.

¶ 19 Affirmed.