

IN THE UNITED STATES DISTRICT COURT  
FOR THE NORTHERN DISTRICT OF OKLAHOMA

**FILED**

DEC 30 1996

Phil Lombardi, Clerk  
U.S. DISTRICT COURT

MARY BIG ELK and SAM McCLANE, )  
 )  
 Plaintiffs, )  
 )  
 vs. )  
 )  
 DONNA KASTNING, et al., )  
 )  
 Defendants. )

No. 96-C-0087-B

ENTERED ON CLERK'S OFFICE  
DEC 31 1996

**ORDER**

The Court has for decision the motions for summary judgment of Defendants, Board of County Commissioners of Osage County, Kastning, Penland, Hivley, Bloomfield and Stuart (Docket #59, 62, 64, 67 and 70), and also the motion for partial summary judgment of Plaintiffs, Big Elk and McClane (Docket # 56); each brought under Fed.R.Civ.P. 56.

After a thorough review of said motions, briefs, and documentation in support, the Court concludes factual issues remain to be resolved by the trier of fact concerning the following:

1. Legal relationship between Big Elk and McClane and Kastning and McClane regarding the subject horses;
2. Scope of employment of various Osage County employee defendants for purposes of 42 U.S.C. § 1983 state action;
3. Existence of an Osage County policy regarding sheriff aiding in "self-help" retrieval of property;

4. Existence of a conspiracy;
5. Qualified immunity; and
6. Statute of limitations defense.

Thus, said motions are hereby **overruled**. The pretrial and trial scheduling order remains in effect.

DATED this 30th day of December, 1996.

  
THOMAS R. BRETT  
UNITED STATES DISTRICT JUDGE

IN THE UNITED STATES DISTRICT  
FOR THE NORTHERN DISTRICT OF OKLAHOMA

**F I L E D**

DEC 30 1996

Phil Lombardi, Clerk  
U.S. DISTRICT COURT

No. 90-C-702-E

LELAND STANLEY,

Plaintiff,

vs.

GEORGE M. COLE, D.O., et al.,

Defendants.

ENTERED ON CLERK'S

DEC 31 1996

**ORDER**

Now before the Court is the Motion to Reopen Case (Docket # 20) of the Plaintiff Leland Stanley.

This case was originally brought by Stanley to determine Cole's ownership in certain land located in Delaware County, Oklahoma, after Stanley received a judgment against Cole in a case brought in Garfield County. After Stanley filed this Complaint, Cole filed Bankruptcy in the Northern District of Texas, Amarillo Division. This matter was then automatically stayed, and eventually closed by an Administrative Closing Order. Stanley seeks to reopen this case, stating that Cole has recently entered into a contract to sell the real estate that is the subject of this suit. Stanley asserts that the issue as to whether Stanley's judgment is nondischargeable is on appeal before the United States District Court for the Northern District of Texas, and therefore the bankruptcy is still open, at least as to his judgment.

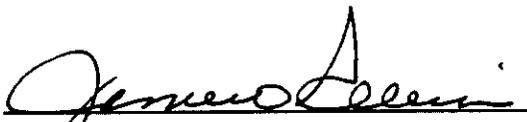
Cole argues that the Bankruptcy has been closed at least since, July 10, 1996, and that the administrative closing order provided that the action shall be deemed dismissed with prejudice if not reopened within twenty days of a final adjudication of the bankruptcy proceedings. Clearly a factual

dispute exists as to whether the bankruptcy proceedings have been finally adjudicated.

The motion to reopen, however, should be denied, not because of Plaintiff's failure to comply with the Administrative Closing Order, but because the dispute at issue in this case was resolved by a settlement agreement entered into between Stanley and Cole. By the terms of the "Comprehensive Compromise and Settlement Agreement" and the "Agreed Modifications to Comprehensive Compromise and Settlement Agreement," Stanley released the defendant with respect to certain property, including the lake property at issue here.

Plaintiff's Motion to Reopen (Docket #20) is denied.

ORDERED this 26<sup>th</sup> day of December, 1996.

  
JAMES O. ELLISON, SENIOR JUDGE  
UNITED STATES DISTRICT COURT

IN THE UNITED STATES DISTRICT COURT  
FOR THE NORTHERN DISTRICT OF OKLAHOMA

LELAND STANLEY,

Plaintiff,

vs.

GEORGE M. COLE, D.O., et al.

Defendants.

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FILED

DEC 30 1996

Phil Lombardi, Clerk  
U.S. DISTRICT COURT

NO. 90-C-702-E

ENTERED ON DOCKET

DEC 31 1996

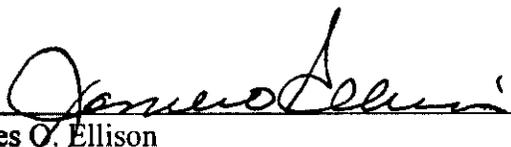
DATE

ORDER DENYING MOTION TO REOPEN

Having considered the Plaintiff's Motion to Reopen, the Court finds that the Motion should be DENIED.

IT IS THEREFORE ORDERED that the Plaintiff's Motion to Reopen should be, and the same is hereby denied. Pursuant to the Court's administrative closing order, this action is dismissed with prejudice.

ORDERED this 26<sup>TH</sup> day of December, 1996.

  
James O. Ellison  
United States District Judge



UNITED STATES DISTRICT COURT FOR THE  
NORTHERN DISTRICT OF OKLAHOMA

SUSAN A. HEIDRICK,  
SS# 488-56-9945

Plaintiff,

v.

SHIRLEY S. CHATER, Commissioner of  
Social Security Administration,

Defendant.

No. 95-C-1172-K ✓

**FILED**

DEC 30 1996

Phil Lombardi, Clerk  
U.S. DISTRICT COURT

ORDER

A Report and Recommendation of the Magistrate was filed December 6, 1996. No objections have been filed by the parties. The Court adopts the Magistrate's Report and Recommendation and **REVERSES** the decision of the Commissioner and **REMANDS** the case for further proceedings consistent with the decision of the Magistrate.

Dated this 24<sup>th</sup> day of December 1996.



TERRY C. KERN

UNITED STATES DISTRICT COURT CHIEF JUDGE

IN THE UNITED STATES DISTRICT COURT  
FOR THE NORTHERN DISTRICT OF OKLAHOMA

DATE: 12-31-96

VON PURVIS, an individual,

Plaintiff,

vs.

MARRIOTT INTERNATIONAL and THE  
PRUDENTIAL INSURANCE COMPANY  
OF AMERICA,

Defendants.

Case No. 96-CV-927-K ✓

**FILED**

DEC 30 1996

Phil Lombardi, Clerk  
U.S. DISTRICT COURT

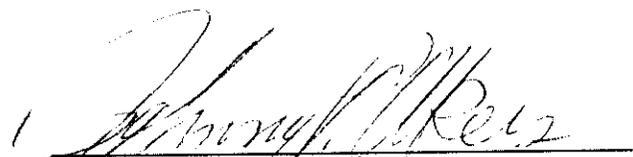
**JOINT STIPULATION OF DISMISSAL WITH PREJUDICE**

Plaintiff, Von Purvis, and Defendant, Marriott International, Inc., pursuant to Rule 41(a)(1) of the Federal Rules of Civil Procedure, hereby jointly stipulate for the dismissal of this cause with prejudice.

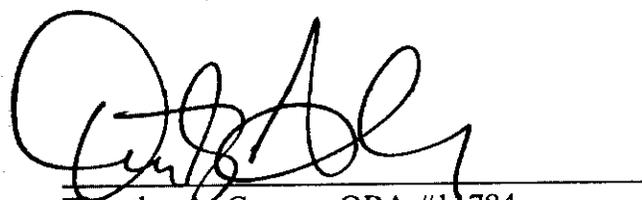
The parties are to bear their own attorney's fees and costs.

DATED: Dec. 30, 1996.

**ATTORNEYS FOR PLAINTIFF**

  
\_\_\_\_\_  
Johnny Akers  
401 W. Dewey St.  
Suite 214  
Bartlesville, OK 74005

**ATTORNEYS FOR DEFENDANT**

  
\_\_\_\_\_  
Timothy A. Carney, OBA #11784  
GABLE & GOTWALS  
15 W. 6th Street, Suite 2000  
Tulsa, OK 74119

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**FILED**

**UNITED STATES DISTRICT COURT  
FOR THE NORTHERN DISTRICT OF OKLAHOMA** DEC 30 1996

Phil Lombardi, Clerk  
U.S. DISTRICT COURT

UNITED STATES OF AMERICA, )  
 )  
 Plaintiff, )  
 )  
 v. )  
 )  
 THE SUM OF ONE THOUSAND )  
 TWENTY-TWO AND NO/100 )  
 DOLLARS (\$1,022.00) IN )  
 UNITED STATES CURRENCY, )  
 )  
 Defendant. )

CIVIL ACTION NO. 96-CV-931-K ✓

ENTERED ON DOCKET

DATE 12-31-96

**JUDGMENT OF FORFEITURE**

This cause having come before this Court upon the plaintiff's Motion for Judgment of Forfeiture against the defendant currency, and all entities and/or persons interested in the defendant currency, the Court finds as follows:

The verified Complaint for Forfeiture In Rem was filed in this action on the 10th day of October 1996, alleging that the defendant currency, to-wit:

**THE SUM OF ONE THOUSAND  
TWENTY-TWO AND NO/100  
DOLLARS (\$1,022.00) IN  
UNITED STATES CURRENCY,**

is subject to forfeiture pursuant to 21 U.S.C. § 881(a)(6), because there is probable cause to believe it was furnished, or intended to be furnished, in exchange for a controlled substance, or is proceeds traceable to such an exchange, in violation of Title 21 United States Code.

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Warrant or Arrest and Seizure was issued by the Clerk of this Court on the 21st day of October, 1996, providing that the United States Marshals Service arrest, attach, and retain the defendant currency and detain it in their custody until further order of the Court.

The United States Marshals Service personally served a copy of the Complaint for Forfeiture In Rem and the Warrant of Arrest and Notice In Rem on the defendant currency on October 30, 1996; that John Hudson Whitaker, the only individual or entity with standing to file a claim to the defendant currency, filed a Stipulation for Forfeiture in this matter on October 15, 1996, agreeing to the forfeiture of the defendant currency, and that the entire \$250 cost bond posted by John Hudson Whitaker in the administrative action shall be returned to John Hudson Whitaker, by mailing to his attorney, Gerald L. Hilsher, Attorney at Law, 201 West Fifth Street, Suite 201, Tulsa, Oklahoma 74103-4230, or by delivery to his attorney in person at the office of the United States Marshals Service, Tulsa, Oklahoma.

USMS 285 reflecting the service upon the defendant currency is on file herein.

All persons or entities interested in the defendant currency were required to file their claims herein within ten (10) days after service upon them of the Warrant of Arrest and Notice In Rem or actual notice of this action, whichever occurred first, and

were required to file their answer(s) to the Complaint within twenty (20) days after filing their respective claim(s).

No persons or entities upon whom service was effected more than thirty (30) days ago have filed a claim, answer, or other response or defense herein, except John Hudson Whitaker, who has filed a Stipulation for Forfeiture of the defendant currency.

No claims in respect to the defendant currency have been filed with the Clerk of the Court, and no persons or entities have plead or otherwise defended in this suit as to the defendant currency, except John Hudson Whitaker, who has filed a Stipulation for Forfeiture of the defendant currency, and the time for presenting claims and answers, or other pleadings, has expired; and, therefore, default exists as to the defendant currency, and all persons and/or entities interested therein, except John Hudson Whitaker.

IT IS, THEREFORE, ORDERED, ADJUDGED, AND DECREED by the Court that judgment of forfeiture be entered against the following-described defendant currency:

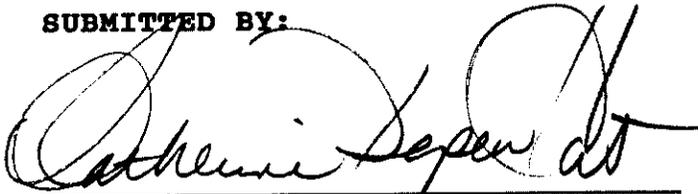
**THE SUM OF ONE THOUSAND  
TWENTY-TWO AND NO/100  
DOLLARS (\$1,022.00) IN  
UNITED STATES CURRENCY,**

and that the defendant currency above described be, and it hereby is, forfeited to the United States of America for disposition according to law.

IT IS FURTHER ORDERED, ADJUDGED, AND DECREED by the Court that the \$250 cost bond posted by John Hudson Whitaker in the administrative action shall be returned to John Hudson Whitaker by mailing to his attorney, Gerald L. Hilsher, Attorney at Law, 201 West Fifth Street, Suite 201, Tulsa, Oklahoma 74103-4230, or by delivery to his attorney in person at the office of the United States Marshals Service in Tulsa, Oklahoma.

  
TERRY C. KERN, Chief Judge of the  
United States District Court for the  
Northern District of Oklahoma

SUBMITTED BY:

  
CATHERINE DEPEW HART  
Assistant United States Attorney

N:\UDD\CHOOK\FC\WHITAKER\05770

IN THE UNITED STATES DISTRICT COURT FOR THE  
NORTHERN DISTRICT OF OKLAHOMA

KIMBERLY J. BURCH for  
JENNIFER D. BURCH, a minor,  
SSN: 446-82-4141,

Plaintiff,

v.

SHIRLEY S. CHATER,  
Commissioner of the Social Security  
Administration,

Defendant.

CASE NO. 95-C-1008-M ✓

EOD 12/31/96

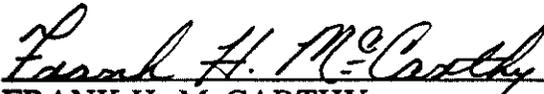
**F I L E D**

DEC 27 1996

Phil Lombardi, Clerk  
U.S. DISTRICT COURT  
NORTHERN DISTRICT OF OKLAHOMA

**JUDGMENT**

Judgment is hereby entered for Plaintiff and against Defendant. Dated this 27<sup>th</sup>  
day of Dec., 1996.

  
FRANK H. McCARTHY  
UNITED STATES MAGISTRATE JUDGE

IN THE UNITED STATES DISTRICT COURT FOR THE  
NORTHERN DISTRICT OF OKLAHOMA

**FILED**

DEC 27 1996

Phil Lombardi, Clerk  
U.S. DISTRICT COURT  
NORTHERN DISTRICT OF OKLAHOMA

KIMBERLY J. BURCH for JENNIFER D.  
BURCH, a minor

446-82-4141

Plaintiff,

vs.

Case No. 95-C-1008-M ✓

SHIRLEY S. CHATER,<sup>1</sup> Commissioner  
Social Security Administration,

Defendant,

EOD 12/31/96

**ORDER**

Plaintiff, Kimberly J. Burch for Jennifer D. Burch, a minor, seeks judicial review of a decision of the Secretary of Health & Human Services denying Social Security disability benefits.<sup>2</sup> In accordance with 28 U.S.C. §636(c)(1) & (3) the parties have consented to proceed before a United States Magistrate Judge, any appeal of this Order will be directly to the Circuit Court of Appeals.

The role of the court in reviewing the decision of the Secretary under 42 U. S. C. §405(g) is limited to determining whether the decision is supported by substantial evidence and whether the decision contains a sufficient basis to determine that the Secretary has applied the correct legal standards. *Winfrey v. Chater*, 92 F.3d 1017

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<sup>1</sup> Effective March 31, 1995, the functions of the Secretary of Health and Human Services in social security cases were transferred to the Commissioner of Social Security. P.L. No. 103-297. However, this order continues to refer to the Secretary because she was the appropriate party at the time of the underlying decision.

<sup>2</sup> Plaintiff's September 1, 1992 application for disability benefits was denied December 3, 1992 and was affirmed on reconsideration. A hearing before an Administrative Law Judge ("ALJ") was held December 3, 1993. By decision dated September 13, 1994 the ALJ entered the findings that are the subject of this appeal. The Appeals Council affirmed the findings of the ALJ on August 9, 1995. The decision of the Appeals Council represents the Secretary's final decision for purposes of further appeal. 20 C.F.R. §§ 404.981, 416.1481.

(10th Cir. 1996) *Castellano v. Secretary of Health & Human Servs.*, 26 F.3d 1027, 1028 (10th Cir. 1994). Substantial evidence is "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Richardson v. Perales*, 402 U.S. 389, 401 (1971) (quoting *Consolidated Edison Co. v. NLRB*, 305 U.S. 197, 229 (1938)). The Court may neither reweigh the evidence nor substitute its discretion for that of the Secretary. *Casias v. Secretary of Health & Human Servs.*, 933 F.2d 799, 800 (10th Cir. 1991).

A four-step sequential evaluation process is required to determine whether a child is disabled. Under this evaluation process the ALJ must consider the following issues: (1) whether the child has engaged in substantial gainful activity, (2) whether the child's impairment or impairments are so severe as to cause more than a minimal limitation on the child's ability to function in an age-appropriate manner, (3) if the impairment is severe, whether it meets or equals an impairment listed in Appendix 1, Subpart P of 20 C.F.R. Part 404, and (4) if the child's impairment does not meet or equal a listed impairment, whether the impairment is of comparable severity to an impairment that would disable an adult. At the fourth step, an individualized functional assessment (IFA) is performed based on the ALJ's evaluation of all of the evidence in the child's claim. To be disabled, the child's impairments must "substantially reduce [his] physical or mental ability to function independently, appropriately and effectively in an age-appropriate manner" and his impairment(s) must meet the durational requirement. 20 CFR § 416.924.

At the time of the hearing Plaintiff, born September 28, 1979, was 14 years old. She was diagnosed with sudden onset of juvenile diabetes which she alleges is disabling. The ALJ found that Plaintiff's impairments do not meet or equal a Listing. He acknowledged that there are times when Plaintiff is required to leave her classes to check her blood sugar and do the procedures necessary to bring it to an acceptable level, including leaving school for an insulin shot and exercise. However, he determined that the record does not reflect that this occurs so frequently that Plaintiff has had limitations imposed on her comparable to those which would disable an adult and that she does not appear to have any limitations in her cognitive development or function. Therefore, the ALJ determined that Plaintiff is not disabled within the meaning of the Social Security Act.

On appeal Plaintiff argues that the case should be remanded because the ALJ did not discuss the medical evidence or give reasons for his conclusion that Plaintiff does not have a listed impairment found in 20 C.F.R. Pt. 404, Subpt. P., App.1. Further, Plaintiff states that the ALJ failed to properly develop the record concerning Plaintiff's alleged mental impairment. The Court agrees.

Although an ALJ is not required to discuss every piece of evidence, the record must demonstrate that the ALJ considered all of the evidence. *Clifton v. Chater*, 79 F.3d 1007, 1009-1010 (10th Cir. 1996); 42 U.S.C. 405(b)(1). Here, the ALJ did not discuss any of the medical evidence. In the absence of ALJ findings supported by specific weighing of the evidence, the Court cannot assess whether relevant evidence supports the ALJ's conclusion. Such a bare conclusion is beyond meaningful judicial

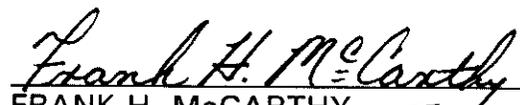
review. Therefore, the case must be remanded for the ALJ to set out reasons for the acceptance or rejection of evidence.

The case must be remanded for the additional reason that the ALJ failed to develop the record concerning Plaintiff's alleged depression. "An ALJ has the duty to develop the record by obtaining pertinent, available medical records which come to his attention during the course of the hearing." *Carter v. Chater* 73 F.3d 1019, 1022 (10th Cir. 1996).

Despite an entry in the record that Plaintiff's mother had reported to Dr. Morgan that Plaintiff had written an 3 page suicide note and Dr. Morgan's notification of this information to Star Mental Health, [R. 164], and Plaintiff's mother's testimony at the hearings that "She's also being treated for depression. . . . [By] Todd at St. John's Youth Center out there," [R. 45-46], the ALJ did not develop the record concerning Plaintiff's mental condition. Receipt of this information gave rise to a duty to attempt to obtain those medical records and to address them in his decision.

The case is hereby REVERSED and REMANDED to the Commissioner of Social Security Administration for further proceedings consistent with this opinion.

SO ORDERED this 27<sup>th</sup> day of December, 1996.

  
FRANK H. McCARTHY  
UNITED STATES MAGISTRATE JUDGE

IN THE UNITED STATES DISTRICT COURT  
FOR THE NORTHERN DISTRICT OF OKLAHOMA

**FILED**

DEC 30 1996

Phil Lombardi, Clerk  
U.S. DISTRICT COURT

MARY BIG ELK and SAM McCLANE, )  
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No. 96-C-0087-B

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After a thorough review of said motions, briefs, and documentation in support, the Court concludes factual issues remain to be resolved by the trier of fact concerning the following:

1. Legal relationship between Big Elk and McClane and Kastning and McClane regarding the subject horses;
2. Scope of employment of various Osage County employee defendants for purposes of 42 U.S.C. § 1983 state action;
3. Existence of an Osage County policy regarding sheriff aiding in "self-help" retrieval of property;

4. Existence of a conspiracy;
5. Qualified immunity; and
6. Statute of limitations defense.

Thus, said motions are hereby **overruled**. The pretrial and trial scheduling order remains in effect.

DATED this 30th day of December, 1996.

  
THOMAS R. BRETT  
UNITED STATES DISTRICT JUDGE

UNITED STATES DISTRICT COURT FOR THE  
NORTHERN DISTRICT OF OKLAHOMA

FILED

DEC 30 1996

Phil Lombardi, Clerk  
U.S. DISTRICT COURT

JAMES M. HANKINS,  
SS# 446-44-1013

Plaintiff,

v.

SHIRLEY S. CHATER, Commissioner of  
Social Security Administration,

Defendant.

No. 95-C-1025-C

ENTERED ON DOCKET

DATE DEC 31 1996

REPORT & RECOMMENDATION<sup>1/</sup>

Plaintiff, James M. Hankins, pursuant to 42 U.S.C. § 405(g), requests judicial review of the decision of the Commissioner denying Social Security benefits.<sup>2/</sup> Plaintiff asserts that the Commissioner erred because (1) the medical evidence established that Plaintiff has met a Listing<sup>3/</sup> for at least two years, and (2) the evidence established that Plaintiff cannot perform a significant number of jobs. For the reasons discussed below, the undersigned United States Magistrate Judge recommends that the District Court affirm the Commissioner's decision.

<sup>1/</sup> By minute order dated October 13, 1995, this case was referred to the United States Magistrate Judge for all further proceedings consistent with his jurisdiction.

<sup>2/</sup> Plaintiff filed an application for disability and supplemental security insurance benefits on April 23, 1993. [R. at 34]. The application was denied initially and upon reconsideration. A hearing before Administrative Law Judge Richard J. Kallsnick (hereafter, "ALJ") was held October 4, 1994. [R. at 331]. By order dated January 13, 1995, the ALJ determined that Plaintiff was not disabled. [R. at 13-24]. Plaintiff appealed the ALJ's decision to the Appeals Council. On August 10, 1995, the Appeals Council denied Plaintiff's request for review. [R. at 3].

<sup>3/</sup> At step three, a claimant's impairment is compared with those impairments listed at 20 C.F.R. Pt. 404, Subpt. P, App. 1, commonly referred to as the "Listings." An individual who meets or equals a Listing is presumed disabled.

## I. PLAINTIFF'S BACKGROUND

### General

Plaintiff was born on December 1, 1947, and was forty-six years old at the time of the hearing. [R. at 235]. Plaintiff claims that he has been unable to work since March 7, 1991, due to an injury to his right arm. [R. at 34].

A Residual Functional Capacity Assessment completed on May 17, 1993 by Thurma Feigel, M.D., indicated that Plaintiff could occasionally lift twenty pounds, frequently lift ten pounds, stand or walk approximately six hours in an eight hour day, sit approximately six hours in an eight hour day, and push or pull an unlimited amount. [R. at 58]. Plaintiff's ability to perform gross and fine hand manipulations was listed as not limited. [R. at 61]. The doctor additionally indicated that Plaintiff's pain did not further limit his residual functional capacity. [R. at 58]. The assessment was "affirmed as written" by Vallis D. Anthony, M.D. on August 27, 1993. [R. at 65].

A Psychiatric Review Technique Form was completed by R.D. Smallwood, Ph.D., on September 14, 1993. [R. at 49]. He indicated that Plaintiff had no severe mental impairments. [R. at 49]. Plaintiff was noted as having no restrictions of daily living, no difficulties in maintaining social functioning, no episodes of deterioration or decompensation, and seldom having deficiencies of concentration. [R. at 56].

In his interview outline, Plaintiff noted that he prepares approximately one meal each day. Plaintiff also washes his own clothes, does some light housekeeping, shops for "the basics," and reads the newspaper. [R. at 96].

### Arm Injury & First Surgery

Plaintiff was injured on the job on March 7, 1991. A bone scan on March 28, 1991, was interpreted as indicating a possible fracture of Plaintiff's right wrist. [R. at 106]. On May 1, 1991, Plaintiff was examined by Michael W. Tanner, M.D. [R. at 109]. Dr. Tanner noted that Plaintiff was injured on March 7, 1991 when a large chain cable was dropped across Plaintiff's forearm. Plaintiff was initially referred to Dr. Tanner on March 21, 1991. [R. at 109]. Dr. Tanner's diagnosis was "internal derangement and possible triangular fibrocartilage tear [of the] right wrist with radial ulnar joint sprain." [R. at 110]. Dr. Tanner recommended arthroscopic surgery and repair of the radial ulnar joint area. Plaintiff had surgery on his right wrist on May 1, 1991. [R. at 111]. Dr. Tanner's notes indicate that Plaintiff "tolerated the procedure well."

Plaintiff's cast was removed on May 30, 1991. [R. at 132]. The doctor noted some soreness about the radial ulnar joint area and advised Plaintiff of a physiotherapy program. [R. at 132]. On June 27, 1991, eight weeks after his surgery, Plaintiff still had some soreness but his condition was improving. [R. at 131]. The doctor noted that in comparing Plaintiff's range of motions, many had improved. Plaintiff's dorsiflexion was 48 degrees, palmar flexion 55 degrees, radial deviation 10 degrees, ulnar deviation 22 degrees, supination 80 degrees, pronation 60 degrees. [R. at 131].

By August 26, 1991 Plaintiff was reported to be "doing well. He has only slight soreness about the wrist area. He has satisfactory [range of motion]." [R. at 130].

Plaintiff returned to work on **October 3, 1991**, and worked until **January 20, 1992**. [R. at 75]. The Social Security **claims** representative noted that because of the duration of the "work attempt" (**less than six months**), it was an "unsuccessful work attempt." [R. at 75].

At his next doctor's appointment, on **December 30, 1991**, eight months after surgery, the doctor noted that Plaintiff had been doing "reasonably well until approximately one month ago when he began having pain throughout the upper extremity." [R. at 130]. According to Plaintiff, the pain was worse in cold areas. [R. at 130]. Plaintiff's doctor observed that "[o]n physical examination there is no evidence of swelling. He has satisfactory [range of motion] of his elbow. . . . Status of his wrist is satisfactory . . . . There was no swelling of his wrist. . . . x-rays of the right elbow appear normal. AP, lateral and oblique x-rays of his wrist appear normal." [R. at 130]. On **January 21, 1992**, Plaintiff reportedly "felt better" about his arm condition and reported less numbness. [R. at 129]. On **February 4, 1992**, Plaintiff's situation had improved. The doctor noted some "crepitus above the posterior aspect of the elbow and . . . tenderness and positive Tinel at the cubital tunnel area. Otherwise, the exam of his upper extremity is satisfactory." [R. at 129]. The doctor additionally noted that Plaintiff should not return to his work. [R. at 129].

#### **Second Surgery**

Plaintiff complained of pain and numbness in his right elbow and hand on **February 12, 1992**. [R. at 121]. **Dr. Tanner** noted that Plaintiff's right elbow had a satisfactory range of motion and that Plaintiff had numbness in his fourth and fifth

fingers. [R. at 121]. The X-rays of Plaintiff's elbow were reported as satisfactory. [R. at 121]. Plaintiff had surgery on his right arm on February 12, 1992. [R. at 123]. Plaintiff was again noted to have tolerated the procedure well. [R. at 124].

On February 24, 1992, twelve days after the operation, Plaintiff was advised to begin "gentle" range of motion exercises. [R. at 144]. By March 16, 1992, Plaintiff was reported as "doing well." Plaintiff had a full range of motion and excellent strength. Plaintiff was "released" to return to his work duties effective April 1, 1992, without restriction. [R. at 144]. Plaintiff returned to his work as a merchant marine from July 15, 1992 until approximately October 12, 1992. [R. at 75].

Plaintiff's next recorded visit to Dr. Tanner was March 9, 1993. The record indicates that Plaintiff informed the doctor that he returned to his work duties in July and worked intermittently until November, with his last day of work occurring sometime in November 1992. (The doctor additionally recorded that during that period of time during the prior year Plaintiff had worked only approximately two months because of problems with his right arm and because his work duties were not available. [R. at 144].) The doctor noted that Plaintiff stated that cold weather caused numbness to his right arm. [R. at 144].

Upon examination, Plaintiff's doctor indicated that Plaintiff's motion of his elbow was satisfactory. Plaintiff's left wrist dorsiflexion was 70 degrees and his right wrist dorsiflexion 56 degrees. [R. at 144]. The doctor noted that he could not detect any wasting or weakness of the "ulnar intrinsic musculature." On March 16, 1993, the doctor reported that Plaintiff's arthrogram appeared normal. Plaintiff's doctor

concluded that additional surgery was not necessary, but that Plaintiff should not perform heavy work duties. "Specifically I do not think he should climb and hang by one hand and do heavy manual labor with his right upper extremity. I feel that he is at high risk for having repeat injury and I suggested that he not return to such work duty. I do not think he should be employed at sea. I feel that permanent work restrictions are in order and I would suggest he do no lifting of more than 20 pounds using his right upper extremity and should not do any repetitive gripping or twisting of more than 5 pounds pressure. I suggested that he seek vocational rehabilitation or retraining program. He is released from my care. I do not anticipate the need for further medical or surgical treatment of his condition." [R. at 144, 146].

In a psychological evaluation, conducted on August 11, 1993, James M. Lee, Ph.D., concluded that Plaintiff appeared eligible for vocational rehabilitation services and appropriate job training. Dr. Lee additionally noted that Plaintiff's I.Q. tests placed Plaintiff within the "dull normal range" as compared to persons his age. [R. at 155].

#### Plaintiff's Testimony

At his hearing on October 4, 1994, Plaintiff testified that he lived alone and drove, on his own, approximately twenty miles each week. Plaintiff stated that he was injured in March of 1991 while working as a merchant seaman. Plaintiff returned to work for approximately three months (in 1992), but last worked as a merchant seaman in 1992. [R. at 238]. Plaintiff additionally testified that he last worked in 1993.

Plaintiff noted that he still has **pain** in his arm, but that to deal with the pain he lays down. Plaintiff does not take **medication** for his pain. Plaintiff stated that he was taking Vasotec for his high blood **pressure**. [R. at 241].

Plaintiff testified that his **grip strength** was very weak and that he could not do all the "every day type of stuff." [R. at 243].

With respect to his surgery and **treatments**, Plaintiff testified that after his first surgery his wrist improved and that **Dr. Tanner** sent him back to work. However, according to Plaintiff, when he **returned** to work he had some problems due to the weather, and the doctor performed a **second** surgery on his elbow. Plaintiff testified that he worked again for a short **time**, but then due to numbness in his hand, he stopped working and went back to **the doctor**. [R. at 244-46].

Plaintiff stated that his arm **feels better** when he does not do anything but that it does not bother his arm to cook **one meal** per day. [R. at 248]. Plaintiff additionally testified that he still experienced **throbbing** and numbness in his right hand. [R. at 246-47].

## II. SOCIAL SECURITY LAW & STANDARD OF REVIEW

The Commissioner has established a five-step process for the evaluation of social security claims.<sup>4/</sup> See 20 C.F.R. § 404.1520. Disability under the Social Security Act is defined as the

inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment . . . .

42 U.S.C. § 423(d)(1)(A). A claimant is disabled under the Social Security Act only if his

physical or mental impairment or impairments are of such severity that he is not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work in the national economy. . . .

42 U.S.C. § 423(d)(2)(A).

The Commissioner's disability determinations are reviewed to determine (1) if the correct legal principles have been followed, and (2) if the decision is supported by

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<sup>4/</sup> Step one requires the claimant to establish that he is not engaged in substantial gainful activity (as defined at 20 C.F.R. §§ 404.1510 and 404.1572). Step two requires that the claimant demonstrate that he has a medically severe impairment or combination of impairments that significantly limit his ability to do basic work activities. See 20 C.F.R. § 1521. If claimant is engaged in substantial gainful activity (step one) or if claimant's impairment is not medically severe (step two), disability benefits are denied. At step three, claimant's impairment is compared with those impairments listed at 20 C.F.R. Pt. 404, Subpt. P, App. 1 (the "Listings"). If a claimant's impairment is equal or medically equivalent to an impairment in the Listings, claimant is presumed disabled. If a Listing is not met, the evaluation proceeds to step four, where the claimant must establish that his impairment or the combination of impairments prevents him from performing his past relevant work. A claimant is not disabled if the claimant can perform his past work. If a claimant is unable to perform his previous work, the Commissioner has the burden of proof (step five) to establish that the claimant, in light of his age, education, and work history, has the residual functional capacity ("RFC") to perform an alternative work activity in the national economy. If a claimant has the RFC to perform an alternate work activity, disability benefits are denied. See Bowen v. Yuckert, 482 U.S. 137, 140-42 (1987); Williams v. Bowen, 844 F.2d 748, 750-51 (10th Cir. 1988).

substantial evidence. See 42 U.S.C. § 405(g); Bernal v. Bowen, 851 F.2d 297, 299 (10th Cir. 1988); Williams, 844 F.2d at 750.

The Court, in determining whether the decision of the Commissioner is supported by substantial evidence, does not examine the issues *de novo*. Sisco v. United States Dept. of Health and Human Services, 10 F.3d 739, 741 (10th Cir. 1993). The Court will not reweigh the evidence or substitute its judgment for that of the Commissioner. Glass v. Shalala, 43 F.3d 1392, 1395 (10th Cir. 1994). The Court will, however, meticulously examine the entire record to determine if the Commissioner's determination is rational. Williams, 844 F.2d at 750; Holloway v. Heckler, 607 F. Supp. 71, 72 (D. Kan. 1985).

"The finding of the Secretary<sup>5/</sup> as to any fact, if supported by substantial evidence, shall be conclusive." 42 U.S.C. § 405(g). Substantial evidence is that amount and type of evidence that a reasonable mind will accept as adequate to support a conclusion. Richardson v. Perales, 402 U.S. 389, 401 (1971); Williams, 844 F.2d at 750. In terms of traditional burdens of proof, substantial evidence is more than a scintilla, but less than a preponderance. Perales, 402 U.S. at 401. Evidence is not substantial if it is overwhelmed by other evidence in the record. Williams, 844 F.2d at 750.

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<sup>5/</sup> Effective March 31, 1995, the functions of the Secretary of Health and Human Services ("Secretary") in social security cases were transferred to the Commissioner of Social Security. P.L. No. 103-296. For the purpose of this Order, references in case law to "the Secretary" are interchangeable with "the Commissioner."

This Court must also determine whether the Commissioner applied the correct legal standards. Washington v. Shalala, 37 F.3d 1437, 1439 (10th Cir. 1994). The Commissioner's decision will be reversed when she uses the wrong legal standard or fails to clearly demonstrate reliance on the correct legal standards. Glass, 43 F.3d at 1395.

### **III. THE ALJ'S DECISION**

In this case, the ALJ determined that Plaintiff was not disabled at Step Five of the sequential evaluation process. The ALJ concluded that although Plaintiff had an injury to his right arm and shoulder the medical evidence established that Plaintiff's injury healed within 12 months after onset and Plaintiff therefore did not meet Listing 1.12. [R. at 15]. The ALJ found, based on the records from Plaintiff's treating physicians, that Plaintiff should not return to his past work. Based on the limitations provided by Plaintiff's treating physicians, the ALJ determined that Plaintiff should lift no more than 20 pounds with his right arm, with no repetitive gripping or twisting of more than five pounds. In addition, the ALJ found that Plaintiff had a slight learning disability. [R. at 17]. Based on these limitations and the testimony of a vocational expert, the ALJ concluded that Plaintiff could perform several jobs in the national economy. [R. at 20-21].

### **IV. REVIEW**

#### **Step Three: Listing 1.12**

At step three of the sequential evaluation process, a claimant's impairment is compared to the Listings (20 C.F.R. Pt. 404, Subpt. P, App. 1). If the impairment is

equal or medically equivalent to an impairment in the Listings, the claimant is presumed disabled. A plaintiff has the burden of proving that a Listing has been equaled or met. Yuckert, 482 U.S. at 140-42; Williams, 844 F.2d at 750-51

Plaintiff initially asserts that the medical evidence conclusively proves that he meets Listing 1.12. Plaintiff alleges that the ALJ erred by finding that the injury healed within 12 months of onset. According to Plaintiff, because his injury required two surgeries, over a period of two years, he conclusively meets Listing 1.12, and should be found disabled.

Listing 1.12 provides:

*Fractures of an upper extremity with non-union of a fracture of the shaft of the humerus, radius, or ulna under continuing surgical management directed toward restoration of functional use of the extremity and such function was not restored or expected to be restored within 12 months after onset.*

20 C.F.R. Pt. 404, Subpt. P, App. 1, § 1.12 (italics in original). To meet this Listing, Plaintiff has the burden of establishing that: (1) he experienced a non-union fracture of the humerus, radius, or ulna, (2) the fracture was under continuing surgical management directed toward restoring the function of the arm, (3) function of the arm was not restored within 12 months.

Plaintiff asserts that his injury was a fracture to the ulna, and that this fact is not disputed.<sup>6/</sup> Neither party addresses whether the "fracture" was under continuing

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<sup>6/</sup> The ALJ does note, in his opinion that the "medical evidence establishes that while the claimant has experienced a fractured ulna. . . ." [R. at 15]. The Court is not convinced that Plaintiff's records adequately support his argument that he experienced the type of non-union fracture required by Listing 1.12. A bone  
(continued...)

surgical management. Plaintiff additionally asserts that the evidence is "overwhelming" that the ALJ was wrong in his determination that Plaintiff's injury "healed within 12 months after onset." The Court disagrees.

Listing 1.12 contemplates that the "functional use of the extremity" is "not restored . . . within 12 months after onset." The ALJ found, and the record provides substantial evidence to support the finding that Plaintiff's functional use of his arm was returned within 12 months of his injury.

The record indicates that Plaintiff was injured on March 7, 1991. By March 28, 1991, a bone scan suggested that Plaintiff had a possible fracture of his right wrist. [R. at 106]. Plaintiff was referred to Dr. Tanner on March 21, 1991. [R. at 109]. Dr. Tanner's diagnosis was "internal derangement and possible triangular fibrocartilage tear [of the] right wrist with radial ulnar joint sprain." [R. at 110]. Plaintiff underwent arthroscopic surgery and repair of his right radial ulnar joint area on May 1, 1991. [R. at 111]. Plaintiff's cast was removed on May 30, 1991. [R. at 132]. Plaintiff's condition was reported as "improving" on June 27, 1991. [R. at 131]. Plaintiff's doctor noted the following with respect to Plaintiff's range of motions: dorsiflexion was 48 degrees, palmar flexion 55 degrees, radial deviation 10 degrees, ulnar deviation 22 degrees, supination 80 degrees, pronation 60 degrees. [R. at 131]. By

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<sup>6/</sup> (...continued)

scan on March 28, 1991 indicated a "possible fracture right wrist." [R. at 106]. Plaintiff's treating physician noted that Plaintiff had an "internal derangement and possible triangular fibrocartilage tear of the right wrist with radial ulnar joint sprain." [R. at 110]. The records do not conclusively establish that Plaintiff's injury was a "non-union fracture" of the "humerus, radius or ulna." Nevertheless, the Court declines to address this issue further. This issue is not addressed by the parties. Furthermore, the Court concludes that Plaintiff cannot establish the remaining requirements of Listing 1.12.

August 26, 1991 Plaintiff was reported to be "doing well. He has only slight soreness about the wrist area. He has satisfactory [range of motion]." [R. at 130].

Plaintiff returned to work on October 3, 1991, and worked until January 20, 1992. [R. at 75]. Therefore, Plaintiff was initially injured in March of 1991, but was able to return to work by October of 1991.<sup>7/</sup> In addition, Plaintiff testified that his doctor permitted him to return to work after the first surgery. [R. at 244].

On December 30, 1991, Plaintiff's doctor noted that Plaintiff had been doing "reasonably well until approximately one month ago when he began having pain throughout the upper extremity." [R. at 130]. Plaintiff's doctor observed that there was "no evidence of swelling. He has satisfactory [range of motion] of his elbow. . . . Status of his wrist is satisfactory . . . . There was no swelling of his wrist. . . . x-rays of the right elbow appear normal. AP, lateral and oblique x-rays of his wrist appear normal." [R. at 130]. Therefore, less than 12 months after his injury, Plaintiff had regained the functional use of his arm.

Plaintiff additionally had surgery on February 12, 1992. [R. at 123]. Plaintiff was "released" to return to his work duties effective April 1, 1992, without restriction. [R. at 144]. Plaintiff returned to his work as a merchant marine from July 15, 1992 until approximately October 12, 1992. [R. at 75].

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<sup>7/</sup> Plaintiff suggests that his return to work should not be considered because it was recognized by the Social Security Administration as "unsuccessful." The Social Security claims representative did note that because of the duration of the "work attempt" (less than six months), it was an "unsuccessful work attempt." [R. at 75]. However, this classification of Plaintiff's work attempt does not detract from the fact that Plaintiff's arm was restored to functional use within 12 months of his injury.

On March 9, 1993, Plaintiff was released from Dr. Tanner's care. He noted that he "[did] not anticipate the need for further medical or surgical treatment of his condition." [R. at 144, 146].

### **Pain**

As a "side-issue" to his Listing argument, Plaintiff asserts that he has been in continual pain since the time of his fracture, and that the ALJ must consider this pain in evaluating Plaintiff's injury.

The legal standards for evaluating pain are outlined in 20 C.F.R. §§ 404.1529 and 416.929, and were addressed by the Tenth Circuit Court of Appeals in Luna v. Bowen, 834 F.2d 161 (10th Cir. 1987). First, the asserted pain-producing impairment must be supported by objective medical evidence. Id. at 163. Second, assuming all the allegations of pain as true, a claimant must establish a nexus between the impairment and the alleged pain. "The impairment or abnormality must be one which 'could reasonably be expected to produce' the alleged pain." Id. Third, the decision maker, considering all of the medical data presented and any objective or subjective indications of the pain, must assess the claimant's credibility.

[I]f an impairment is reasonably expected to produce some pain, allegations of disabling pain emanating from that impairment are sufficiently consistent to require consideration of all relevant evidence.

Id. at 164. In assessing the credibility of a claimant's complaints of pain, the following factors may be considered.

[T]he levels of medication and their effectiveness, the extensiveness of the attempts (medical or nonmedical) to

obtain relief, the frequency of medical contacts, the nature of daily activities, subjective measures of credibility that are peculiarly within the judgment of the ALJ, the motivation of and relationship between the claimant and other witnesses, and the consistency or compatibility of nonmedical testimony with objective medical evidence.

Hargis v. Sullivan, 945 F.2d 1482, 1488 (10th Cir. 1991). See also Luna, 834 F.2d at 165 ("For example, we have noted a claimant's persistent attempts to find relief for his pain and his willingness to try any treatment prescribed, regular use of crutches or a cane, regular contact with a doctor, and the possibility that psychological disorders combine with physical problems. The Secretary has also noted several factors for consideration including the claimant's daily activities, and the dosage, effectiveness, and side effects of medication.").

The record indicates that the ALJ adequately considered Plaintiff's complaints of pain. The ALJ summarized Plaintiff's medical records and additionally noted that Plaintiff's records from his treating physician indicated that Plaintiff admitted he was feeling better and experiencing less pain with treatment. The ALJ observed that Plaintiff took no medication for his pain, and that Plaintiff performed several activities. In addition, the ALJ considered the limitations placed upon Plaintiff by his treating physician. The record indicates that the ALJ did give appropriate consideration to Plaintiff's complaints of pain. Plaintiff does not specifically allege how the ALJ or Commissioner erred, but merely asserts that the ALJ must consider Plaintiff's pain. The record establishes that the ALJ did give due consideration to Plaintiff's pain.

### **Vocational Expert and Alternative Jobs**

Finally, Plaintiff asserts that although the ALJ correctly concluded that Plaintiff could not return to his work as a merchant marine, the ALJ erred in finding Plaintiff could perform other work in the national economy. Plaintiff observes that based on the testimony of a vocational expert the ALJ improperly concluded that Plaintiff could work as a janitor, a parking lot attendant, or a hand packager. Plaintiff states that he did try to work as a janitor, but was unable to do such work. Plaintiff also asserts that the vocational expert admitted that somebody with Plaintiff's limitations could not work as a parking lot attendant, and that his physical impairments would also prevent him from working as a hand packager.

The ALJ presented the following hypothetical to the vocational expert.

Assume that we have a claimant who is 47 years of age, has a 12th grade-education, however, based upon some of the information in the file, apparently his education ability as far as reading, writing, and use [sic] numbers, using numbers would be somewhat of a -- probably at the grade school level, varying levels. Let's [sic] see, I think he reads at 3.9 grade level, spells at the 3.6 grade level, and math at about the 5 to 6 grade level. So, anyway, so it would be limited or less ability to read, write, and use numbers in that regard, but based upon his past work experienced, his testimony, and that information as I indicated, the ability to read, write, and use numbers would be limited in that regard. This individual would have a physical capability of performing I'd like you to consider light and also consider sedentary work activity. As far as sitting or walking, there would be -- he would be able to do those six -- sitting for up to six hours in an eight-hour workday with normal breaks, standing and or walking up to six hours in an eight-hour workday with normal breaks. There would be no limitation in that regard. Using the feet for foot controls and that type of thing, no problem. His right -- in regard to his right

upper extremity, he would be limited to lifting 20 pounds. Actually as far as the left arm, he can lift -- lifting in that regard is not in any way affected, but the right upper extremity would be limited to lifting 20 pounds. On a repetitive basis he would only have five pounds of grip strength to be used on a repetitive basis. Now, this individual does have a learning disorder. I think we have Exhibit 26 in our file regarding that, and as I indicated to you, the reading and the writing and the math are somewhat affected. He has a verbal IQ of 90, performance IQ of 81, full scale IQ of 84, but there would be some -- the learning disorders I indicated in regard to reading, writing, and using numbers would be as I indicated previously. Now this individual is afflicted with symptomatology from a variety of sources to include mild to moderate pain on an occasional basis and that we have sufficient severity to be noticeable to him at all times, but nonetheless, he could remain attentive and responsive in a work setting and could carry out work assignments satisfactorily. He currently [sic] takes Vasotec for high blood pressure.

[R. at 264-66]. Based on this hypothetical, the vocational expert concluded that such an individual could perform work in the light janitorial area (5,500 jobs in Oklahoma), at the unskilled sedentary level for hand packaging (200 or 2,000 jobs in Oklahoma), and at the unskilled level for a parking lot attendant (56 jobs in Oklahoma).

The limitations presented to the vocational expert adequately described Plaintiff's limitations. Plaintiff's treating physician concluded on March 16, 1993, that additional surgery was not necessary, but that Plaintiff should not perform heavy work duties. "Specifically I do not think he should climb and hang by one hand and do heavy manual labor with his right upper extremity. I feel that he is at high risk for having repeat injury and I suggested that he not return to such work duty. I do not think he should be employed at sea. I feel that permanent work restrictions are in

order and I would suggest he do no lifting of more than 20 pounds using his right upper extremity and should not do any repetitive gripping or twisting of more than 5 pounds pressure. I suggested that he seek vocational rehabilitation or retraining program. He is released from my care. I do not anticipate the need for further medical or surgical treatment of his condition." [R. at 144, 146]. In addition, a Residual Functional Capacity Assessment was on May 17, 1993 by Dr. Feigel. Dr. Feigel indicated that Plaintiff could occasionally lift twenty pounds, frequently lift ten pounds, stand or walk approximately six hours in an eight hour day, sit approximately six hours in an eight hour day, and push or pull an unlimited amount. [R. at 58]. Plaintiff's ability to perform gross and fine hand manipulations was listed as not limited. [R. at 61]. The doctor additionally indicated that Plaintiff's pain did not further limit his residual functional capacity. [R. at 58]. The assessment was "affirmed as written" by Vallis D. Anthony, M.D. on August 27, 1993. [R. at 65]. The hypothetical question presented to the vocational expert adequately included Plaintiff's limitations and therefore constitutes substantial evidence to support the Commissioner's decision.

Plaintiff asserts that given Plaintiff's restrictions of lifting 20 pounds and repetitive lifting of five pounds, that Plaintiff cannot perform work as a janitor. Plaintiff further asserts that Plaintiff attempted to work as a janitor but the ALJ properly recognized Plaintiff's work attempt as "unsuccessful." The ALJ's recognition of Plaintiff's attempt to work as "unsuccessful" is not an acknowledgment that Plaintiff is unable to do the work. The regulations provide that, for the purposes of calculating substantial gainful activity a work attempt that is less than six months in duration does

not constitute a "successful" work attempt. See, e.g., 20 C.F.R. § 404.1574(a)(1); Soc. Sec. Rep. Serv., Rulings 1983-1991, SSR 84-25, 1984 WL 49799. This has no bearing on the ALJ's conclusion that based on the testimony of the vocational expert Plaintiff is able to perform such work.

Plaintiff additionally suggests that the vocational expert acknowledged that Plaintiff would be unable to perform the work. However, Plaintiff relies on testimony from the vocational expert which includes additional limitations that the ALJ found were not supported by substantial evidence.<sup>8/</sup> However, an ALJ need include only those limitations in the question to the vocational expert which he properly finds are established by the evidence. Evans v. Chater, 55 F.3d 530, 532 (10th Cir. 1995); Talley v. Sullivan, 908 F.2d 585, 588 (10th Cir. 1990). In addition, credibility determinations by the trier of fact are given great deference on review. Hamilton v. Secretary of Health & Human Services, 961 F.2d 1495 (10th Cir. 1992). Considering Plaintiff's medical record and the ALJ's determinations, the hypothetical posed by the ALJ adequately included Plaintiff's restrictions.

## RECOMMENDATION

Based on the legal and factual issues in this case, the United States Magistrate Judge recommends that the District Court **AFFIRM** the decision of the Commissioner.

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<sup>8/</sup> For example, Plaintiff's attorney added limitations based on hand coordination, visual perception, gross and fine motor skills, etc. [R. at 267-77]. As noted above, these limitations are not substantiated by the medical record. Plaintiff's Residual Functional Capacity Assessment indicated that Plaintiff had no gross or fine manipulative limitations, and no visual or acuity limitations. [R. at 61]. Furthermore, Plaintiff's treating physician placed no such limitations upon Plaintiff.

Any objection to this Report and Recommendation must be filed with the Clerk of the Courts within ten days of service of this notice. Failure to file objections within the specified time will result in a waiver of the right to appeal the District Court's legal and factual findings. See, e.g., Moore v. United States, 950 F.2d 656 (10th Cir. 1991).

Dated this 30 day of December 1996.

  
Sam A. Joyner  
United States Magistrate Judge

IN THE UNITED STATES DISTRICT COURT FOR THE  
NORTHERN DISTRICT OF OKLAHOMA

FILED

DEC 30 1996

Phil Lombardi, Clerk  
U.S. DISTRICT COURT

MICHAEL BLACK,  
SSN: 441-58-8825,

Plaintiff,

v.

SHIRLEY S. CHATER,  
Commissioner of the Social Security  
Administration,

Defendant.

CASE NO. 95-C-633-M ✓

ENTERED ON DOCKET

DATE 12/31/96

**JUDGMENT**

Judgment is hereby entered for Defendant and against Plaintiff. Dated  
this 30<sup>th</sup> day of Dec., 1996.

  
FRANK H. McCARTHY  
UNITED STATES MAGISTRATE JUDGE

IN THE UNITED STATES DISTRICT COURT FOR THE  
NORTHERN DISTRICT OF OKLAHOMA

MICHAEL BLACK  
441-58-8825

Plaintiff,

vs.

SHIRLEY S. CHATER, Commissioner  
Social Security Administration,

Defendant,

**ORDER**

**FILED**

DEC 30 1996

Phil Lombardi, Clerk  
U.S. DISTRICT COURT

Case No. 95-C-633-M

ENTERED ON DOCKET

DATE 12/31/96

Plaintiff, Michael Black, seeks judicial review of a decision of the Commissioner of Health & Human Services denying Social Security disability benefits.<sup>1</sup> In accordance with 28 U.S.C. §636(c)(1) & (3) the parties have consented to proceed before a United States Magistrate Judge, any appeal of this Order will be directly to the Circuit Court of Appeals.

The role of the court in reviewing the decision of the Commissioner under 42 U. S. C. §405(g) is limited to determining whether the decision is supported by substantial evidence and whether the decision contains a sufficient basis to determine that the Commissioner has applied the correct legal standards. *Winfrey v. Chater*, 92 F.3d 1017 (10th Cir. 1996); *Castellano v. Secretary of Health & Human Servs.*, 26 F.3d 1027, 1028 (10th Cir. 1994). Substantial evidence is more than a scintilla, less than a preponderance, and is such relevant evidence as a reasonable mind might

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<sup>1</sup> Plaintiff's July 28, 1992 application for disability benefits was denied December 14, 1992 and was affirmed on reconsideration. A hearing before an Administrative Law Judge ("ALJ") was held February 2, 1994. By decision dated October 14, 1994 the ALJ entered the findings that are the subject of this appeal. The Appeals Council affirmed the findings of the ALJ on May 9, 1995. The decision of the Appeals Council represents the Commissioner's final decision for purposes of further appeal. 20 C.F.R. §§ 404.981, 416.1481.

accept as adequate to support a conclusion. *Richardson v. Perales*, 402 U.S. 389, 401, 91 S.Ct. 1420, 1427, 28 L.Ed.2d 842 (1971) (quoting *Consolidated Edison Co. v. NLRB*, 305 U.S. 197, 229 (1938)). The Court may neither reweigh the evidence nor substitute its discretion for that of the Commissioner. *Casias v. Secretary of Health & Human Servs.*, 933 F.2d 799, 800 (10th Cir. 1991).

Plaintiff was born December 4, 1954 and was 39 years old at the time of the hearing. He has a 12th grade education and past relevant work as a laborer in a cement factory and a foundry. He claims to be unable to work as a result of back pain and depression. The ALJ determined that Plaintiff is impaired by back pain and depression but found that he is able to perform his past relevant work as a foundry laborer and therefore is not disabled. The case was thus decided at step four of the five-step evaluative sequence for determining whether a claimant is disabled. See *Williams v. Bowen*, 844 F.2d 748, 750-52 (10th Cir. 1988) (discussing five steps in detail).

Plaintiff alleges that ALJ's determination is not supported by substantial evidence. Specifically, Plaintiff states that the ALJ: failed to consider the effect of his poor hearing or dizziness on his ability to work; failed to take account of all the medical evidence related to his back; and improperly evaluated his depression. The Court affirms the ALJ's determination as supported by substantial evidence.

According to the medical records, Plaintiff was examined by William K. Zollinger, M.D. in December 1991 for complaints of decreased hearing, tinnitus, and dizziness. [R. 119]. Dr. Zollinger reported a normal audiogram (hearing test), with

a sensorineural (nerve-related) loss in the very high and very low frequencies. He recommended additional testing to **make certain** that there is no significant inner ear pathology. The record does not reflect that the additional testing was done, nor does it reflect continued complaints of **dizziness** or hearing loss. One mention of dizziness occurred in the patient provided history portion of a physical examination. There Plaintiff stated that he had no difficulty with dizziness, "unless he is in a dark room, then he sometimes feels somewhat dizzy." [R. 125]. It was not error for the ALJ to conclude that Plaintiff did not have a **severe** limitation based upon "poor hearing or dizziness."

The Court finds that the ALJ **appropriately** evaluated the medical evidence concerning Plaintiff's back. Although complaints of back pain appear intermittently throughout the medical record, these are mostly Plaintiff's subjective statements. Physical examination performed by David B. Dean, M.D. on November 11, 1992 revealed "full range of motion of **lumbosacral** spine with no reflex, motor or sensory deficit noted at either lower extremity." [R. 151]. Dr. Dean diagnosed: "osteoarthritis, traumatic, **lumbosacral** spine, history of degenerative disease, no residual limitation of range of motion or objective lumbosacral radiculopathy." *Id.* Plaintiff states that the ALJ ignored the **abnormal** x-rays of the cervical spine at page 205 of the record. In fact, the ALJ specifically noted this record. [R. 18]. Additionally, subsequent cervical spine x-rays on January 6, 1993, were reported to be "unremarkable." [R. 165].

Plaintiff has asserted that the ALJ mischaracterized an EMG as normal. The otherwise normal EMG report indicates there is a recent partial denervation present in the left gastrocnemius (calf) muscle suggesting L5-S1 root irritation. [R. 118]. However, neurosurgeon, Dr. Stephen J. Eichert, stated that review of Plaintiff's x-rays and CT scan of the lumbar spine failed to reveal significant pathology. In Dr. Eichert's opinion, Plaintiff "has no evidence of neurologic abnormality." [R. 116]. Viewing the record as a whole, the ALJ's decision concerning Plaintiff's physical impairments is supported by substantial evidence.

As permitted by Social Security regulations, Plaintiff submitted additional medical records to the Appeals Council, including a Psychiatric Review Technique Form (PRT) dated November 18, 1994 from Plaintiff's treating psychiatrist, David B. Dean, M.D. [R. 260-263]. The PRT by Dr. Dean is internally inconsistent. At page 260 of the record the PRT reflects that Plaintiff meets or equals Listing § 12.04. At page 263 the PRT reflects that Plaintiff does not meet the functional limitations required to meet Listing § 12.04. In correspondence to the Appeals Council Plaintiff's representative acknowledged that Dr. Dean "does not mark the "B" criteria of the PRT as being severe enough to meet a listing. . ." [R. 264]. The Appeals Council considered this additional evidence but stated that Dr. Dean failed to provide sufficient objective documentation to support his findings, concluding that the additional evidence did not provide a basis for changing the ALJ's decision. [R. 6].

Where, as here, the Appeals Council denies review, the ALJ's decision becomes the Commissioner's final decision. See 20 C.F.R. § 404.981. The decision

is reviewed for substantial evidence, based on “the record viewed as a whole.” *O’Dell v. Shalala*, 44 F.3d 855, 858 (10th Cir. 1994) (quoting *Castellano v. Secretary of Health & Human Servs.*, 26 F.3d 1027, 1028 (10th Cir. 1994)). In *O’Dell* the Tenth Circuit held that new evidence submitted to the Appeals Council “becomes part of the administrative record to be considered when evaluating the Secretary’s decision for substantial evidence.” *O’Dell*, 44 F.3d at 859. The Court must therefore include Dr. Dean’s opinion that Plaintiff meets Listing 12.04 in its review of the denial decision.

As it pertains to this case, Listing 12.04 requires that the Plaintiff have a depressive syndrome meeting the requirements of Listing parts A and B. Part A requires documented persistence of:

- a. Anhedonia or pervasive loss of interest in almost all activities; or
- \* \* \*
- c. Sleep disturbance; or
- d. Psychomotor agitation or retardation, or
- e. Decreased energy; or
- f. Feelings of guilt or worthlessness; or
- g. Difficulty concentrating or thinking;
- \* \* \*

20 C.F.R. Pt. 404, Subpt. P, App.1. § 12.04. Dr. Dean found Plaintiff to have met the above-listed *Part A* criteria. [R. 262]. These requirements are unquestionably met as they are documented throughout the medical records. However, to meet Listing 12.04, Plaintiff’s depression must also cause functional limitations in at least two of the following areas:

1. Marked restriction of activities of daily living; or
2. Marked difficulties in maintaining social functioning; or

3. Deficiencies of concentration, persistence or pace resulting in frequent failure to complete tasks in a timely manner (in work settings or elsewhere); or

4. Repeated episodes of deterioration of decompensation in work or work-like settings which cause the individual to withdraw from that situation or to experience exacerbation of signs and symptoms (which may include deterioration of adaptive behaviors).

*Id.* § 12.04 B.

Dr. Dean found that Plaintiff met the listing criteria for only one of these four functional limitations. He found "marked" limitations in social functioning, but only moderate, not marked, restriction of activities of daily living. According to Dr. Dean, Plaintiff often, not frequently displayed deficiencies of concentration and there was insufficient evidence to determine whether there had been episodes of deterioration or decompensation in a work-like setting.

Before this Court Plaintiff has characterized Dr. Dean's failure to mark two categories of the functional limitations at the listing level as "an error." [Dkt. 14, p.3]. The Court is convinced, however, that Dr. Dean's assessment of Plaintiff's functional limitations was not an "error." The PRT contains a section which summarizes the functional limitation rating. This summary section asks the preparer to fill in a box which indicates the number of the functional limitations manifested at the degree of limitation that satisfies the listings, and reminds the preparer that "[t]he number in the box must be at least 2 to satisfy the requirements of paragraph B in Listing . . . 12.04." [R. 263]. Dr. Dean placed a "1" in the box, thus confirming that Dr. Dean's rating was not an "error" as Plaintiff now suggests.

Dr. Dean is Plaintiff's treating physician for his depression. His medical records were not submitted to the Appeals Council but they are in the record. [R. 207-210, 255]. They reflect Dr. Dean's diagnosis of "major depression" and treatment of Plaintiff from September 1992 to December 1993. In December 1993 Dr. Dean noted chronic depression with minimal benefit from medication. Dr. Dean's notes primarily relate Plaintiff's subjective comments about his interest level, energy level and sleep habits, the "A" criteria of the Listing. On each visit Dr. Dean's objective findings reflect that Plaintiff is reality oriented and has no perceptual or thought disorders. There is nothing within Dr. Dean's notes to substantiate or contradict his rating of Plaintiff's functional ability on the PRT. So, although Dr. Dean's rating of Plaintiff on the PRT differs from the rating completed by the ALJ, those differences do not change the fact that Plaintiff has not met Listing 12.04.

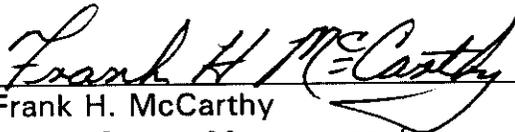
The ALJ's hypothetical questioning of the vocational expert took into account the functional limitations caused by Plaintiff's depression, in that the ALJ included the limitation of the ability to perform simple and some complex tasks with no active involvement with the public. [R. 22, 306]. These limitations are supported by the report of Dr. Lakin-Brewer that: "Client's subjective report is that he is not able to concentrate on tasks except for short span's of time. Cognitively, he appears to be able to remember, comprehend and carry out complex instructions." [R. 147].

The Court notes Plaintiff's suggestion that the decision in this case is somehow related to the fact that the file was in disarray at the hearing. Plaintiff states that he copied the file and left it in a mess and that this is evidence of his inability to

concentrate. Plaintiff also mentions that the ALJ interrupted him several times at the hearing. These matters do not afford a basis for reversal of the decision. The Court notes that there is no evidence to suggest that the inability to copy and organize a file is necessary to perform the work of a foundry laborer. Further, Plaintiff was represented at the hearing and there were no objections made as to the conduct of the hearing.

The Court finds that the ALJ evaluated the record in accordance with the legal standards established by the Commissioner and the courts. The Court further finds there is substantial evidence in the record to support the ALJ's decision. Accordingly, the decision of the Commissioner finding Plaintiff not disabled is AFFIRMED.

DATED this 30<sup>th</sup> day of December, 1996.

  
Frank H. McCarthy  
UNITED STATES MAGISTRATE JUDGE

IN THE UNITED STATES DISTRICT COURT FOR THE  
NORTHERN DISTRICT OF OKLAHOMA

FILED

NATHAN R. GRIFFITH,  
SSN: 548-60-8763,

Plaintiff,

v.

SHIRLEY S. CHATER,  
Commissioner of the Social Security  
Administration,

Defendant.

DEC 30 1996

Phil Lombardi, Clerk  
U.S. DISTRICT COURT

CASE NO. 95-C-1117-M ✓

ENTERED ON DOCKET

DATE 12/31/96

**JUDGMENT**

Judgment is hereby entered for Plaintiff and against Defendant. Dated  
this 30<sup>th</sup> day of Dec., 1996.

  
FRANK H. McCARTHY  
UNITED STATES MAGISTRATE JUDGE

IN THE UNITED STATES DISTRICT COURT FOR THE  
NORTHERN DISTRICT OF OKLAHOMA

**F I L E D**

NATHAN R. GRIFFITH

Plaintiff,

vs.

SHIRLEY S. CHATER, <sup>1</sup> Commissioner  
Social Security Administration,

Defendant,

Case No. 95-C-1117-M

DEC 30 1996

Phil Lombardi, Clerk  
U.S. DISTRICT COURT  
NORTHERN DISTRICT OF OKLAHOMA

ENTERED ON DOCKET

DATE 12/31/96

**ORDER**

Plaintiff, Nathan R. Griffith, **seeks** judicial review of a decision of the Secretary of Health & Human Services denying Social Security disability benefits.<sup>2</sup> In accordance with 28 U.S.C. §636(c)(1) & (3) the parties have consented to proceed before a United States Magistrate Judge, any appeal of this Order will be directly to the Circuit Court of Appeals.

The role of the court in reviewing the decision of the Secretary under 42 U. S. C. §405(g) is limited to determining whether the decision is supported by substantial evidence and whether the decision contains a sufficient basis to determine that the Secretary has applied the correct legal standards. *Winfrey v. Chater*, 92 F.3d 1017 (10th Cir. 1996); *Castellano v. Secretary of Health & Human Servs.*, 26 F.3d 1027,

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<sup>1</sup> Effective March 31, 1995, the functions of the Secretary of Health and Human Services in social security cases were transferred to the Commissioner of Social Security. P.L. No. 103-297. However, this order continues to refer to the Secretary because she was the appropriate party at the time of the underlying decision.

<sup>2</sup> Plaintiff's January 31, 1994 application for Supplemental Security Income was denied April 7, 1994 and was affirmed on reconsideration. A hearing before an Administrative Law Judge ("ALJ") was held November 16, 1994. By decision dated December 30, 1994 the ALJ entered the findings that are the subject of this appeal. The Appeals Council affirmed the findings of the ALJ on September 8, 1995. The decision of the Appeals Council represents the Secretary's final decision for purposes of further appeal. 20 C.F.R. §§ 404.981, 416.1481.

1028 (10th Cir. 1994). Substantial evidence is more than a scintilla, less than a preponderance, and is such relevant evidence as a reasonable mind might accept as adequate to support a conclusion. *Richardson v. Perales*, 402 U.S. 389, 401, 91 S.Ct. 1420, 1427, 28 L.Ed.2d 842, (1971) (quoting *Consolidated Edison Co. v. NLRB*, 305 U.S. 197, 229 (1938)). The Court may neither reweigh the evidence nor substitute its discretion for that of the Secretary. *Casias v. Secretary of Health & Human Servs.*, 933 F.2d 799, 800 (10th Cir. 1991).

Plaintiff was born January 1, 1945 and was 49 years old at the time of the hearing. He has an 8th grade education and past relevant work as a truck driver. He claims to be unable to work as a result of back pain. The ALJ determined that Plaintiff is impaired by low back pain and found that, although Plaintiff was unable to perform his past relevant work, he was capable of performing a full range of light work. The case was thus decided at step five of the five-step evaluative sequence for determining whether a claimant is disabled. See *Williams v. Bowen*, 844 F.2d 748, 750-52 (10th Cir. 1988) (discussing five steps in detail).

Plaintiff asserts that the ALJ's determination is not supported by substantial evidence. Specifically, Plaintiff argues that the ALJ: erroneously relied on the grids; failed to consider the limiting effects of his obesity in combination with his other impairments; and substituted his own opinion for medical evidence. For the reasons expressed below, the Court holds that the existing record and findings will not support the denial of benefits on the ALJ's stated rationale and, therefore the case must be reversed and remanded.

The Secretary bears the burden of proof at step five to establish that, in light of Plaintiff's residual functional capacity (RFC), age, education and work experience, he could still perform other jobs existing in significant numbers in the national economy. *Ragland v. Shalala*, 992 F.2d 1056, 1057 (10th Cir. 1993). The ALJ relied on the Medical-Vocational Guidelines ("Grids"), 20 C.F.R., Pt. 404, Subpt. P, App. 2, Table No. 2, Rule 202.18, to support the determination that Plaintiff is not disabled. It is well established that an ALJ may not rely conclusively on the grids unless he finds: (1) that the claimant has no significant nonexertional impairment; (2) that the claimant can do the full range of work at some RFC level on a daily basis; and (3) that the claimant can perform most of the jobs in that RFC level. Furthermore, "[e]ach of these findings must be supported by substantial evidence." *Thompson v. Sullivan*, 987 F.2d 1482, 1488 (10th Cir. 1993).

The ALJ found that Plaintiff had no nonexertional impairments, that finding is not seriously challenged by Plaintiff. The Court must therefore assess the record to determine whether the Secretary presented substantial evidence demonstrating that notwithstanding his physical impairments and alleged pain, Plaintiff could perform the full range of light work and would qualify for most of the jobs falling within that RFC category. Absent such evidence, the Secretary cannot satisfy the burden at step five without producing expert vocational testimony or other similar evidence to establish the existence of significant work within the claimant's capabilities. *Hargis v. Sullivan*, 945 F.2d 1482, 1491 (10th Cir. 1991)

The ALJ found that Plaintiff "has the residual functional capacity to perform a full range of light work, as defined in 20 CFR. Section 404.1567, of an unskilled nature as defined in 20 CFR Section 404.1568." [R. 15]. Social Security regulations define light work as:

involv[ing] lifting no more than 20 pounds at a time with frequent lifting or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be very little, a job is in this category when it requires a good deal of walking or standing, or when it involves sitting most of the time with some pushing and pulling of arm or leg controls. To be considered capable of performing a full or wide range of light work, you must have the ability to do substantially all of these activities.

*Id.* Since the ALJ found that Plaintiff "has the residual functional capacity to perform a full range of light work," the record must contain substantial evidence to support that finding.

The medical records in this case consist of: a consultative examination performed by Dr. Glenn W. Cosby on May 15, 1994, [R. 98-104]; a Medical Assessment of Ability to Do Work-Related Activities (Physical) form completed November 15, 1994 by Dr. Clark I. Osborn, [R. 112-13]; Dr. Osborn's examination notes dated June 14, 1994, [R. 114-15]; and a report of x-ray spinal studies performed June 14, 1994 [R. 116].

The examinations by Drs. Cosby and Osborn yielded similar range of motion findings. Dr. Cosby noted that Plaintiff's low back is "very painful on movement to 45 degrees," that he had "rather marked muscle spasm in both the cervical and lumbar areas", and that straight leg raising was positive bilaterally at about 40

degrees. [R. 100]. Dr. Osborn noted **positive** straight leg raise at 45 degrees on the right and 60 degrees on the left, **as well as** decreased strength and gait limited by slight forward flexion of the lumbar **spine**. [R. 114].

The Medical Assessment of **Ability** to Do Work-Related Activities (Physical) form, completed by Dr. Osborn, **states that** Plaintiff has the ability to: occasionally lift and carry 5-10 pounds; stand **and/or** walk 5-15 minutes at a time for a total of 1 hour of an 8 hour day; sit up to **one hour** without interruption for a total of 2 hours in an 8 hour day. Dr. Osborn **identified** the positive straight leg raise, marked limitation of motion secondary to **pain and** pain with walking as medical findings that support these limitations. He also **noted** limitations in Plaintiff ability to reach, handle and push/pull, stating "any positions **where** Nathan is unsupported could exacerbate his back condition." [R. 113].

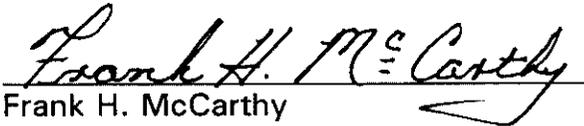
The ALJ found that the **objective** medical evidence does not support the limitations imposed by Dr. Osborn. **The only** statement in the decision directly related to his finding is the statement that: "**The** x-ray studies show some degeneration, but not the degree found by Dr. Osborn." [R. 13]. The Court notes, however, that the x-ray report showed "**marked degenerative** changes." [R. 116]. It is not for the ALJ to determine what degree of limitation **is supported** by *marked* degenerative changes, and it was error for the ALJ to **have done so**. See *Miller v. Chater*, 99 F.3d 972, 977 (10th Cir. 1996) (ALJ may not **substitute** his own opinion for that of claimant's doctor).

The ALJ stated that he based his finding that Plaintiff can perform the full range of light work on: Plaintiff's lack of medical treatment; paucity of findings; and demeanor. [R. 13]. The Tenth Circuit has been quite clear in ruling that "[t]he absence of evidence is not evidence." *Thompson v. Sullivan*, 987 F.2d 1482, 1491 (10th Cir. 1993). The Secretary's burden of proof is not met by saying that information is absent. *Huston v. Bowen* 838 F.2d 1125, 1132 (10th Cir. 1988). The finding that Plaintiff can perform the lifting, walking, pushing and pulling required of light work is not supported by substantial evidence.

The Court finds that the Secretary was not entitled to rely upon the Grids to establish the existence of jobs in the national economy which Plaintiff can perform because the record does not support the ALJ's finding that Plaintiff has the capacity to perform the full range of light work.

The decision of the Secretary is REVERSED and the case REMANDED for further proceedings consistent with this Order.

SO ORDERED this 30<sup>th</sup> day of December, 1996.

  
Frank H. McCarthy  
UNITED STATES MAGISTRATE JUDGE

IN THE UNITED STATES DISTRICT COURT FOR THE  
NORTHERN DISTRICT OF OKLAHOMA

**FILED**

DEC 30 1996

Phil Lombardi, Clerk  
U.S. DISTRICT COURT  
NORTHERN DISTRICT OF OKLAHOMA

JOHNNIE RENEE McDANIEL, )

Plaintiff, )

v. )

Case No. 95-C-1096-W

SHIRLEY S. CHATER, )

COMMISSIONER OF SOCIAL )

SECURITY,<sup>1</sup> )

Defendant. )

ENTERED ON DOCKET

DATE 12/31/96

**ORDER**

Plaintiff brought this action pursuant to 42 U.S.C. § 405(g) for judicial review of the final decision of the Secretary of Health and Human Services ("Secretary") denying plaintiff's application for disability insurance benefits under §§ 216(i) and 223 and supplemental security income under §§ 1602 and 1614(a)(3)(A) of the Social Security Act, as amended.

The procedural background of this matter was summarized adequately by the parties in their briefs and in the decision of the United States Administrative Law Judge Glen E. Michael (the "ALJ"), which summaries are incorporated herein by reference.

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<sup>1</sup>Effective March 31, 1995, the functions of the Secretary of Health and Human Services in social security cases were transferred to the Commissioner of Social Security. P.L. No. 103-296. Pursuant to Fed.R.Civ.P. 25(d)(1), Shirley S. Chater, Commissioner of Social Security, is substituted for Donna E. Shalala, Secretary of Health and Human Services, as the Defendant in this action. Although the court has substituted the Commissioner for the Secretary in the caption, the text of this Order will continue to refer to the Secretary because she was the appropriate party at the time of the underlying decision.

The only issue now before the court is whether there is substantial evidence in the record to support the final decision of the Secretary that claimant is not disabled within the meaning of the Social Security Act.<sup>2</sup>

In the case at bar, the ALJ made his decision at the fifth step of the sequential evaluation process.<sup>3</sup> He found that claimant suffers from obesity, but that she does not have an impairment or combination of impairments listed in, or medically equal to, an impairment listed in Appendix 1, Subpart P, Regulation No. 4. He concluded that the claimant has the residual functional capacity (RFC) to perform the physical exertional requirements of sedentary work. The ALJ further concluded that the

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<sup>2</sup>Judicial review of the Secretary's determination is limited in scope by 42 U.S.C. § 405(g). The court's sole function is to determine whether the record as a whole contains substantial evidence to support the Secretary's decisions. The Secretary's findings stand if they are supported by "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." Richardson v. Perales, 402 U.S. 389, 401 (1971) (citing Consolidated Edison Co. v. N.L.R.B., 305 U.S. 197, 229 (1938)). In deciding whether the Secretary's findings are supported by substantial evidence, the court must consider the record as a whole. Hephner v. Mathews, 574 F.2d 359 (6th Cir. 1978).

<sup>3</sup>The Social Security Regulations require that a five-step sequential evaluation be made in considering a claim for benefits under the Social Security Act:

1. Is the claimant currently working?
2. If claimant is not working, does the claimant have a severe impairment?
3. If the claimant has a severe impairment, does it meet or equal an impairment listed in Appendix 1 of the Social Security Regulations? If so, disability is automatically found.
4. Does the impairment prevent the claimant from doing past relevant work?
5. Does claimant's impairment prevent him from doing any other relevant work available in the national economy?

20 C.F.R. § 404.1520 (1983). See generally, Talbot v. Heckler, 814 F.2d 1456 (10th Cir. 1987); Tillery v. Schweiker, 713 F.2d 601 (10th Cir. 1983).

claimant was a 38 year old woman, which is defined as a younger individual, has a high school degree, and because of claimant's age and RFC, the issue of transferability of work skills is not material. The ALJ found that claimant suffered from no non-exertional impairments that could effect her job base. (TR 20). The ALJ finally concluded that claimant could not return to her past relevant work as a nurse's aid, but that she could perform a full range of sedentary jobs with more than 200 different occupations in the regional and national economies. Having determined that claimant can perform a full range of sedentary jobs, the ALJ concluded that she was not disabled under the Social Security Act at any time through the date of the decision.

Claimant now appeals this ruling and asserts alleged errors by the ALJ:

- (1) The ALJ erred by not finding that claimant had a condition that met or was equivalent to a listing specified in 20 C.F.R. Ch. III. Pt. 404, Subpt. P., App. 1, § 9.09 ("Listing 9.09").
- (2) The ALJ's conclusions to be recorded on the Psychiatric Review Technique ("PRT") Form were not closely and affirmatively linked to substantial evidence.
- (3) Because the claimant demonstrated both exertional and non-exertional impairments, the ALJ erred in failing to solicit testimony from a vocational expert concerning the erosion of her job base.

It is well settled that the claimant bears the burden of proving disability that prevents any gainful work activity. Channel v. Heckler, 747 F.2d 577, 579 (10th Cir. 1984).

Claimant contended that she has been unable to work since January 6, 1992, because of obesity and a mental disorder. (TR 54, 57). Claimant is 5 feet 6 ½

inches tall and weighed between 280 and 331 pounds from April 1991 to August 1993. (TR 216). Claimant has not engaged in substantial gainful employment since January 6, 1992. (TR 20). Records from Morton Health Service show that she weighed 296 on June 12, 1992 and was diagnosed as being "excessively obese" and experiencing mild hypertension (TR 216, 220).

Claimant has seen several different doctors for diagnosis and treatment. The notes of Dr. Ronald English dated September 21, 1992 to October 2, 1993 are largely illegible, as the ALJ noted, but included complaints of anxiety and depression and diagnoses of obesity, hypertension, and diabetes, with no objective findings except blood pressure readings to support them (TR 16, 197-214).

Claimant was examined by Dr. Vanessa Werlla on April 12, 1993 and complained about obesity, diabetes mellitus, hypertension, and anxiety. (TR 183-185). She claimed that she could not work because of back and right foot pain, because her diabetes gets affected, and because she gets anxiety reactions when she is working. (TR 184). Dr. Werlla stated:

[Claimant] makes good eye contact. . . . She knows the current president as Bill Clinton and the previous president as Bush and Reagan. She performs serial 7s accurately to 65, when she is asked to stop. She is calm in motor activity although subjectively she reports she is very anxious. Her affect is bright and she smiles frequently during the examination. . . . She has good memory for immediate and recent events, as she can recall three out of three objects at one minute and five minutes. (TR 184-185).

Dr. Werlla concluded that:

At best, this patient might be considered as having an anxiety disorder NOS (not otherwise specified) and I do not feel that this is a incapacitating condition. This is treatable with appropriate medication and probably should seek care under a psychiatrist for anxiety. If she is awarded disability benefits, she should be mentally capable of managing monies in her own best interests. (TR 185) (emphasis added).

Claimant was also examined by Dr. Merle Jennings on April 13, 1993. Dr.

Jennings observed:

During this examination, the patient showed no evidence of anxiety. The gait and stance are normal. Patient ambulates normally without assistance or assistive devices. The cervical and lumbar curves are normal and there is no evidence of scoliosis. The upper extremities have full physiological range of motion. The right hand is dominant. There is no sensory loss of either upper extremity, and all digits have full physiological range of motion including the wrists, in flexion, extension and lateral flexion. The DTRs are plus one.

The lower extremities have full physiological range of motion. There is no sensory loss nor is there any loss of strength. There is no evidence of peripheral edema of either lower extremity, nor is there evidence of varicosities. DTRs are plus one. The knees and hips have full physiological range of motion without pain, and the ankles have full physiological range of motion. Palpation of the abdomen reveals no organomegaly. There is evidence of scarring in the pubic area where cesarean sections were performed. There is also an old appendectomy scar. On examination of the back, in the superior portion of the left scapula, there is evidence of old shingles scars. The head and neck have full physiological range of motion without pain. (emphasis added).

Dr. Jennings concluded that while claimant was obese, she had a full physiological range of motion in all major joints. No major physical problems were even mentioned.

On April 16, 1993, the Social Security Administration requested that the State of Oklahoma Disability Determination Unit examine claimant's records and offer an

opinion on her mental status. (TR 193). Renee Brown, MSW, examined claimant on April 26, 1993, and noted that she was oriented as to person, place, and time. (TR 193). Claimant appeared to be alert but had a hard time comprehending information, demonstrated poor eye contact, and used bad judgment when stressed. (TR 193). The report noted that claimant was going to counseling once a week and stated that claimant's prognosis for recovery was fair to good. (TR 193).

Claimant was examined by the Disability Determination Unit on December 2, 1993. (TR 280-282). Dr. Thomas A. Goodman, M.D., concluded:

The claimant is a markedly overweight, medium height black woman who was very pleasant and cooperative during the interview. She was in no acute distress at the time I saw her. Her psychomotor activity, mood, and affect were all normal. Her speech was logical and appropriate. She gave no indications of hallucinations, delusions, or suicidal thinking.

Her sensorium was clear. She was oriented to time, place, and person. She could immediately repeat three separate objects and could remember two of them after two minutes. She was able to spell world backward correctly, and name the last two Presidents. She could not do even simple arithmetic problems and said she had to count using her fingers. When asked similarities, she said a bird and a plan had wings. When asked what she would do if she found a sealed, stamped, addressed envelope in the street, she said put it in the "mail box."

The claimant presents a history of what would seem to be an atypical anxiety disorder which was correctly diagnosed by Dr. Werlla in April 1993. However, in addition, because of mistreatment, she has become addicted to Xanax. The most crucial element she faces at this point is to withdraw from Xanax and to be placed on the proper anxiolytic medication or antidepressant for control of her anxiety disorder. This may need hospitalization in order to affect a detoxification and withdrawal from Xanax. Otherwise, with proper treatment, I see no reason why this woman cannot return to the same level of work that she was doing previously.

The claimant has retained her **basic** intellectual abilities. If she were to be withdrawn from Xanax and be properly treated for her anxiety disorder, I see no reason why she cannot return to gainful employment. At this time she appears capable of managing her own funds. (TR 281-282) (emphasis added).

Three weeks after being examined by Dr. Goodman, claimant checked herself into Hillcrest Medical Center complaining of insomnia, fear, panic attacks, mood swings and undoubtedly her addiction to Xanax. (TR 285-290). At the time of her admission into the hospital, claimant's GAF functioning was 35-45. (TR 287). Claimant remained in the hospital from December 23, 1993 until January 2, 1994. (TR 285). Claimant gradually improved and had an "uneventful recovery." (TR 286). She was even given passes to leave the hospital on December 29, 1993 and December 30, 1993 which were successful. (TR 286). When discharged, claimant's insomnia, rapid thinking, and mood swings had been improved, and she was no longer on Xanax. (TR 286). Finally, claimant's GAF functioning had risen from 35-45 upon admission to a score of 65-75 at the time of discharge, a rise of 30 points in less than two weeks. (TR 287).

Claimant was seen at the Family Mental Health Center, Inc. several times from March 8, 1994 through June 7, 1994. (TR 293-304). At her March 8, 1994 exam she was diagnosed with anxiety, depressive, and bipolar disorders. (TR 296). On March 16, 1994, she reported that her depression and anxiety were under fair control, she had not suffered a panic attack recently, and her slight depression was caused by situational stressors. (TR 304). The doctor encouraged her to participate in a relaxation group and eliminated one of her medications (TR 303). She was seen

several more times and by May 20 she reported no problems and requested medication refills. (TR 300).

There is no merit to claimant's first alleged error that the claimant's condition met or was equivalent to Listing 9.09. That Listing requires that the claimant exceed certain weight requirements for that person's height. The record indicates that the claimant is 66 ½ inches tall and has weighed over 282 pounds since she stopped working. (TR 17, 72, 243). While her height and weight satisfy § 9.09, in order to satisfy the Listing, claimant must also meet one of five different conditions. Claimant must prove the presence of:

- A. History of pain and limitation of motion in any weight-bearing joint or the lumbosacral spine (on physical examination) associated with findings on medically acceptable imaging techniques of arthritis in the affected joint or lumbosacral spine; or
- B. Hypertension with diastolic blood pressure persistently in excess of 100 mm. Hg. measured with appropriate size cuff; or
- C. History of congestive heart failure manifested by past evidence of vascular congestion such as hepatomegaly, peripheral or pulmonary edema; or
- D. Chronic venous insufficiency with superficial varicosities in a lower extremity with pain on weight bearing and persistent edema; or
- E. Respiratory disease with total forced vital capacity equal to about 2.0 L. or a level of hypoxemia at rest equal to or less than the values specified in Table III-A or III-B or III-C.

Claimant offered no verified medical evidence to support any of these conditions. No physician found that she had arthritis, blood pressure persistently in excess of 100 mm. Hg., evidence of vascular congestion, venous insufficiency, or

respiratory disease. The ALJ's conclusion that claimant does not have a medically determinable condition that meets or is equivalent to § 9.09 is supported by substantial evidence.

The claimant next alleges that the ALJ erred because the conclusions that he recorded on the Psychiatric Review Technique (PRT) form were not closely and affirmatively linked to substantial evidence. This claim is without merit. The ALJ completed the PRT form without the aid of a medical advisor, which is within the province of the ALJ. 20 C.F.R. § 416.921(d)(1)(i). The record must contain substantial competent evidence to support the conclusions recorded on the PRT form. Cruse v. U.S. Dept. of Health and Human Services, 49 F.3d 614, 617 (10th Cir. 1995).

The PRT form was completed on December 27, 1994 (TR 22-25). The ALJ found that there was evidence to establish the presence of an affective disorder and an anxiety based disorder. He concluded that the affective disorder was not depressive syndrome, manic syndrome, or bipolar syndrome. He also concluded that the anxiety related disorder was not a generalized persistent anxiety, a persistent irrational fear of a specific object, activity, or situation, recurrent severe panic attacks manifested by a sudden unpredictable onset of intense apprehension, fear, terror or sense of impending doom, a recurrent obsession or compulsion, or recurrent and intrusive recollections of a traumatic experience. However, he did conclude that the claimant suffers from some anxiety and depression. (TR 22-25).

The ALJ next rated the impairment severity of the claimant. He concluded that claimant's restrictions of activities of daily living and difficulties in maintaining social functioning are slight. He found that claimant seldom has deficiencies in concentration, persistence, or pace resulting in failure to complete tasks in a timely manner. He concluded that claimant had never experienced episodes of deterioration or decomposition in work or work-like settings which caused her to withdraw from that situation or to experience exacerbation of signs and symptoms. Finally, he concluded that claimant was absent of any symptoms resulting in complete inability to function independently outside the area of one's home. The record indicates that these conclusions are supported by substantial evidence.

There is no merit to claimant's argument that the ALJ's conclusions on the PRT form were not supported by substantial evidence. The record indicates that the ALJ considered all of the evidence and that his conclusions were supported by claimant's testimony and the medical reports.

The claimant reported some limitation of her activities of daily living. She testified that she can cook, dress herself and her child, and play with her youngest child in the play area near their apartment. (TR 44-45, 132). Claimant also indicated that she washes dishes, cleans the house, and does laundry "when she feels like it," reads, and shops about once a month. (TR 134). The ALJ's conclusion that claimant has a slight limitation with activities of daily living is supported by substantial evidence.

There is also evidence to support the claimant has a slight degree of limitation in maintaining social functioning. According to Dr. Stephen J. Miller, claimant "can't tolerate active involvement with public but can relate adequately to co-workers [and] supervisors for superficial work relationships." (TR 94). Claimant admitted that she attends Beautiful Gate Church and is motivated to go back to school. (TR 295).

There is evidence to support the conclusion of the ALJ that claimant seldom experiences deficiencies in concentration, persistence, or pace. Both Dr. Werlla and Goodman felt that claimant could concentrate well enough to return to work. (TR 185, 281-282).<sup>4</sup> Dr. Werlla found that claimant could concentrate well enough to spell the word "world" backwards, and that she has good memory for recent events. (TR 185). Claimant could recall three out of three objects at one minute and five minutes. (TR 185). Dr. Werlla concluded that claimant's condition was not incapacitating, and was treatable with medication and counseling. (TR 185). Dr. Goodman reached the same conclusions and found that claimant's main problem was addiction to Xanax, which she no longer takes. (TR 281-282, 286). When claimant was released from Hillcrest Medical Center on January 2, 1994, her GAF functioning was rated as 65-75.<sup>5</sup> (TR 287).

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<sup>4</sup> The ALJ fully developed the record concerning claimant's psychiatric condition, both by obtaining pertinent medical records, and by having claimant independently examined. See, Carter v. Chater, 73 F.3d 1019 (10th Cir. 1996).

<sup>5</sup> The court in Irwin v. Shalala, 840 F.Supp. 751, 759 n.5 (D.Or. 1993), described the significance of a GAF score:

The Global Assessment of Functioning Scale ("GAF") ranges from 90

There is no evidence in the record that claimant has suffered any episodes of deterioration or decomposition in work or work-like settings, so the ALJ's conclusion in this regard is correct.

The claimant's final alleged error that the ALJ erred in failing to solicit testimony from a vocational expert is also without merit. Claimant argues that the ALJ overlooked her non-exertional impairments when determining her residual functional capacity. She argues that a vocational expert should have testified about her eroded job base. However, the ALJ is only required to utilize the test of a vocational expert if the claimant suffers from nonexertional impairments that limit her ability to perform the full range of work in a specific guideline category. Reed v. Sullivan, 988 F.2d 812, 816 (8th Cir. 1993).

The ALJ concluded that claimant had the residual functional capacity for unskilled sedentary work and found no non-exertional impairments requiring the testimony of a vocational expert. (TR 19-20). He noted that 20 C.F.R. 404.1566 and 416.966 authorized him to take administrative notice that a significant number of sedentary jobs existed that she could perform. (TR 19). He also noted that Appendix 2 in 404.1569 and 416.969 specify that approximately 200 separate

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(absent or minimal symptoms) to 1 (persistent danger of severely hurting self or others, or unable to care for herself). A score between 41 and 50 is defined as manifesting "serious symptoms" (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) or any serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job).

sedentary unskilled occupations in eight broad categories exist in the national economy. (TR 19).

After fully developing the record with regard to claimant's psychiatric condition, the ALJ correctly found no non-exertional impairments to further reduce claimant's sedentary work base. (TR 20). A residual physical functional capacity assessment performed on December 14, 1993 concluded that her major limitation was obesity, but there was no evidence of limitations secondary to obesity, since she walked with a normal gait, had no limitation of motion in her spine or joints, and had normal blood pressure. (TR 85-86). A mental functional capacity assessment showed that only claimant's ability to understand and remember detailed instructions, her ability to carry out detailed instructions, and her ability to interact appropriately with the general public were markedly limited. (TR 92-93). Dr. Stephen J. Miller commented on the assessment: "[Claimant] can perform simple tasks only. Can't tolerate active involvement with public but can relate adequately to co-workers [and] supervisors for superficial work relationships." (TR 94). These conclusions are consistent with the ALJ's conclusion that claimant can perform unskilled sedentary work.<sup>6</sup>

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<sup>6</sup>"Unskilled work" is defined in 20 C.F.R. 404.1568 as:

Unskilled work is work which needs little or no judgment to do simple duties that can be learned on the job in a short period of time. The job may or may not require considerable strength. For example, we consider jobs unskilled if the primary work duties are handling, feeding and offbearing (that is, placing or removing materials from

The decision of the ALJ is supported by substantial evidence and is a correct application of the regulations. The decision is affirmed.

Dated this 26<sup>th</sup> day of December, 1996.



JOHN LEO WAGNER  
UNITED STATES MAGISTRATE JUDGE

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machines which are automatic or operated by others), or machine tending, and a person can usually learn to do the job in 30 days, and little specific vocational preparation and judgment are needed. A person does not gain work skills by doing unskilled jobs.

IN THE UNITED STATES DISTRICT COURT FOR THE  
NORTHERN DISTRICT OF OKLAHOMA

JASON MURRAY, by and through  
his next friend Lavon Bohannon,

Plaintiff,

v.

SHIRLEY S. CHATER,  
COMMISSIONER OF SOCIAL  
SECURITY,<sup>1</sup>

Defendant.

Case No. 95-C-481-W

ENTERED ON DOCKET

DATE 12/31/96

**FILED**

DEC 30 1996

Phil Lombardi, Clerk  
U.S. DISTRICT COURT  
NORTHERN DISTRICT OF OKLAHOMA

**ORDER**

Plaintiff brought this action pursuant to 42 U.S.C. § 405(g) for judicial review of the final decision of the Secretary of Health and Human Services ("Secretary") denying plaintiff's application for supplemental security income under §§ 1602 and 1614(a)(3)(A) of the Social Security Act, as amended.

The procedural background of this matter was summarized adequately by the parties in their briefs and in the decision of the United States Administrative Law Judge Stephen C. Calvarese (the "ALJ"), which summaries are incorporated herein by reference.

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<sup>1</sup>Effective March 31, 1995, the functions of the Secretary of Health and Human Services in social security cases were transferred to the Commissioner of Social Security. P.L. No. 103-296. Pursuant to Fed.R.Civ.P. 25(d)(1), Shirley S. Chater, Commissioner of Social Security, is substituted for Donna E. Shalala, Secretary of Health and Human Services, as the Defendant in this action. Although the court has substituted the Commissioner for the Secretary in the caption, the text of this Order will continue to refer to the Secretary because she was the appropriate party at the time of the underlying decision.

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The only issue now before the court is whether there is substantial evidence in the record to support the final decision of the Secretary that claimant is not disabled within the meaning of the Social Security Act.<sup>2</sup>

Section 1614(a)(3)(A) of the Act provides that a child under age eighteen will be considered disabled for purposes of eligibility for Supplemental Security Income (SSI), "if he suffers from any medically determinable physical or mental impairment of comparable severity" to which would make an adult disabled. "Comparable severity", as defined in the regulations, means that a child's physical or mental impairment(s) so limits his or her ability to function independently, appropriately, and effectively in an age-appropriate manner that the impairment(s) and limitations resulting from it are comparable to those which would disable an adult.

Specifically, the impairment(s) must substantially reduce (or, if the child is under age one, be reasonably expected to substantially reduce) the child's ability to: (1) grow, develop, or mature physically, mentally, or emotionally, and thus to attain developmental milestones at an age-appropriate rate; or (2) grow, develop, or mature physically, mentally, or emotionally, and thus to engage in age-appropriate activities

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<sup>2</sup>Judicial review of the Secretary's determination is limited in scope by 42 U.S.C. § 405(g). The court's sole function is to determine whether the record as a whole contains substantial evidence to support the Secretary's decisions. The Secretary's findings stand if they are supported by "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." Richardson v. Perales, 402 U.S. 389, 401 (1971) (citing Consolidated Edison Co. v. N.L.R.B., 305 U.S. 197, 229 (1938)). In deciding whether the Secretary's findings are supported by substantial evidence, the court must consider the record as a whole. Hephner v. Mathews, 574 F.2d 359 (6th Cir. 1978).

of daily living in self-care; play, recreation, and sports; school and academics; vocational settings; peer and family relationships, or (3) acquire the skills needed to assume roles reasonably expected of adults.

The ALJ found that claimant had not engaged in substantial gainful activity since September 15, 1992, had attention deficit with hyperactivity, and did not have an impairment of comparable severity to that which would disable an adult. (TR 26) Therefore he concluded that claimant was not disabled. (TR 26)

Claimant has been diagnosed as having attention deficit and hyperdysfunction syndrome (ADHD) (TR 156). Claimant's mother testified that, since he was 3½ years old, he has set fires (TR 65, 67), never played normally with his toys (TR 63, 64, 67), is easily distracted and argumentative (TR 62-63), does not have friends (TR 63), and hurts his sister and animals (TR 63-64). Medication has lessened his destructive behavior, but not stopped it. (TR 66).

Claimant contends that the ALJ ignored the testimony of the medical expert, Dr. Leonard Kisher, that the child met the requirements of Listing 112.11, one of the impairments listed in Appendix 1 of the Social Security Regulations, and thus must automatically be found disabled. This listing pertains to "attention deficit hyperactivity disorder."<sup>3</sup> It is true that Dr. Kisher testified at a hearing on January 4,

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<sup>3</sup>Listing 112.11 reads as follows:

**112.11 Attention Deficit Hyperactivity Disorder:** Manifested by developmentally inappropriate degrees of inattention, impulsiveness, and hyperactivity.

The Required level of severity from these disorders is met when

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the requirements in both **A** and **B** are satisfied.

- A. Medically documented findings of all three of the following:**
- 1. Marked inattention; and**
  - 2. Marked impulsiveness; and**
  - 3. Marked hyperactivity;**

**[Dr. Kisher found that these "A" criteria were met.]**

**AND**

**B. ...for children (age 3 to attainment of age 18), resulting in at least two of the appropriate age-group criteria in paragraph B2 of 112.02.**

Listing 112.02, Paragraph B2, reads:

**2. For children (age 3 to attainment of age 18), resulting in at least two of the following:**

**a. Marked impairment in age-appropriate cognitive/communicative function, documented by medical findings (including consideration of historical and other information from parents or other individuals who have knowledge of the child, when such information is needed and available) and including, if necessary, the results of appropriate standardized psychological tests, or for children under age 6, by appropriate tests of language and communication; or [Dr. Kisher found only a "less than moderate" impairment of cognitive development, and found no functional impairment in communicative development.]**

**b. Marked impairment in age-appropriate social functioning, documented by history and medical findings (including consideration of information from parents or other individuals who have knowledge of the child, when such information is needed and available) and including, if necessary, the results of appropriate standardized tests; or [Dr. Kisher found only "moderate" functional impairment of social development]**

**c. Marked impairment in personal/behavioral function, as evidenced by:**

**(1) Marked restriction of age-appropriate activities of daily living, documented by history and medical findings (including consideration of information from parents or other individuals who have knowledge of the child, when such information is needed and available) and including, if necessary, appropriate standardized tests; or**

**(2) Persistent serious maladaptive behaviors destructive to self, others, animals, or property, requiring protective intervention; or**

1994 that the child suffered from marked inattention, marked impulsiveness, and marked hyperactivity, thus satisfying the "A" criteria of listing 112.11. However, the doctor completed an individualized functional assessment for claimant before the hearing and revised two of his answers during the hearing (TR 42-49), and the assessment clearly reflects that the claimant did not meet the "B" criteria of the listing. Although he suffered moderate impairment in a few areas, Dr. Kisher was emphatic, when pressed on cross-examination by claimant's counsel, that the child's "B" criteria functional impairments were no more than moderate--not "marked" or "extreme." (TR 60-61)<sup>4</sup> The assessment reflected that the doctor found that the

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[Dr. Kisher found only "moderate" functional impairment in personal/behavior development, evidenced by maladaptive destructive behaviors.]

d. Deficiencies of concentration, persistence, or pace resulting in frequent failure to complete tasks in a timely manner.

[Dr. Kisher found only "less than moderate" functional impairment of concentration, persistence, or pace.] (emphasis and bracketed commentary added)

<sup>4</sup> Dr. Kisher testified:

Q Okay. What I'm trying to reconcile, Doctor, is the apparently very mild evaluation that you've done here with this child's behavior, as reported both by his teachers and by his parents. This evaluation that you've completed would seem to indicate that this child is not markedly impaired.

A Oh, I think he's moderately impaired. I don't argue with that.

Q Well, Doctor, is he more than moderately impaired? Because this is sort of an indication that he is not anything more than moderately impaired; that he's functional.

A If you talk about mild, moderate and severe, he is moderate. In other words, he still is functioning. He is not severe. I mean, if he was severe, he would be out of school and be on homebound or something like that. So he's not severe and therefore, I feel like he's moderate.

child had less than moderate limitation in cognitive development/function, no evidence of limitation in communicative development/function, no evidence of limitation in motor development/function, moderate limitation in social development/function, moderate limitation in personal/behavioral development/function, and less than moderate limitation in concentration, persistence, and pace. (TR 216-218).

The ALJ reviewed Dr. Kisher's assessment before he concluded that the child was "functional, that is, he is attending school and is no more impaired than moderately." There is substantial evidence in the record to support this conclusion. On September 15, 1992, the child had a consultative evaluation by Dr. Cullen Mancuso (TR 166-167). Dr. Mancuso found he was alert, "a little bit overactive, but not fully hyperactive while in [the] office," and did not seem to have "any difficulty with organizing his thoughts or expressing himself." (TR 166). The doctor found the child had an average range of general mental ability and had been diagnosed as having attention deficit disorder and dyslexia. (TR 167).

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Q Okay. So, if I understand your opinion correctly, Doctor, the only way that you would check a marked or extreme box would be is if he were nonfunctional?

A Right.

Q Okay.

A Severe means that he is not functioning at all in school and that he cannot function in a classroom.

Q Okay. Doctor, the choices are no evidence of limitation, less than moderate, moderate, marked and extreme, and you chose a moderate as the highest rank.

A Okay.

Q So you don't think that his behavior is marked or extreme in any of these areas?

A I think I'm satisfied with moderate.

On September 17, 1992, the child was referred to Children's Medical Center in Tulsa, Oklahoma for evaluation because of problems with overactivity. (TR 157-159, 199-201). He was found to be functioning in the average to below average range, but "his potential may be higher." (TR 200). He was diagnosed with attention deficit with hyperactivity disorder, and his parents participated in a parent education program to learn about the disorder and strategies to manage the child (TR 201).

On October 6, 1992, a multidisciplinary evaluation team concluded that the child needed stability and structure in a controlled environment, because he had "average ability with average to high average achievement in testing", but does not "stay on task in the classroom." (TR 123). The team concluded that there was not evidence of a severe discrepancy between ability and achievement which was not correctable without special education and/or related services. (TR 124). He was diagnosed as "ADHD", and had not yet been placed on medication (TR 124). He was placed in a special education program. (TR 125).

On March 30, 1993 his teacher reported that he "appears to enjoy learning, grasps concepts quickly, completes assignments on an average within an acceptable amount of time. Assignments are on grade level or above." (TR 152). She also stated that he "is very cooperative and attentive in group and individual activities. Academic functioning is above majority of the students. Behavior is generally appropriate for school and in line with age appropriate expectations." (TR 152). Finally, she reported that he "[g]ets along well with other students, has a couple of particular friends in class." (TR 152). The teacher noted that the occasional

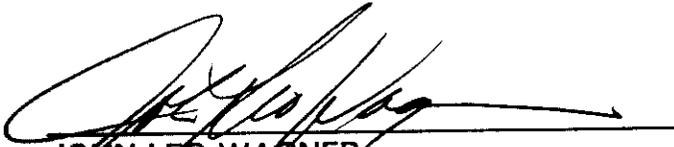
difficulties he experienced seemed to result from "issues outside the school settings, as indicated by his continual academic growth and ability to get along socially with peers and teachers." (TR 153).

During the fall of 1993, the child's teacher reported three incidents of "out of control behavior" when he failed to take his medication and stated that, with "prompting to stay on task," he completed assignments with most answers correct. (TR 198). He was mainstreamed in reading in December of 1993, but continued to need direction and reminders to stay on task because of distractibility. (TR 196). His medication report showed that he was taking 20 milligrams of Ritalin three times a day in January of 1994. (TR 215), and the medical expert stated that this was a "very high dose" of Ritalin. (TR 59).

Claimant's counsel admits that he does not "exactly meet the requirements" of listing 112.11 and that it is "hard to quantify" his functioning in the school environment. (Plaintiff's Brief, Docket #8, p.3). However, the child's teachers have reported that he completes his work and gets correct answers in spite of being easily distracted and occasionally missing the school bus (TR 194), being slow to travel between school buildings (TR 196), and failing twice to make it to the bathroom on time. (TR 197). As long as he takes his medication, he does not exhibit behavior problems. While the medication dosage is high, he is under a doctor's supervision and his teachers monitor him closely. His limitations are moderate, not severe.

There is substantial evidence to support the decision of the ALJ that claimant does not have an impairment of comparable severity to that which would disable an adult and is therefore not disabled. Affirmed.

Dated this 27<sup>th</sup> day of December, 1996.

  
JOHN LEO WAGNER  
UNITED STATES MAGISTRATE JUDGE

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IN THE UNITED STATES DISTRICT COURT FOR THE  
NORTHERN DISTRICT OF OKLAHOMA **F I L E D**

DEC 27 1996

RONNIE E. REED,  
SSN: 442-60-2611,

Plaintiff,

v.

SHIRLEY S. CHATER,  
Commissioner of the Social Security  
Administration,

Defendant.

Phil Lombardi, Clerk  
U.S. DISTRICT COURT

CASE NO. 95-C-104-M /

ENTERED ON DOCKET

DATE 12/27/96

**JUDGMENT**

Judgment is hereby entered for Plaintiff and against Defendant. Dated this 27<sup>th</sup>  
day of Dec, 1996.

*Frank H. McCarthy*

FRANK H. McCARTHY  
UNITED STATES MAGISTRATE JUDGE

20

IN THE UNITED STATES DISTRICT COURT FOR THE  
NORTHERN DISTRICT OF OKLAHOMA

**FILED**

RONNIE E. REED, )  
SS# 442-60-2611, )

Plaintiff, )

v. )

SHIRLEY S. CHATER,<sup>1</sup> Commissioner )  
Social Security Administration, )

Defendant. )

NO. 95-C-104-M ✓

ENTERED ON DOCKET

DATE 12/27/96

DEC 26 1996  
Phil Lombardi, Clerk  
U.S. DISTRICT COURT  
NORTHERN DISTRICT OF OKLAHOMA

**ORDER**

Plaintiff, Ronnie E. Reed, seeks judicial review of a decision of the Secretary of Health & Human Services denying Social Security disability benefits. In accordance with 28 U.S.C. §636(c)(1) & (3) the parties have consented to proceed before a United States Magistrate Judge. Any appeal of this Order will be directly to the Circuit Court of Appeals.

The role of the court in reviewing the decision of the Secretary under 42 U. S. C. §405(g) is limited to determining whether the decision is supported by substantial evidence and whether the decision contains a sufficient basis to determine that the Secretary has applied the correct legal standards. *Winfrey v. Chater*, 92 F.3d 1017 (10th Cir. 1996); *Castellano v. Secretary of Health & Human Servs.*, 26 F.3d 1027, 1028 (10th Cir. 1994). Substantial evidence is "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Richardson v. Perales*, 402 U.S. 389, 401 (1971) (quoting *Consolidated Edison Co. v. NLRB*, 305 U.S. 197,

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<sup>1</sup> Effective March 31, 1995, the functions of the Secretary of Health and Human Services in social security cases were transferred to the Commissioner of Social Security. P.L. No. 103-297. However, this order continues to refer to the Secretary because she was the appropriate party at the time of the underlying decision.

229 (1938)). The Court may neither reweigh the evidence nor substitute its discretion for that of the Secretary. *Casias v. Secretary of Health & Human Servs.*, 933 F.2d 799, 800 (10th Cir. 1991).

The record of the proceedings before the Secretary has been meticulously reviewed by the Court. The undersigned United States Magistrate Judge finds that the Administrative Law Judge (ALJ) has adequately and correctly set forth the relevant facts of this case and has properly outlined the required sequential analysis. The Court therefore incorporates that information into this order as duplication of the effort would serve no useful purpose.

Mr. Reed filed an application for disability benefits on January 7, 1993 claiming disability beginning on November 1, 1991. He claimed he could not work due to back, hip and right shoulder pain caused by severe scoliosis, degenerative arthritis, right shoulder bursitis and sacroilitis. [R. 68]. His application was denied by the Social Security Administration on February 19, 1993. [R. 40]. The denial was affirmed on reconsideration. [R. 55]. A hearing before an ALJ was held March 11, 1994. The ALJ rendered a denial decision on May 24, 1994 and entered the findings which are the subject of this appeal. [R. 20-29]. In the denial decision, the ALJ determined that Plaintiff is not able to return to his past relevant work as a welder, but that he has no nonexertional limitations and retains the residual functional capacity to perform the full range of light work as identified in 20 C.F.R. 404.1567. [R. 28]. Accordingly, the ALJ found Plaintiff was not "disabled" within the meaning of the Social Security Act. The Appeals Council affirmed the findings of the ALJ on October 27, 1994. [R. 4-6]. The decision of the Appeals Council represents the Secretary's final decision for purposes of further appeal. 20 C.F.R. §§ 404.981, 416.1481.

Plaintiff alleges that substantial **evidence** in the record does not support the determination of non-disability and that the ALJ failed to perform the correct legal analysis. Specifically, Plaintiff asserts the ALJ failed to perform an **evaluation** of Plaintiff's credibility and subjective complaints of disabling pain as required by **regulation** and case law. [Plf's Brief, p. 5]. The Court agrees.

The record contains medical notes from as early as November 4, 1969 by Monroe R. Jennings, M.D. of Claremore, Oklahoma. [R. 146]. "Scoliosis"<sup>2</sup> first appears in the record in Dr. Jennings's notes of April 18, 1975. [R. 145]. Dr. Jennings wrote that Plaintiff complained of low back pain. Physical examination **revealed** Scoliosis with convexity to the right. Dr. Jennings referred Plaintiff to Jerry Sisler, M.D. [R. 145].

Dr. Sisler, an orthopedic surgeon, **examined** Plaintiff on October 17, 1977 and noted that Scoliosis had been discovered two years **previously** by Dr. Jennings. [R. 86]. X-rays of the spine revealed a right thoraco-lumbar curvature **measuring** 38 degrees from T-7 through L-1.<sup>3</sup> Dr. Sisler suggested that Plaintiff initiate a "Paul Williams exercise program" or to obtain back support if the exercise program is **unsuccessful**. [R. 86].

Plaintiff continued under **general care** with Dr. Jennings from 1977 through April, 1985. [R. 143-145]. Included in the records **from that time period** are two notes, one in 1979 and

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<sup>2</sup> Defined in *Dorland's Illustrated Medical Dictionary*, Philadelphia: W.B. Saunders Co., 28th Edition (1994) p. 1497 as: "an appreciable **lateral deviation** in the normally straight vertical line of the spine."

<sup>3</sup> "T" standing for thoracic spine (**defined in Dorlands, id.**, at p. 1819): the vertebrae, usually twelve in number, situated between the **cervical** and the lumbar vertebrae, giving attachment to the ribs and forming part of the posterior wall of the thorax; and "L" standing for lumbar spine: the five vertebrae between the thoracic vertebrae **and the sacrum**.

another in 1981, of "rather marked Scoliosis" and increased Scoliosis with back pain and chest wall pain and advice to check again with Dr. Sisler. [R. 144].

The next record regarding Scoliosis is a diagnosis by H.T. Wittenberg, D.O., at the Blue Star Clinic in Claremore, Oklahoma, on November 1, 1991. [R. 128]. Plaintiff was treated there until March 20, 1992 and was prescribed Tylenol #3 and Parafon for pain associated with Scoliosis. [R. 127].

Thomas A. Chandy, M.D., F.A.C.S., examined Plaintiff on February 17, 1992. [R. 87-88]. Dr. Chandy's X-rays revealed "significant Scoliosis of 50 degrees between T/7 and L/1 with a convexity to the right between L/1 to L/4 15 degrees convexity to the left, the curve is an 'S' shape curve. The X-ray shows also moderate degenerative arthritis of the entire spine with narrowing of the disk space in the lower lumbar spine." [R. 87]. Dr. Chandy also recommended "Williams exercises" and noted that there may be some compromise in Plaintiff's lung function because of the curve pressing on the lung. [R. 87]. Dr. Chandy's assessment was that Plaintiff is totally disabled from doing heavy physical work but noted that, with training, Plaintiff "may be able to do an office type of work on a limited basis, he may not be able to sit for eight hours at a time but he can sit most of the day." [R. 88].

Between March 20, 1992 and July 31, 1992, Plaintiff was incarcerated. [R. 162, 163]. The record contains medical treatment notes on Oklahoma Department of Corrections (DOC) forms for the time period April 30, 1992 through October 7, 1992. [R. 101-116]. On the DOC physical examination report, dated May 7, 1992, a "bad scolio [sic] back is noted and work limitations and activities restricted to "almost sedentary type work or activities." [R. 115]. Medication for pain and muscle relaxants were provided by the DOC during Plaintiff's period of

incarceration. [R. 109-113]. On May 18, 1992, a Kate Barnard Community Corrections Center Medical Services memorandum was hand-written and signed by B.J. Kay, R.N., stating: "No prolonged stooping, bending, twisting, walking or heavy lifting. May use cane when necessary." [R. 142]. Plaintiff testified at the hearing that, while incarcerated, he was assigned to do custodian type work but that he was able to take half-hour breaks to lie down for relief of pain. [R. 163]. The remainder of the DOC and Claremore Regional Medical Center records relate only to the Colostomy and Reversed Colostomy and associated care Plaintiff underwent from August 25, 1992 to November 30, 1992. [R. 100-106 and 117-124]. Although Plaintiff cited "stomach problems" in his application as one of his disabling conditions, he has fully recovered from this condition and apparently has abandoned that portion of his claim as no mention of the condition is referenced further in the record and no error is cited in his brief. [R. 69, 81, Plf's Brief]. Therefore, these records are not relevant to the issues raised in this appeal.

While Plaintiff was incarcerated he was seen by Wesley M. Ingram, D.O. with whom he continued treatment after his release from prison. [R. 129]. Dr. Ingram's December 9, 1992 hand-written notes recorded subjective complaints of back pain and objective evidence of "severe Scoliosis." [R. 133]. He prescribed medication for pain. [R. 129]. Plaintiff continued treatment with Dr. Ingram and was still under his care on March 29, 1994, when the RFC, at issue in this case, was written. [R. 153].

The framework for the proper analysis of the evidence of allegedly disabling pain was set out in *Luna v. Bowen*, 834 F.2d 161 (10th Cir.1987). The Court "must consider (1) whether Claimant established a pain-producing impairment by objective medical evidence; (2) if so, whether there is a "loose nexus" between the proven impairment and the Claimant's subjective

allegations of pain; and (3) if so, **whether** considering all the evidence, both objective and subjective, Claimant's pain is in fact **disabling**." *Glass v. Shalala*, 43 F.3d 1392, 1395 (10th Cir.1994) (quoting *Musgrave v. Sullivan*, 966 F.2d 1371, 1375-76 (10th Cir.1992) (citing *Luna*, 834 F.2d at 163-64)); *see also Thompson v. Sullivan*, 987 F.2d 1482, 1488 (10th Cir.1993).

The ALJ did address claimant's **complaints** of disabling pain. However, he did so in conclusory fashion. After noting the **general regulations** and law governing assessments of pain, the ALJ stated:

After careful evaluation of **claimant's** signs and symptoms; the nature, duration, frequency, **and** intensity of the pain; the factors precipitating and **aggravating the** pain; the dosage, effectiveness, and side effects of the **medication** taken for relief of pain; the claimant's **functional restrictions** and the combined impact on the claimant's daily activities, **the Administrative Law Judge** finds that the claimant is not suffering **from** a totally disabling pain syndrome according to the criteria **established** in 20 CFR 404.1529 as interpreted by **Social Security Ruling #88-13**.

[R. 26-27]. "[I]t is well settled that **administrative agencies** must give reasons for their decisions." *Reyes v. Bowen*, 845 F.2d 242, 244 (10th Cir.1988). Here, the ALJ gave his conclusion but not the reasons for his conclusion. The ALJ **stated** that he was applying the framework set forth in *Luna*, but the Court is left to speculate **what specific** evidence led the ALJ to find claimant's pain was not disabling.

Though the ALJ did not state **whether the** objective evidence established a pain-producing impairment or whether there was a loose **nexus** between that impairment and Plaintiff's subjective complaints of pain, there appears to be **evidence that** Plaintiff's Scoliosis caused him some degree of pain. Objective medical evidence in **the record** shows that Plaintiff had Scoliosis described as "marked", [R. 144], "severe", [R. 133], "**significant**", [R. 87], and "pronounced" [R. 115] by

a number of medical care providers. X-rays confirmed the diagnoses. [R. 87, 99, 125]. Thus, at the very least, a “loose nexus” between the impairment and the allegations of pain associated with that impairment has been established. The ALJ was required to consider Plaintiff’s assertions of severe pain and to “decide whether he believe[d them].” *Thompson*, 987 F.2d at 1489 (quoting *Luna*, 834 F.2d at 163). To do this, he should have considered factors such as “the levels of medication and their effectiveness, the extensiveness of the attempts (medical or nonmedical) to obtain relief, the frequency of medical contacts, the nature of daily activities, subjective measures of credibility that are peculiarly within the judgment of the ALJ, the motivation of and relationship between the claimant and other witnesses, and the consistency or compatibility of nonmedical testimony with objective medical evidence.” *Id.*, quoting *Hargis*, 945 F.2d at 1489) (further quotation omitted). Although the ALJ listed some of these factors, he did not explain why the specific evidence relevant to each factor led him to conclude Plaintiff’s subjective complaints were not credible. Moreover, there is evidence that could be viewed as supporting Plaintiff’s contention: he has consistently sought medical treatment; he has taken medication to relieve pain; he uses a cane; his daily activities have been greatly restricted; and, the ALJ himself found Plaintiff’s testimony to be “credible to the extent that it is consistent with a residual functional capacity of sedentary and light.” [R. 28].

Credibility determinations are peculiarly the province of the finder of fact and the Court will not upset such determinations when supported by substantial evidence. *Diaz v. Secretary of Health & Human Servs.*, 898 F.2d 774, 777 (10th Cir.1990). However, “[f]indings as to credibility should be closely and affirmatively linked to substantial evidence and not just a conclusion in the guise of findings.” *Huston v. Bowen*, 838 F.2d 1125, 1133 (footnote omitted);

*see also Marbury v. Sullivan*, 957 F.2d 837, 839 (11th Cir.1992) (ALJ “must articulate specific reasons for questioning the claimant’s **credibility**” where subjective pain testimony is critical); *Williams on Behalf of Williams v. Bowen*, 859 F.2d 255, 261 (2d Cir.1988) (“failure to make credibility findings regarding ... **critical testimony** fatally undermines the Secretary’s argument that there is substantial evidence **adequate to support** his conclusion that claimant is not under a disability”). Here, the link between the **evidence** and credibility determination is missing. The ALJ’s conclusion is all that has been **provided**. See *Kepler v. Chater*, 68 F.3d 387 (10th Cir. 1995) (finding that the ALJ’s opinion **contained** only conclusory findings concerning pain and credibility, remanding the case for the **limited** purpose of requiring the express findings in accordance with *Luna*).

This case must be remanded to the Commissioner for the purpose of making express findings in accordance with *Luna* concerning Plaintiff’s claim of disabling pain.

Plaintiff further argues that the ALJ **erred** in evaluating the medical evidence of Plaintiff’s limitations, in particular missing the “**shortness of breath**” impairment; in rejecting Plaintiff’s treating physician’s residual functional **capacity** (RFC) evaluation; and, in not ordering a consultative medical examination. In view of the Court’s finding on the ALJ’s pain analysis, these arguments are briefly addressed.

Plaintiff testified that he experiences “**shortness of breath.**” [R. 172]. In his decision, the ALJ stated that Plaintiff had “no **nonexertional** impairments which would reduce the residual functional capacity” he had assessed as **sedentary** or light. [R. 26]. The ALJ did not reject Plaintiff’s testimony in this regard as **incredible**. The ALJ simply ignored it. The medical record contains some objective medical evidence of the effect of Scoliosis upon Plaintiff’s breathing as

well as references to Plaintiff's subjective **complaints** of breathing difficulties. [R. 87, 114, 125, 137, 144]. The Court notes that there is **no indication** in the record that any of Plaintiff's treating or examining physicians considered the **effect** of Scoliosis on Plaintiff's ability to breathe as restrictive of his activities or severe enough to affect Plaintiff's ability to work. However, it is impossible to tell whether the ALJ chose to **disregard** this evidence because he found that this condition did not significantly limit Plaintiff's physical ability to do basic work activities, which might have been appropriate in this case. **Therefore**, upon remand, the Commissioner is directed to examine the evidence as to Plaintiff's **complaints** of shortness of breath and make specific findings as to whether such complaints **are credible** and, if so, the functional impact upon Plaintiff's ability to perform basic work activities.

Dr. Ingram became Plaintiff's treating physician on December 9, 1992. His hand-written treatment notes, two typewritten "To Whom It May Concern" letters and an RFC form are part of the record before this Court. The first letter is dated March 30, 1993. [R. 129]. The second is dated May 19, 1993. [R. 130]. After the hearing, Dr. Ingram prepared an RFC on a form provided by the SSA which is dated March 29, 1994. [R. 151-153]. That form and the handwritten office notes of Dr. Ingram for the time period between December 15, 1993 and March 2, 1994 were submitted to the ALJ after the hearing. [R. 148].

The first "To Whom It May Concern" letter contained the opinion of Dr. Ingram which was based upon the condition of Plaintiff on March 5, 1993, the date he had last examined Plaintiff before writing the letter. It set forth the history of treatment rendered and ended in the following paragraph:

I believe the patient cannot perform heavy labor or associated jobs, but I believe that he could be re-trained for a desk type job if this did not aggravate his scoliosis too much. I would request that an orthopedic surgeon examine Ronnie Reed for further disability determination for a better voice of authority on this issue.

[R. 129].

The second letter was written six weeks later and said:

Ronnie Reed has been seen and evaluated by me in July of 1992 and has been treated for severe scoliosis of his thoracolumbar area, as well as chronic degenerative joint disease of the right shoulder, new onset degenerative joint disease of the right hip and sacroiliac joints. The patient has noticed increased pain and decreased ambulation abilities with pain in the right hip and sacroiliac area, despite continued medication.

On evaluation on May 18, 1993, the patient brought this to my attention. I evaluated him and he does have pain in the sacroiliac area and hip region. No x-rays were taken to confirm early degenerative joint disease but due to crepitation in his shoulder, his severe scoliosis and his antalgic gait, it is assumed that he has early degenerative joint disease.

This adds to his above disabilities and his inability to perform as a functioning worker.

[R. 130].

The RFC was filled out after Plaintiff's hearing date of March 11, 1994. Dr. Ingram's hand-written "medical findings" in support of the limitations were as follows:

Ronnie has severe tendonitis in his (R) shoulder which limits his reaching carrying and lifting abilities. He also has disfiguring Scoliosis from T10 to L, with apex to the right causing chronic back pain, limited standing, walking, sitting & lifting. He has increased pain in his (R) hip & knee making him unstable on his feet as the pain sometimes forces him to fall or near-fall. Ronnie has been my patient for nearly 2 years and has tried his best to function in society but is severely limited physically due to his multi-factorial problems.

[R. 152-153].

The ALJ decided that Dr. Ingram's RFC opinion is not fully supported because he limited the claimant using a medical diagnosis which is not supported in the medical evidence. [R. 25]. The ALJ concluded that Plaintiff's actual physical capacity lies between Dr. Ingram's opinion expressed in the first letter and the RFC. The medical evidence, he said, demonstrates no exacerbation of the claimant's preexisting condition of scoliosis. The only reference made by the ALJ to Dr. Ingram's second letter was that Dr. Ingram had changed his opinion of Plaintiff's ability to perform work-related activities by substantially reducing the claimant's physical capabilities. [R. 25]. The ALJ found that this reduction was not substantiated by Dr. Ingram's notes. Dr. Ingram's examinations of Plaintiff during the time period between his first "To Whom It May Concern" letter and the RFC are recorded in hand-written notes. [R. 137-140, 148]. These notes record frequent treatment and consistent findings of decreased range of motion, chronic pain, muscle spasm, crepitance in the right shoulder, antalgic gait with loss of balance and chronic degenerative disc disease. Injections of cortizone and renewal of pain medications were routinely given.

It is well established that the Secretary must give controlling weight to the opinion of a treating physician if it is well supported by clinical and laboratory diagnostic techniques and if it is not inconsistent with other substantial evidence in the record, 20 C.F.R. §§ 404.1527 (d)(1) and (2); *Kemp v. Bowen*, 816 F.2d 1469 (10th Cir. 1987). A treating physician's opinion may be rejected if it is brief, conclusory and unsupported by medical evidence. However, good cause must be given for rejecting the treating physician's views and, if the opinion of the claimant's physician is to be disregarded, specific, legitimate reasons for rejection of the opinion must be set

forth by the ALJ, *Frey v. Bowen*, 816 F.2d 508 (10th Cir. 1987); *Byron v. Heckler*, 742 F.2d 1232, (10th Cir. 1984) .

The Court notes that Dr. Ingram **did not** state outright that he considered Plaintiff unable to perform any substantial gainful activity. The Court also notes that the final responsibility for determining the ultimate issue of **disability** is reserved to the Secretary. 20 C.F.R. §§ 404.1527(e)(2), 416.927(e)(2); *Castellano v. Secretary of Health & Human Services*, 26 F.3d 1027, 1029 (10th Cir. 1994). However, **in light** of the evidence submitted by Dr. Ingram and the weight to be accorded to it, the ALJ's note that Dr. Ingram's RFC was not supported in the medical evidence is an insufficient reason to **disregard** his findings. See *Goatcher v. United States Department of Health & Human Services*, 52 F.3d 288 (10th Cir. 1995); *Byron v. Heckler*, 742 F.2d 1232 (10th Cir. 1984). The Commissioner is directed, upon remand, to reconsider the medical evidence under the appropriate **legal standards** required by the regulations and case law.

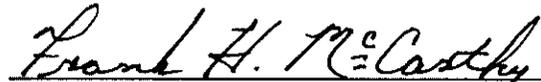
Finally, Plaintiff has asserted that **the** ALJ should have ordered a consultative medical examination in order to document his **specific** limitations if he doubted their severity. [Plf's Brief, p. 4]. While the ALJ must consider all **relevant** medical evidence of record, *Baker v. Bowen*, 886 F.2d 289 (10th Cir. 1989), he has **broad latitude** in ordering a consultative examination, *Diaz v. Secretary of Health & Human Servs.*, 898 F.2d 774 (10th Cir. 1990). A consultative examination is not required unless the record **establishes that** such an examination is necessary to enable the administrative law judge to make the **disability** decision, *Turner v. Califano*, 563 F.2d 669 (5th Cir. 1977). Because this case is being **remanded** for the purpose of making express findings in accordance with *Luna* concerning Plaintiff's claim of disabling pain, for examination of the evidence as to Plaintiff's complaints of **shortness** of breath and for review of the medical evidence

in accordance with the regulations, the **necessity** of ordering a consultative examination is left to the discretion of the ALJ after proper review and analysis of the evidence.

In remanding this case the Court **does not** dictate the result, nor does it suggest that the record is insufficient. Rather, remand is **ordered** to assure that a proper analysis is performed and the correct legal standards are invoked **in reaching** a decision based on the facts of the case. *Kepler*, 68 F.3d at 391.

THE CASE IS REMANDED to the Commissioner for a full consideration of Plaintiff's claim of disability under established legal **standards** as outlined above.

SO ORDERED this 26<sup>th</sup> day of Dec., 1996.

  
FRANK H. McCARTHY  
UNITED STATES MAGISTRATE JUDGE

IN THE UNITED STATES DISTRICT COURT FOR THE  
NORTHERN DISTRICT OF OKLAHOMA

**F I L E D**

DEC 23 1996

Phil Lombardi, Clerk  
U.S. DISTRICT COURT

RICKY D. TEETS,

Plaintiff,

v.

SHIRLEY S. CHATER,  
Commissioner of Social Security,<sup>1</sup>

Defendant.

Case No: 95-C-791-W

ENTERED ON DOCKET

DATE 12/25/96

**JUDGMENT**

Judgment is entered in favor of the defendant, Shirley S. Chater, Commissioner of Social Security, in accordance with this court's Order filed December 20, 1996.

Dated this 23<sup>rd</sup> day of December, 1996.



JOHN LEO WAGNER  
UNITE STATES MAGISTRATE JUDGE

<sup>1</sup>Effective March 31, 1995, the functions of the Secretary of Health and Human Services in social security cases were transferred to the Commissioner of Social Security. P.L. No. 103-296. Pursuant to Fed.R.Civ.P. 25(d)(1), Shirley S. Chater, Commissioner of Social Security, is substituted for Donna E. Shalala, Secretary of Health and Human Services, as the Defendant in this action. Although the Court has substituted the Commissioner for the Secretary in the caption, the text of this Order will continue to refer to the Secretary because she was the appropriate party at the time of the underlying decision.

IN THE UNITED STATES DISTRICT COURT FOR THE  
NORTHERN DISTRICT OF OKLAHOMA

**F I L E D**

DEC 23 1996

Phil Lombardi, Clerk  
U.S. DISTRICT COURT

ROBERT W. RIDDLE,

Plaintiff,

v.

SHIRLEY S. CHATER,  
COMMISSIONER OF SOCIAL  
SECURITY,<sup>1</sup>

Defendant.

Case No. 95-C-427-W

ENTERED ON DOCKET

DATE 12/26/96

**ORDER**

Plaintiff brought this action pursuant to 42 U.S.C. § 405(g) for judicial review of the final decision of the Secretary of Health and Human Services ("Secretary") denying plaintiff's application for disability insurance benefits under §§ 216(i) and 223 of the Social Security Act, as amended.

The procedural background of this matter was summarized adequately by the parties in their briefs and in the decision of the United States Administrative Law Judge Leslie S. Hauger, Jr. (the "ALJ"), which summaries are incorporated herein by reference.

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<sup>1</sup>Effective March 31, 1995, the functions of the Secretary of Health and Human Services in social security cases were transferred to the Commissioner of Social Security. P.L. No. 103-296. Pursuant to Fed.R.Civ.P. 25(d)(1), Shirley S. Chater, Commissioner of Social Security, is substituted for Donna E. Shalala, Secretary of Health and Human Services, as the Defendant in this action. Although the court has substituted the Commissioner for the Secretary in the caption, the text of this Order will continue to refer to the Secretary because she was the appropriate party at the time of the underlying decision.

The only issue now before the court is whether there is substantial evidence in the record to support the final decision of the Secretary that claimant is not disabled within the meaning of the Social Security Act.<sup>2</sup>

In the case at bar, the ALJ made his decision at the fifth step of the sequential evaluation process.<sup>3</sup> He found that claimant had the residual functional capacity to perform the full range of sedentary work of an unskilled nature and had no nonexertional impairments. The ALJ concluded that claimant's impairments and residual functional capacity precluded him from performing his past relevant work. By application of Rule 201.18 et seq. of the Medical Vocational Guidelines, 20 C.F.R.

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<sup>2</sup>Judicial review of the Secretary's determination is limited in scope by 42 U.S.C. § 405(g). The court's sole function is to determine whether the record as a whole contains substantial evidence to support the Secretary's decisions. The Secretary's findings stand if they are supported by "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." Richardson v. Perales, 402 U.S. 389, 401 (1971) (citing Consolidated Edison Co. v. N.L.R.B., 305 U.S. 197, 229 (1938)). In deciding whether the Secretary's findings are supported by substantial evidence, the court must consider the record as a whole. Hephner v. Mathews, 574 F.2d 359 (6th Cir. 1978).

<sup>3</sup>The Social Security Regulations require that a five-step sequential evaluation be made in considering a claim for benefits under the Social Security Act:

1. Is the claimant currently working?
2. If claimant is not working, does the claimant have a severe impairment?
3. If the claimant has a **severe** impairment, does it meet or equal an impairment listed in Appendix 1 of the Social Security Regulations? If so, disability is automatically found.
4. Does the impairment prevent the claimant from doing past relevant work?
5. Does claimant's impairment prevent him from doing any other relevant work available in the national economy?

20 C.F.R. § 404.1520 (1983). See generally, Talbot v. Heckler, 814 F.2d 1456 (10th Cir. 1987); Tillery v. Schweiker, 713 F.2d 601 (10th Cir. 1983).

Part 404, Subpart P, Appendix 2 ("the grids"), the ALJ found that he was not disabled under the Social Security Act by December 31, 1991, the date he was last insured.

Claimant now appeals this ruling and asserts alleged errors by the ALJ:

- (1) The ALJ erred in finding that claimant retained the residual functional capacity to perform the full range of sedentary work.
- (2) The ALJ erred in finding that claimant did not have nonexertional limitations.
- (3) The ALJ erred in finding that the Social Security Act and regulations required claimant to be precluded from sedentary work for a period in excess of twelve months.
- (4) The ALJ erred in relying on the medical-vocational guidelines ("the grids") to reach his conclusions.
- (5) The ALJ erred in relying on improper criteria to evaluate claimant's complaints of pain.

It is well settled that the claimant bears the burden of proving disability that prevents any gainful work activity. Channel v. Heckler, 747 F.2d 577, 579 (10th Cir. 1984).

Claimant contends that he became unable to work on September 17, 1986 due to degenerative arthritis of the joints, a fused left ankle joint, and a right hip replacement (TR 106). He met the disability insured status requirements of the Social Security Act on that date and continued to meet them through December 31, 1991, but not thereafter. (TR 21, 23). Therefore, the only evidence that was relevant to the ALJ's decision was evidence prior to December 31, 1991.

The claimant has had joint problems in his foot, hips, knees, and shoulders for several years. He underwent a total left ankle arthroplasty for degenerative arthritis

in July of 1985, and by November 29, 1985 he had "essentially normal range of motion of the ankle." (TR 139, 141). He had a total left ankle arthroplasty revision on April 30, 1986 (TR 155-167). He was working and had a new position in June of 1986 (TR 284).

Claimant had a left ankle fusion and right knee arthroscopic subtotal lateral meniscectomy on September 18, 1986 (TR 168-187). X-rays on his knees and hands on March 25, 1987 showed degenerative changes (TR 438). On April 14, 1987, he told his doctor that Naprosyn had decreased his joint pain and he was feeling "much better." (TR 188). On June 17, 1987, his doctor reported that he had "good motion." (TR 329).

It is significant that on May 7, 1987, Dr. Eugene Feild evaluated claimant and concluded as follows:

[T]his gentleman is undergoing polyfocal degenerative arthritis. Clearly, his left ankle is having progressive stiffening in the subtalar joint and is symptomatic. He cannot protect the left ankle because of early moderate degenerative changes in the right hip and right knee. He did provide us the additional history that he has had arthroscopy of the right knee identifying only degenerative changes. In respect to prognosis, I feel that he will require subtalar arthrodesis within the next two to five years on the left ankle which will further stiffen his foot and render walking more awkward yet somewhat more comfortable. However, I expect he will require total hip arthroplasty of the right hip within a ten year time frame and probably total knee arthroplasty of the right knee within the next fifteen year time frame. Therefore, I do agree that this gentleman is totally disabled from any job description in which he is required to stand or walk for considerable periods of the day.

The patient further denies that he has adequate training to perform managerial or non-active job skills. This man is young and at age 44, would be a candidate for vocational rehabilitation for a light duty job description in which he would not be required to lift or carry any

significant weight over ten to twenty pounds and primarily of a sedentary nature. Even with his upcoming potential problems, I feel retraining could return him to a functional capacity.

(TR 194-195) (emphasis added).

Claimant had a right total hip arthroplasty on September 8, 1987 (TR 190-211). On September 28, 1987, a residual functional capacity "(RFC)" assessment revealed that he could lift up to twenty pounds, frequently lift ten pounds, and stand, walk, or sit for six hours a day (TR 57). By October 16, 1987, his doctor found that he had "excellent" hip movement (TR 272). On July 20, 1988, his doctor reported that "everything seems fine." (TR 328).

On May 11, 1990, claimant told his doctor that he had just been diagnosed as diabetic and was taking medication as a result (TR 413). On May 18, 1990, he told the doctor he was exercising two hours a day (TR 412). On June 6, 1990, he told his doctor he had joined the YMCA and was bicycling six times a week (TR 348). The doctor found that he had hypoglycemia and hypertension (TR 348). On September 17, 1990, he underwent a talonavicular fusion of his left foot (TR 212-224). By November 16, 1990, he reported he was exercising on a treadmill, stationary bike, and water-walli for thirty minutes five days a week (TR 408).

X-rays of claimant's right knee on March 8, 1991 showed degenerative changes (TR 434). On August 5, 1991, he had a right total hip revision (TR 229-242). Ten months later, on June 4, 1992, he told his doctor his hip was "ok" with no pain (TR 257). On November 13, 1991, he had umbilical hernia repair surgery (TR 243-248).

There are no further medical records for the relevant period ending December 31, 1991. On March 4, 1993, claimant was found to be obese, hypertense, and disabled based on his surgeries (TR 347). In June of 1993, he underwent a right total knee arthroplasty, and two weeks later his doctor reported that he had a stable gait, with pain only at full extension and flexion (TR 249-250, 399). On September 30, 1993, a second RFC assessment showed that he could occasionally lift ten pounds and frequently lift lesser weight, could stand and/or walk for at least two hours in an eight-hour day, and could sit about six hours in an eight-hour day (TR 83-90). On December 13, 1993, he had left shoulder surgery (TR 337, 383-389). He was involved in a motor vehicle accident in March of 1994 and hit his knee and hip (TR 341, 378-381).

At the hearing on June 9, 1994, claimant testified that he can lift ten to fifteen pounds regularly and up to forty pounds occasionally, stand for fifteen to twenty minutes, and walk for five minutes (TR 43-44). He can sit only a short time before he starts getting stiff (TR 44). However, he stated that he goes to the lake often to fish, visits friends and relatives, drives, vacuums, does dishes, folds laundry, washes floors, mows the lawn, cleans windows, and feeds the dog at home (TR 42-43, 109, 117).

There is no merit to claimant's contentions, which are based in large part on evidence after the relevant time period. The Tenth Circuit has stated that "the relevant analysis is whether the claimant was actually disabled prior to the expiration of [his] insured status." Potter v. Secretary of Health & Human Serv., 905 F.2d

1346, 1348 (10th Cir. 1990). There is substantial evidence to support the ALJ's finding that claimant retained the residual functional capacity to perform the full range of sedentary work through December 31, 1991. The only evidence that he cannot perform the sitting and walking requirements of such work is his own self-serving statements. While he had joint problems in his left ankle for several years, there is no evidence of disabling problems with the ankle after the fusion in September of 1990, and these would not have kept him from doing sedentary work. (TR 212-224).

While claimant had a hip problem requiring a right hip arthroplasty on September 8, 1987, a month after the surgery his doctor found he had excellent hip movement (TR 190-211, 272). Only at the end of the relevant period, in July of 1991, was a right hip revision required, and ten months later in June of 1992 he told the doctor his hip was "ok," with no pain (TR 229-242, 257). Claimant had no problems with his right knee or shoulder during the relevant period. His diabetes was not diagnosed until May of 1990, and he was able to work out at the YMCA six times a week at that time (TR 348, 408, 412-413).

No doctors found during the relevant period that claimant was disabled from all work. In fact, Dr. Feild stated in May of 1987 that claimant could definitely be vocationally rehabilitated to do sedentary work. The joint problems in his ankle and hip during the time did not preclude sedentary work activity, especially since he was able to bicycle and work out at the YMCA.

There is also no merit to claimant's contention that the ALJ erred in finding claimant did not have nonexertional limitations, such as diabetes, hypertension, and

depression. While claimant was diagnosed as diabetic in May of 1990, he told the doctor at the time he was exercising two hours a day (TR 412-413). In June of that year, the doctor reported he had hypoglycemia and hypertension, but that he was bicycling six times a week (TR 348). Similar findings were reported in November of 1990 (TR 408).

There is substantial evidence that claimant's diabetes, hypertension, and depression did not preclude him from doing sedentary work prior to December 31, 1991. While he testified in June of 1994 that these conditions caused him to feel weak and faint and to sweat, this was long after the relevant period. The only reference in the record to depression was a medical report dated March 3, 1994, shortly after claimant was involved in the automobile accident, which stated that he was "[e]motionally better." (TR 340). This, too, was long after the relevant period.

There is also no merit to claimant's contention that the ALJ erred in finding that the Social Security Act required him to be precluded from work for more than twelve months. To qualify for disability insurance benefits under the Act, a claimant must suffer a "disability." Under 42 U.S.C. § 423(d)(1)(A), "disability" means "inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months; . . ."

According to 20 C.F.R. § 404.1567, "sedentary work" involves "lifting no more than 10 pounds at a time and occasionally lifting or carrying articles like docket files,

ledgers, and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required occasionally and other sedentary criteria are met." The joint problems in claimant's left ankle and hip and his diabetes, controlled by medication which allowed him to work out at the YMCA, did not prevent him from doing sedentary work before December 31, 1991, regardless of whether the conditions could be expected to last for more than twelve months.

There is no merit to claimant's contention that the ALJ erred in relying on the grids to reach his conclusions. The grids were developed by the Social Security Administration to relate a claimant's age, education, and job experience with his ability to engage in work in the national economy at various levels of exertion to determine his ability to work. The court in Trimiar v. Sullivan, 966 F.2d 1326, 1332-1333 (10th Cir. 1992), found that there are only two situations in which the grids may not be applied. First, they may not be applied conclusively in a case unless a claimant's characteristics precisely match the criteria of a particular grid. Second, where nonexertional impairments are also present, the grids alone cannot be used to determine the claimant's ability to perform alternative work.

The ALJ properly applied the grids in this case, since claimant matched the criteria of a particular grid, and, as already stated, had no nonexertional impairments during the relevant period. While the ALJ noted that claimant testified in 1994 that

he could "stand for only 15-20 minutes and walk for only 5 minutes" (TR 21), the ALJ did not find that claimant had such limitations during the relevant period.

Finally, there is no merit to claimant's fifth contention that the ALJ erred in relying on improper criteria to evaluate claimant's complaints of pain. Pain, even if not disabling, is a nonexertional impairment to be taken into consideration, unless there is substantial evidence for the ALJ to find that it is insignificant. Thompson v. Sullivan, 987 F.2d 1482 (10th Cir. 1993). Both physical and mental impairments can support a disability claim based on pain. Turner v. Heckler, 754 F.2d 326, 330 (10th Cir. 1985). However, the Tenth Circuit has said that "subjective complaints of pain must be accompanied by medical evidence and may be disregarded if unsupported by any clinical findings." Frey v. Bowen, 816 F.2d 508, 515 (10th Cir. 1987). The court in Luna v. Bowen, 834 F.2d 161, 165-66 (10th Cir. 1987), discussed the factors in addition to medical test results that agency decision makers should consider when judging the credibility of subjective claims of pain greater than that usually associated with a particular impairment.

[W]e have noted a claimant's persistent attempts to find relief for his pain and his willingness to try any treatment prescribed, regular use of crutches or a cane, regular contact with a doctor, and the possibility that psychological disorders combine with physical problems . . . [and] the claimant's daily activities, and the dosage, effectiveness, and side effects of medication. Of course no such list can be exhaustive.

See also, Hargis v. Sullivan, 945 F.2d 1482, 1489 (10th Cir. 1991).

Not only must the ALJ consider the factors set out in Luna, but he must discuss the specific evidence relevant to each factor which leads him to conclude that

a claimant's subjective complaints are or are not credible. Kepler v. Chater, 68 F.3d 387, 391 (10th Cir. 1995).

Because there was some objective medical evidence to show that plaintiff had joint problems producing pain, the ALJ was required to consider the assertions of severe pain and to "decide whether he believe[d them]." Luna, 834 F.2d at 163; 42 U.S.C. § 423(d)(5)(A). "[T]he absence of an objective medical basis for the degree of severity of pain may affect the weight to be given to the claimant's subjective allegations of pain, but a lack of objective corroboration of the pain's severity cannot justify disregarding those allegations." Luna, 834 F.2d at 165. This court need not give absolute deference to the ALJ's conclusion on this matter. Frey, 816 at 517.

The ALJ properly considered the factors in Luna and, after that, he discussed the primary reasons he found claimant's allegations not to be fully credible, including the objective findings by treating physicians, the objective findings by examining physicians, the lack of medication for severe pain, the lack of frequent treatments for pain, testimony regarding his daily activities and limitations, and the lack of discomfort shown by claimant at the hearing (TR 22). The ALJ did not, as claimant contends, rely only on his own observations to determine whether claimant's pain was disabling.

There was substantial evidence to support the ALJ's conclusions that claimant's hip problem was corrected in 1991, his knee condition was corrected in 1986, his ankle problems were resolved in 1990, and therefore there was "a substantial absence of evidence of disabling limitations from about August, 1991 until

1993. From such time he had few complaints, and his medical treatment was primarily for diabetes and hypertension, and then only to regulate his medication, as he seemed to have few complaints." (TR 22). The ALJ questioned claimant at the 1994 hearing about his alleged pain, and claimant testified that his right hip didn't bother him, his left hip only was painful occasionally, and his back had only recently become painful. (TR 36).

There was substantial evidence that, in spite of claimant's impairments, he retained the residual functional capacity to do sedentary work during the relevant period. While there were times that he was not able to work, there is no evidence that he was ever precluded from work for a period in excess of twelve months, as required by the Act and the Regulations.

The decision of the ALJ is supported by substantial evidence and is a correct application of the regulations. The decision is affirmed.

Dated this 23<sup>rd</sup> day of December, 1996.



JOHN LEO WAGNER  
UNITED STATES MAGISTRATE JUDGE

IN THE UNITED STATES DISTRICT COURT FOR THE  
NORTHERN DISTRICT OF OKLAHOMA

ROBERT W. RIDDLE,

Plaintiff,

v.

SHIRLEY S. CHATER,  
Commissioner of Social Security,<sup>1</sup>

Defendant.

ENTERED ON BOOKS

DATE 12/24/96

Case No: 95-C-427-W

**FILED**

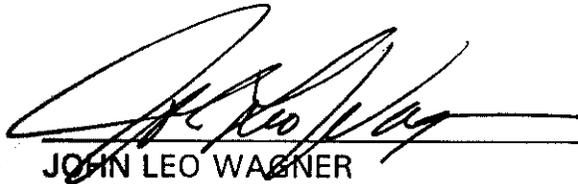
DEC 24 1996

Phil Lombardi, Clerk  
U.S. DISTRICT COURT

**JUDGMENT**

Judgment is entered in favor of **the defendant**, Shirley S. Chater, Commissioner of Social Security, in accordance with this court's Order filed December 24, 1996.

Dated this 24<sup>th</sup> day of December, 1996.



JOHN LEO WAGNER  
UNITE STATES MAGISTRATE JUDGE

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<sup>1</sup>Effective March 31, 1995, the functions of the Secretary of Health and Human Services in social security cases were transferred to the Commissioner of Social Security. P.L. No. 103-296. Pursuant to Fed.R.Civ.P. 25(d)(1), Shirley S. Chater, Commissioner of Social Security, is substituted for Donna E. Shalala, Secretary of Health and Human Services, as the Defendant in this action. Although the Court has substituted the Commissioner for the Secretary in the caption, the text of this Order will continue to refer to the Secretary because she was the appropriate party at the time of the underlying decision.

UNITED STATES DISTRICT COURT FOR THE  
NORTHERN DISTRICT OF OKLAHOMA

**FILED**

DEC 23 1996

Phil Lombardi, Clerk  
U.S. DISTRICT COURT  
NORTHERN DISTRICT OF OKLAHOMA

YUELL O. CANIDA  
(SSN: 431-66-9588)

Plaintiff,

v.

SHIRLEY S. CHATER,  
Commissioner of Social Security,

Defendant.

No. 95-CV-1231-J ✓

ENTERED ON DOCKET

DATE 12/22/96

**JUDGMENT**

This action has come before the Court for consideration and an Order affirming the Commissioner's denial of benefits to Plaintiff has been entered. Judgment for the Defendant and against the Plaintiff is hereby entered pursuant to the Court's Order.

It is so ordered this 23 day of December 1996.

  
Sam A. Joyner  
United States Magistrate Judge

12

UNITED STATES DISTRICT COURT FOR THE  
NORTHERN DISTRICT OF OKLAHOMA

**F I L E D**

YUELL O. CANIDA,  
(SSN: 431-66-9588)

Plaintiff,

v.

SHIRLEY S. CHATER,  
Commissioner of Social Security,

Defendant.

DEC 23 1996 Sre

Phil Lombardi, Clerk  
U.S. DISTRICT COURT  
NORTHERN DISTRICT OF OKLAHOMA

No. 95-CV-1231-J

ENTERED ON DOCKET

DATE 12/26/96

**ORDER**<sup>1/</sup>

Now before the Court is Plaintiff's appeal of the Commissioner's decision denying Plaintiff Disability Insurance Benefits and Supplemental Security Income Benefits under Titles II and XVI of the Social Security Act.. The Administrative Law Judge ("ALJ"), James D. Jordan, found that Plaintiff was not disabled because Plaintiff retained the Residual Functional Capacity ("RFC") to perform his past work as a janitor.

Plaintiff argues that the ALJ erred (1) by not giving Plaintiff's treating doctors' opinions, the vocational expert's testimony and the Plaintiff's wife's testimony the appropriate weight, (2) by failing to consider the limitations caused by the combination of all of Plaintiff's impairments, (3) by failing to make specific findings as to how Plaintiff could perform his past work as that work is defined in the Dictionary of Occupational Titles, and (4) by failing to determine that Plaintiff was presumptively

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<sup>1/</sup> This Order is entered in accordance with 28 U.S.C. § 636(c) and pursuant to the parties' Consent to Proceed Before United States Magistrate Judge, filed March 5, 1996.

disabled under Listing 12.05. The undersigned finds that the ALJ's conclusion that Plaintiff could perform his past work as a janitor is supported by substantial evidence. Consequently, the Commissioner's denial of benefits is **AFFIRMED**.

#### **I. STANDARD OF REVIEW**

A disability under the Social Security Act is defined as the

inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment. . . .

42 U.S.C. § 423(d)(1)(A). A claimant will be found disabled

only if his physical or mental impairment or impairments are of such severity that he is not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work in the national economy. . . .

42 U.S.C. § 423(d)(2)(A). To make a disability determination in accordance with these provisions, the Commissioner has established a five-step sequential evaluation process.<sup>2/</sup>

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<sup>2/</sup> Step one requires the claimant to **establish** that he is not engaged in substantial gainful activity as defined at 20 C.F.R. §§ 416.910 and 416.972. **Step two** requires the claimant to demonstrate that he has a medically severe impairment or combination of impairments that significantly limit his ability to do basic work activities. See 20 C.F.R. § 416.921. If claimant is engaged in substantial gainful activity (step one) or if claimant's impairment is not medically **severe** (step two), disability benefits are denied. At step three, claimant's impairment is compared with those impairments listed at 20 C.F.R. Pt. 404, Subpt. P, App. 1 (the "Listings"). See 20 C.F.R. § 416.925. If a claimant's impairment is equal or medically equivalent to an impairment in the Listings, claimant is **presumed disabled**. If a Listing is not met, the evaluation proceeds to step four, where the claimant must **establish that his** impairment or combination of impairments prevents him from performing his past relevant work. A claimant is not disabled if he can perform his past work. If a claimant is unable to perform his past work, the Commissioner has the burden of proof at step five to establish that the claimant, in light of his **age, education, and work history**, has the residual functional capacity ("RFC") to perform an **alternative work activity** in the national economy. If a claimant has the RFC to perform an alternate work activity, **disability benefits** are denied. See, 20 C.F.R. § 416.920; Bowen v. Yuckert, 482 U.S. 137, 140-142 (1987); and Williams v. Bowen, 844 F.2d 748, 750-53 (10th Cir. 1988).

The standard of review to be applied by this Court to the Commissioner's disability determination is set forth in 42 U.S.C. § 405(g), which provides that "the finding of the Commissioner as to any fact, if supported by substantial evidence, shall be conclusive." Substantial evidence is that amount and type of evidence that a reasonable mind will accept as adequate to support the ALJ's ultimate conclusion. Richardson v. Perales, 402 U.S. 389, 401 (1971); Williams, 844 F.2d at 750. In terms of traditional burdens of proof, substantial evidence is more than a scintilla, but less than a preponderance. Perales, 402 U.S. at 401. Evidence is not substantial if it is overwhelmed by other evidence in the record. Williams, 844 F.2d at 750.

To determine whether the Commissioner's decision is supported by substantial evidence, the Court will not undertake a *de novo* review of the evidence. Sisco v. U.S. Dept. of Health and Human Services, 10 F.3d 739, 741 (10th Cir. 1993). The Court will not reweigh the evidence or substitute its judgment for that of the Commissioner. Glass v. Shalala, 43 F.3d 1392, 1395 (10th Cir. 1994). The Court will, however, meticulously examine the entire record to determine if the Commissioner's determination is rational. Williams, 844 F.2d at 750; Holloway v. Heckler, 607 F. Supp. 71, 72 (D. Kan. 1985).

In addition to determining whether the Commissioner's decision is supported by substantial evidence, it is also this Court's duty to determine whether the Commissioner applied the correct legal standards. Washington v. Shalala, 37 F.3d 1437, 1439 (10th Cir. 1994). The Commissioner's decision will be reversed when

she uses the wrong legal standard or fails to clearly demonstrate reliance on the correct legal standards. Glass, 43 F.3d at 1395.

## **II. MEDICAL/VOCATIONAL EVIDENCE**

At the time of the hearing below, Plaintiff was a 53 year old male with a 9th grade education. *R. at 40*. Plaintiff testified that in the last 15 years, he had worked primarily as a welder from 1963 to 1989. Plaintiff testified that he was a "certified" welder. For five and a half to six months in 1985 Plaintiff worked as a janitor at Hissom Memorial Center. During this 15 year period, Plaintiff also did some concrete work for approximately one to two months. *R. at 40-43 & 132-35*. Plaintiff alleges that he became unable to work as of April 1989 due to (1) pain in his back; and (2) hearing loss. *R. at 45, 84 & 88*.

From July 1981 to December 1981, Plaintiff was treated by Timothy L. Huettner, M.D., a rheumatologist for problems with his left knee, left foot and low back. Plaintiff apparently dropped a wooden block on his left instep on July 15, 1981. Plaintiff went to the emergency room the same day and his left knee was drained of fluid. Plaintiff saw Dr. Huettner one week later on July 22, 1981. Plaintiff reported to Dr. Huettner that he had a motorcycle accident and a fall in 1978 in which he injured his left knee. The knee swelled and Plaintiff had to have fluid drained. Plaintiff also had swelling of his left knee in 1979 and 1980, but the swelling was not associated with any trauma. Plaintiff's left knee and foot were treated by Dr. Huettner and Plaintiff recovered from his injury. Plaintiff does not now complain of any limitation associated with his left knee or foot. *R. at 52-53 & 170-181*.

Plaintiff reported to Dr. Huettner that he had been experiencing pain in his low back since April 1981. Upon examination, Dr. Huettner found that Plaintiff's hips were normal with some limitation of internal rotation. Plaintiff also had markedly decreased extension and lateral flexion of his "thoratical" lumbar spine. Plaintiff could not touch his fingers to his toes -- he could only come within 24" of the floor. Dr. Huettner also found that Plaintiff was deaf in his right ear. X-rays were taken and "[n]one of the x-ray revealed any erosions or joint space narrowing." Dr. Huettner prescribed various medications, bed rest, exercises and heat treatments. *R. at 176-78.*

Dr. Huettner's impression was that Plaintiff had a decreased range of motion in his lumbosacral spine and some evidence of "sacroilitis," an inflammation of the sacroiliac joint. Dr. Huettner stated that the most likely diagnosis was "seronegative spondyloarthropathy,"<sup>3/</sup> with another strong possibility being "episodic [sic] Rheumatoid Arthritis." *R. at 176-78.* Plaintiff was examined by Dr. Huettner a month later and Plaintiff reported that his back was better and he had no pain in his sacroiliac. A bone scan was done and Dr. Huettner felt that the results "possibly represent[ed] arthritis" of an unknown etiology. *R. at 172-174.* A month later, Plaintiff was seen again and he reported that his low back continued to improve with very little pain. *R. at 172.*

From July 1981 to November 1981, Plaintiff was not working. He returned to work in November 1981 after "a long lay off." *R. at 171.* In a letter to what appears

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<sup>3/</sup> A joint disease in the vertebrae, not found in the serum of the blood. Taber's Cyclopedic Medical Dictionary 155, 1784 & 1854, (17th ed. 1993) (defining "arthropathy," "spondylo," and "seronegative").

to be a workers' compensation insurance carrier, Dr. Huettner reported that from July 1981 to November 1981, Plaintiff was 100% disabled. As of December 1981, Dr. Huettner opined that Plaintiff was only 25% disabled but that "he is able to put in a full days work despite [his] symptoms." *R. at 170.*

Plaintiff sought no medical treatment in connection with his back for approximately the next nine and a half years (i.e., from December 1981 to June 1992), when he began to see Emil Childers, M.D.<sup>4/</sup> Plaintiff saw Dr. Childers in June 1992, asking for a letter so he could obtain health insurance. Plaintiff complained of pain in his low back and told Dr. Childers that he had a history of arthritis. Dr. Childers examined Plaintiff and found that he was not very flexible and that he was not able to touch his toes. Dr. Childers had a x-ray taken of Plaintiff's back. According to Dr. Childers, the x-ray "does not really show any significant arthritic changes which would account for [Plaintiff's] back pain." *R. at 183.* Plaintiff also saw Jack Brown, M.D. in June 1991. Plaintiff complained of pain in his back. Dr. Brown had an x-ray taken of Plaintiff's back. Based on this x-ray, Dr. Brown stated that it "does not appear that [Plaintiff] has any real arthritis to his back as such." *R. at 188.* Plaintiff did not see another doctor for his back for the next three months, when he began seeing Charles H. McCarty, M.D.

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<sup>4/</sup> Plaintiff did see Dr. Childers in November 1990 as a result of a dizzy spell. Plaintiff had been cutting wood, bringing it home and splitting it. He became dizzy, had a headache, was nauseous, and eventually passed out in the car. Plaintiff was concerned that he had heart problems. Dr. Childers examined Plaintiff. Plaintiff had no chest pain. His pulse was regular. His heart was normal. His EKG was normal. An X-ray of the heart was normal, except for an enlargement of the heart. Dr. Childers' impression was high blood pressure. Dr. Childers prescribed medication and Plaintiff reported no more problems. *R. at 183.*

In September 1992, Plaintiff was lifting 80 pounds bags of something and at the end of the day he slipped and fell while walking up an inclined ramp. Plaintiff reported to Dr. McCarty that he was having low back pain with no radicular symptomology. Plaintiff stated that he was taking no regular pain medications, other than the Advil he took directly after the fall. Upon examination, Dr. McCarty found Plaintiff to be in significant pain. Plaintiff had some problem getting on and off the examination table. Plaintiff also had a positive straight leg raising test. Right and left lateral flexion caused some pain and Plaintiff had some muscle spasm. Dr. McCarty determined that Plaintiff had an acute lumbar sprain/strain. Dr. McCarty prescribed a muscle relaxant, pain medications, bed rest, heat and exercises. Plaintiff was not seen again for three months. *R. at 199.*

In December 1992, Plaintiff reported to Dr. McCarty that he was still having back pain. Plaintiff reported that his back pain was worse in the morning (i.e., he was incapacitated). Plaintiff reported that he had no problems with his other joints and there was no pain radiating into his hips or legs. Upon examination, Plaintiff had a positive straight leg raising test. Raising the right leg and rotating the right hip caused pain. There was no swelling, inflammation or deformity of any joints. Plaintiff's muscle strength was good. Plaintiff's range of motion was, however, limited due to muscle spasm. An x-ray was taken, which showed the lumbar spine to be in good alignment. There was some "mild hypertrophic spurring at [the] L2-L3 level. The intervertebral disc space heights at the L3-L4 and L4-L5 levels [also appeared] mildly narrowed." *R. at 206.*

Several weeks later, Plaintiff reported to Dr. McCarty that his back pain had improved. *R. at 196.* In a letter to Plaintiff's attorney, Dr. McCarty reported that Plaintiff's rheumatoid profile showed **no evidence** of serologic arthritic disease and no evidence of elevated uric acid levels, which would be associated with gout. Tests for rheumatoid arthritis, systemic lupus erythematosus, and post infectious arthritis were all negative. Plaintiff's sedimentation rate, which detects the presence of chronic inflammation was also negative. *R. at 227-29.* Dr. McCarty's impression was that Plaintiff had mild degenerative joint disease in his lumbar spine.

Plaintiff reported to Dr. McCarty in February and March 1993 that his back pain was getting worse. Dr. McCarty referred Plaintiff to John B. Vosburgh, M.D., for an orthopedic evaluation. Plaintiff saw Dr. Vosburgh on March 26, 1993. Dr. Vosburgh was to evaluate Plaintiff's complaints of chronic pain in the low back, which seemed to have gotten worse over the last six months. Plaintiff told Dr. Vosburg that he hurt his back in 1981 in an industrial accident. *R. at 212.*<sup>5/</sup> Plaintiff reported that he had quit his job two weeks prior to the visit because he was not able to perform the physical demands expected of a welder. Dr. Vosburgh examined Plaintiff and found all of his joints to be normal. Plaintiff had a full range of motion in his back, but he did have some pain on the extremes of movement. Plaintiff stood erect and was able to walk on his heels and toes without difficulty. Plaintiff did have some pain when pulling his knees to his chest. The x-rays of Plaintiff's back showed normal bone and joint

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<sup>5/</sup> Plaintiff never reported an industrial accident causing injury to his back to Dr. Huettner while Plaintiff was seeing Dr. Huettner during the last half of 1981. *R. at 170-78.*

structures. Dr. Vosburgh concluded that Plaintiff had a chronic strain of the low back.

*R. at 212.* Following is an excerpt from Dr. Vosburgh's concluding report:

[Plaintiff's] examination was unremarkable except for stiffness in the low back. X-rays of his low back were likewise unremarkable except for some early degenerative changes.

This man somewhat over-reacts to his examiner and I am not quite sure why he is having the trouble he alleges. I have recommended outpatient therapy to see if he can get a handle on it.

I think he is tired of doing hard manual labor and possibly will have to direct him to something that is not so physically demanding.

*R. at 213.*

In October 1993, Plaintiff was examined by Roger E. Wehrs, M.D., an ear doctor. Upon examination of Plaintiff, Dr. Wehrs found a considerable amount of impacted wax in Plaintiff's ears. This wax was removed and Plaintiff's tympanic membranes were examined and found to be normal. Plaintiff was found to have total, nerve-type hearing loss in his right ear. The hearing in Plaintiff's left ear was normal through the speech range (i.e., low tones). Plaintiff did, however, have considerable high tone hearing loss in his left ear. Dr. Wehrs concluded that Plaintiff's understanding for speech was fair, with a speech discrimination score of 84% compared to a normal score of 90%. *R. at 217-18.*

In October 1993, Plaintiff was referred by the Social Security Administration to Minor Gordon, Ph.D., for a consultive, psychological examination. Upon examination, Dr. Gordon found Plaintiff attentive and alert. Plaintiff maintained good eye contact

and his mood was calm and normal. Plaintiff's social-adaptive behavior was normal. The organization of Plaintiff's thought process was coherent. Plaintiff's short term and long term memory were adequate. Dr. Gordon's gross estimate of Plaintiff's intelligence was low to average. Plaintiff reported to Dr. Gordon that he had frequent thoughts of suicide, but no intent. Plaintiff denied phobic ideation, paranoia, delusions, hallucinations and any other perception problems. *R. at 214-15.*

Dr. Gordon administered the Wechsler Adult Intelligence test and obtained the following scores for Plaintiff: verbal IQ of 73, performance IQ of 80, and a full scale IQ of 76. According to Dr. Gordon, these scores place Plaintiff in the "high part of the borderline range of mental retardation." *R. at 215.* From a psychological standpoint, Dr. Gordon concluded that Plaintiff "is certainly capable of performing some type of routine and repetitive task on a regular basis." *Id.*

In November 1993, Ron Smallwood, Ph.D., reviewed Plaintiff's file for the Social Security Administration to determine Plaintiff's Mental RFC. Dr. Smallwood found that Plaintiff's mental impairments did cause a marked limitation in Plaintiff's ability to understand, remember and carry out detailed instructions. *R. at 106-108.* Dr. Smallwood concluded, however, that Plaintiff "can perform simple tasks and adapt to work situations." *R. at 107.* Dr. Smallwood also evaluated whether Plaintiff met Listing 12.05 relating to mental retardation. Based on Plaintiff's IQ scores from Dr. Gordon, Dr. Smallwood determined that Plaintiff did not meet Listing 12.05. Despite the fact that Plaintiff did not meet Listing 12.05, Dr. Smallwood did find that due to Plaintiff's low intelligence scores, Plaintiff (1) would have slight restrictions of

activities of daily living, (2) would have slight difficulty in maintaining social functioning, (3) often have deficiencies of concentration, persistence or pace, and (4) would not have episodes of deterioration or decompensation in work or work-like settings. *R. at 109-117.*

Plaintiff saw Dr. McCarty again in February and May 1994. In February 1994, Plaintiff complained of pain in his left elbow, left shoulder, hands, ankles and back. Upon examination, Dr. McCarty found the range of motion in all of Plaintiff's joints was normal. Dr. McCarty did find that Plaintiff had tennis elbow in his left elbow and tendinitis in his left shoulder. A rheumatoid profile was repeated and it showed no evidence of significant rheumatologic disorder. In May 1994, it appears as if Plaintiff was treated by Dr. McCarty for chronic myofibrositis, which is an inflammation of the fibrous tissue that encloses muscle tissue. Taber's Cyclopedic Medical Dictionary p. 1264 (17th ed. 1993). This is simply reported by Dr. McCarty in a letter to Plaintiff's attorney and there is no other information regarding this impairment. Dr. McCarty concludes that Plaintiff suffers from myofibrositis, chronic musculoskeletal low back disorder, and mild degenerative joint disease of the back. *R. at 227-29.* As Dr. Huettner had noted, Dr. McCarty felt that Plaintiff might have "seronegative spondyloarthropathy" in the low back. Dr. McCarty conceded, however, that "x-rays and laboratory studies do not support this diagnosis." *R. at 229.* Dr. McCarty also notes that the objective test results do not corroborate the pain Plaintiff alleges he has. Id.

Plaintiff was examined in February 1995 by Judith K. Adams, Ph.D. for a total of four hours of testing. Dr. Adams' examination occurred after the hearing before the ALJ in this case. Thus, the ALJ did not have the benefit of Dr. Adams' report. The report was, however, submitted to the Appeals Counsel and is a part of the record before this Court. O'Dell v. Shalala, 44 F.3d 855, 859 (10th Cir. 1994). Plaintiff reported to Dr. Adams that he was depressed, anxious, irritable, had difficulty concentrating and remembering, was withdrawn from people, was fearful of leaving his house and had suicidal thoughts. Plaintiff told Dr. Adams that he never advanced beyond the third grade.<sup>6/</sup> Plaintiff also reported to Dr. Adams that he was in agony all of the time due to his back. As far as daily activities, Plaintiff reported that he watched TV, ran small errands for his wife and occasionally went on a drive or out to eat with his wife. *R. at 254-60.*

Dr. Adams found that Plaintiff had good orientation to current events. Plaintiff also had good recall of narrative passages. Plaintiff did not have good mental control over numerical sequences, but he could add and subtract simple numbers. Plaintiff also reported on his Vocational Report that he could use a tape measure. *R. at 132-35.* Plaintiff had limited recall of two-dimensional geometric figures. Plaintiff is also able to manage the most simple of reading and writing tasks. Plaintiff was able to sign his name, but not able to fill out an application. Plaintiff had functional verbal communications skills, and he was able to communicate his wants, needs and

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<sup>6/</sup> Plaintiff told Dr. Gordon and he testified at the hearing before the ALJ that he had completed the ninth grade. *R. at 40& 215-15.*

preferences. Plaintiff spoke in full sentences and had good articulation. Plaintiff was capable of conversing at a slow to average level. In Dr. Adams' opinion, Plaintiff was functionally illiterate and his overall mental functioning was in the dull to normal range. *R. at 254-60.* Dr. Adams was of the opinion that Plaintiff "will not be able to return to a productive work force in any imaginable way." *R. at 260.*

Plaintiff reported to Dr. Adams that he was depressed due to the death of his son in 1989 and due to his own inability to be productive. Plaintiff did not report depression due to his son's death or for any other reason when he was examined by Dr. Gordon in 1993. In any event, Dr. Adams administered the Beck Depression test and Plaintiff scored a 36, which suggests that Plaintiff is experiencing severe depression. Dr. Adams opined that if Plaintiff could return to work, she believed that he would do so. She concluded by stating that Plaintiff was not malingering and that she felt that Plaintiff should be awarded disability benefits. *R. at 254-60.*

### **III. DISCUSSION**

#### **A. Listing 12.05**

Plaintiff did not argue before the ALJ that Listing 12.05 was met. In his brief before this Court, however, Plaintiff raises the issue of whether Listing 12.05 is met in this case. Listing 12.05 provides as follows:

**12.05 *Mental Retardation and Autism:*** Mental retardation refers to a significantly subaverage general intellectual functioning with deficits in adaptive behavior initially manifested during the developmental period (before age 22). (Note: The scores specified below refer to those obtained on the WAIS, and are used only for reference purposes. Scores obtained on other standardized and individually

administered tests are acceptable, but the numerical values obtained must indicate a similar level of intellectual functioning.). . . .

- A. Mental incapacity evidenced by dependence upon others for personal needs (e.g., toileting, eating, dressing, or bathing) and inability to follow directions, such that the use of standardized measures of intellectual functioning is precluded; OR
- B. A valid verbal, performance, or full scale IQ of 59 or less; OR
- C. A valid verbal, performance, or full scale IQ of 60 through 70 and a physical or other mental impairment imposing additional and significant work-related limitation of function; OR
- D. A valid verbal, performance, or full scale IQ of 60 through 70, or in the case of autism, gross deficits of social and communicative skills, with either condition resulting in two of the following:
  - 1. Marked restriction of activities of daily living; or
  - 2. Marked difficulties in maintaining social functioning; or
  - 3. Deficiencies of concentration, persistence or pace resulting in frequent failure to complete tasks in a timely manner (in work settings or elsewhere); or
  - 4. Repeated episodes of deterioration or decompensation in work or work-like settings which cause the individual to withdraw from that situation or to experience exacerbation of signs and symptoms (which may include deterioration of adaptive behaviors).

20 C.F.R., Pt. 404, Subpt. P, App. 1, § 12.05.

The ALJ completed a PRT form and attached it to his opinion. On this form, the ALJ evaluated whether or not Plaintiff met Listing 12.05. The ALJ determined that Plaintiff did not meet Listing 12.05 because Plaintiff's IQ scores were not sufficiently

low enough to meet the presumptive disability requirements of Listing 12.05. *R. at 30-32.*

To meet the requirements of any part of Listing 12.05, Plaintiff must have a verbal, performance or full scale IQ below 71 or it must be the case that the "use of standardized measures of intellectual functioning is precluded." Plaintiff does not satisfy any of these criteria. First, Dr. Gordon was able to administer an IQ test. This in itself prevents a finding that the use of standardized testing would be precluded in this case. Second, Plaintiff's verbal IQ was 73. His performance IQ was 80 and his full scale IQ was 76. None of these values is below 71. Thus, Plaintiff does not meet the requirements of Listing 12.05.

In his brief on this issue, Plaintiff does not address the fact that his IQ scores prevent him from meeting Listing 12.05. Rather, he makes a hodgepodge of statements which are rather disjointed. First, Plaintiff quotes from Dr. Gordon's report as showing Plaintiff in the "high part of mental retardation." Plaintiff's brief, p. 4. Plaintiff completely mis-quotes Dr. Gordon's report. What Dr. Gordon actually found was that Plaintiff "is functioning in the high part of the borderline range of mental retardation." *R. at 215.* There is a significant difference between what Dr. Gordon actually said and what Plaintiff represents that Dr. Gordon said. According to Dr. Gordon, Plaintiff is in the gray area between mental retardation and normal functioning, and in fact he is closer to normal functioning than he is to mental retardation. Thus, Dr. Gordon's findings do not support a conclusion that Listing 12.05 has been met in this case.

Plaintiff also points to 20 C.F.R. § 404.1564 as support for his conclusion that he meets Listing 12.05. Section 404.1564 defines how the Social Security Administration will evaluate a person's education as a vocational factor. Plaintiff argues that under the definitions in § 404.1564, he only has a "marginal" education. If a person has a "marginal" education, he has the "ability in reasoning, arithmetic, and language skills which are needed to do simple, unskilled types of jobs." 20 C.F.R. § 404.1564(b)(2). Section 404.1564 can in no way support a conclusion that Plaintiff meets Listing 12.05. A determination that Plaintiff has "marginal" education is a determination that Plaintiff has the skills to do simple, unskilled types of jobs, and it does not support a conclusion that Plaintiff is completely unable to work. Furthermore, § 404.1564 is designed to be used at step five of the sequential evaluation procedure, not at step three. Section 404.1564 only applies once the Administration determines that it can not decide if a claimant is disabled based on medical evidence alone (i.e., at step three), and that a claimant cannot perform his past relevant work (i.e., step four). Thus, § 404.1564 does not support a conclusion that Listing 12.05 has been meet in this case.

Plaintiff also refers to Dr. Adams' conclusion that Plaintiff is functionally illiterate. Plaintiff fails, however, to demonstrate how a finding of functional illiteracy should equate to a finding of mental retardation for purposes of Listing 12.05. Dr. Adams herself never makes a finding of mental retardation. Thus, Plaintiff's argument that he meets Listing 12.05 is without merit.

## **B. Past Relevant Work**

The ALJ determined that Plaintiff retained the mental and physical RFC to perform his past job as a janitor at Hissom Memorial Center ("Hissom") in 1985. Plaintiff testified that he performed this job for five and a half to six months, and that his job duties were to sweep and mop floors and take out the trash. *R. at 41-42 & 148*. Plaintiff objects to the use of this job as past relevant work because he only performed it for a short period of time and because welding, not janitorial services, was his "primary employment." Neither of these arguments has merit.

The Secretary's regulations define past relevant work as work done within the 15 years preceding the ALJ's decision, which lasted long enough for a claimant to learn to do it. 20 C.F.R. § 404.1560(b) & 404.1566(a). See also Jozefowicz v. Heckler, 811 F.2d 1352, 1355 (10th Cir. 1987). The hearing in this case was held on June 6, 1994. Plaintiff performed his janitorial work in 1985 (i.e., 9 years earlier). This is clearly within the past 15 years. Plaintiff's janitorial work will, therefore, serve as past relevant work if five and a half to six months was long enough for Plaintiff to learn to sweep and mop floors and take out the trash. The Court finds that five and a half to six months is a sufficient amount of time to learn such tasks. See, e.g., Dictionary of Occupational Titles § 381.687-034 (4th ed. 1991) (indicating that training for this type of job would be less than one month);<sup>7/</sup> and Jozefowicz, 811 F.2d

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<sup>7/</sup> Plaintiff refers to the Dictionary of Occupational Titles in his brief. Plaintiff does not, however, indicate to what section he is referring. Rather, Plaintiff simply states the reasoning, mathematical and language development levels required of the position to which he refers (i.e., R3 M2 L3). The Court has reviewed the relevant jobs in the DOT and matched the combination of development levels cited by Plaintiff (continued...)

at 1355-56 (finding that eight months was sufficient for a claimant to learn a telephone verification job).

### C. Plaintiff's RFC

Plaintiff argues that the ALJ erred in concluding that he retained the physical and mental RFC to perform the demands of the janitorial job at Hissom. The Court does not agree. After reviewing the entire record as a whole, the Court finds that the ALJ's determination that Plaintiff retains the mental and physical RFC to perform his past janitorial job is supported by substantial evidence.

#### 1. Mental RFC

Plaintiff points to Dr. Adams' report which finds that Plaintiff is functionally illiterate. Plaintiff then points to the Dictionary of Occupational Titles and argues that his prior position at Hissom requires a reasoning development level of 3,<sup>8/</sup> a math

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<sup>7/</sup> (...continued)

to only one relevant job -- § 382.664-010. The job referred to by Plaintiff is titled "Janitor (any industry) alternate titles: maintenance engineer; superintendent, building." The job description includes the following types of duties: keeping an office or similar building in clean and orderly condition; tending to a boiler, furnace or air conditioning system; performing minor painting, plumbing and electrical wiring; and cleaning snow off of walks and maintaining the grounds. This job clearly does not describe the job performed by Plaintiff at Hissom. Upon questioning by the ALJ, Plaintiff stated that he did no maintenance work and no paper work. All Plaintiff did was sweep and mop floors and empty trash. *R. at 41-42.*

The job referred to by the Court in the text is titled "Waxer, Floor." The job description includes the following types of duties: cleaning, waxing and polishing floors by hand or machine. This job more closely resembles the job Plaintiff actually did at Hissom. While this job does not include the taking out of trash, the Court finds that the additional duty of light trash removal would not significantly alter the demands of this job as defined in the DOT.

<sup>8/</sup> A reasoning development level of 3 requires a claimant to "[a]pply commonsense understanding to carry out instructions furnished in written, oral, or diagrammatic form. Deal with problems involving several concrete variables in or from standardized situations." Dictionary of Occupational Titles App. C, p. 1011 (4th ed. 1991).

development level of 2,<sup>9/</sup> and a language development level of 3.<sup>10/</sup> Based on the record before it, the Court agrees that Plaintiff is not capable of performing at these levels. However, as discussed above, Plaintiff is referring to a maintenance engineer/building superintendent job (i.e., § 382.664-010) which is not even close to the job which Plaintiff actually performed at Hissom Memorial Center. See note 7, *supra*. The DOT job which most closely matches the job Plaintiff performed at Hissom is a floor waxer (i.e., § 381.687-034). The floor waxer job only requires reasoning, math and language development levels of 1, which are significantly lower in terms of abilities than the maintenance engineer/building superintendent job referred to by Plaintiff. Nevertheless, the debate over which DOT job applies is academic in this case.

The Tenth Circuit has held that "past relevant" work can be assessed using either (1) the actual functional demands of the past work as actually performed by Plaintiff, or (2) the functional demands of Plaintiff's past work as it is normally performed in the national economy. Andrade v. DHHS, 985 F.2d 1045, 1050-51 (10th Cir. 1993). See also Social Security Ruling 82-61. The DOT's definitions relate

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<sup>9/</sup> A math development level of 2 requires a claimant to "[a]dd, subtract, multiply, and divide all units of measure. Perform the four operations with like common and decimal fractions. Compute ratio, rate, and percent. Draw and interpret bar graphs. Perform arithmetic operations involving all American monetary units." Dictionary of Occupational Titles App. C, p. 1011 (4th ed. 1991).

<sup>10/</sup> A language development level of 3 requires a claimant to be able to read novels, magazines, atlases, encyclopedias, safety rules, instructions in the use and maintenance of shop tools, and methods and procedures in mechanical drawings. A claimant must be able to write reports and essays with proper format, punctuation, spelling and grammar. A claimant must also be able to speak before an audience with poise, voice control, and confidence, using correct English. Dictionary of Occupational Titles App. C, p. 1011 (4th ed. 1991).

to the second of these two categories. That is, the DOT provides a definition of how a particular job is normally performed in the national economy. The record in this case clearly demonstrates, however, that Plaintiff is fully capable of performing the mental demands of his past janitorial job, as that job was actually performed by Plaintiff in 1985.

In this case, Plaintiff performed his janitorial job at a time when he was "functionally illiterate." There is nothing in the record to establish that Plaintiff's mental capabilities became worse after his employment at Hissom in 1985. Dr. Adams concludes that Plaintiff is functionally illiterate primarily due to his inability to learn in school. Dr. Adams theorizes that Plaintiff's inability to learn in school may be due to some type of organic brain damage Plaintiff received as the result of (1) blows to the head by his alcoholic father when Plaintiff was a child, (2) high childhood fevers, or (3) childhood accidents in which Plaintiff injured his head. Dr. Adams' diagnosis is based on Plaintiff's life history and nothing indicates that Plaintiff became illiterate after his employment at Hissom. *R. at 254-262.* Plaintiff worked at Hissom despite his illiteracy.<sup>11/</sup> Thus, Plaintiff is fully capable of performing the mental demands of his past work at Hissom Memorial Center, as he performed that job in 1985.

The only mental condition which may have changed since 1985 is Plaintiff's alleged depression. Depression was not addressed by the ALJ because Plaintiff never

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<sup>11/</sup> The same can be said of Plaintiff's welding jobs. Plaintiff apparently was capable of performing the demands of a welding job, despite his illiteracy.

mentioned depression during the entire administrative process until he saw Dr. Adams in 1995, eight months after the hearing before the ALJ. Plaintiff did not mention depression to Dr. Gordon in 1993. In answer to the ALJ's questioning in 1994, Plaintiff told the ALJ that the main thing that prevented him from working was his back. *R. at 53*. Plaintiff never mentioned depression to the ALJ. Dr. Adams' report was presented to the Appeals Council and is part of the record. The Court must, therefore, determine whether this new evidence tips the balance and makes the ALJ's determination no longer supported by substantial evidence. *O'Dell*, 44 F.3d at 859.

After reviewing Dr. Adams' report the Court finds that it does not require a change in the outcome. The ALJ's determination that Plaintiff could perform the mental demands of his past work is still supported by substantial evidence. Despite the fact that Dr. Adams concludes that Plaintiff is severely depressed over the death of his son and over his own unproductivity, Dr. Adams does not state how such depression would affect Plaintiff's ability to work. Dr. Adams simply concludes that Plaintiff's back problems, hearing loss, depression and his illiteracy all combine to make him unable to work.

The Court has already demonstrated that Plaintiff worked at Hissom, despite his illiteracy. With regard to his hearing loss, Plaintiff himself testified that this would not prevent him from working. Plaintiff testified in 1994 as follows:

Q     Okay. Are there any other problems that would keep you from working? We all have a corn on our toe or some of these things. I'm not interested in those things. We just go on without, but --

A Well, I'm deaf in my right ear.

.....

Q Okay. How does **that** affect you or does it have any bearing on you?

A Well, I've been **that way** as far as I remember all my life and I --

Q So it's something **you** worked with?

A I wouldn't know **how** a normal person was.

Q Any other problems keeping you from working?

A Not that I can think of, just my back mainly.

Q So is it fair for **me** to understand that if you did not have the back problem then you'd still be working?

A Yes, sir, I sure would. I mean I've worked with my ear like that **all my life** because it comes natural.

*R. at 53.* Nothing in the record indicates that Plaintiff's hearing deteriorated significantly between June 1994 when he testified before the ALJ and February 1995, when he saw Dr. Adams.

Plaintiff's son died in 1989 and Plaintiff himself quit working in 1989. Plaintiff's son had been dead and Plaintiff had been unemployed/unproductive for five to six years when Plaintiff saw Dr. Gordon and when Plaintiff testified before the ALJ. Despite these facts, Plaintiff did not mention depression as a reason for his inability to work until 1995, when he saw Dr. Adams. There is no objective evidence in the record to establish that Plaintiff's depression became so severe between the time he testified before the ALJ (i.e., June 1994) and the time he saw Dr. Adams (i.e.,

February 1995) that Plaintiff became unable, due to depression, to perform the mental demands of his past work at Hissom. The ALJ's conclusion that Plaintiff could perform the mental demands of his job at Hissom is, therefore, supported by substantial evidence.

## 2. Physical RFC

The ALJ concedes that Plaintiff does have an impairment (i.e., some vertebral spurring and mild narrowing of the vertebral disc space) which could reasonably produce some back pain. The ALJ was, therefore, required to consider all evidence relating to Plaintiff's allegations of disabling pain. Luna v. Bowen, 834 F.2d 161 (10th Cir. 1987). After reviewing the record as a whole, the Court agrees with the ALJ's conclusion that the overall tenor of the remarks made by those doctors examining Plaintiff suggests a lack of "objective" medical findings to support the degree of pain alleged by Plaintiff. Thus, the only evidence left to evaluate is Plaintiff's subjective complaints of disabling pain. This places Plaintiff's credibility squarely at issue.

Plaintiff alleges that he became disabled in March or April 1989. *R. at 45*. As the ALJ points out, the record demonstrates that Plaintiff received no medical care from December 1981 to December 1989. Thus, Plaintiff was receiving no medical care for approximately eight years prior to his alleged date of disability. Nineteen months after Plaintiff's alleged disability date, he saw Dr. Childers. Dr. Childers' November 1990 progress notes indicate that Plaintiff was cutting wood, bringing it home and splitting it. *R. at 183*. Plaintiff was obviously not disabled as of November 1990. Plaintiff sought no further treatment for a year and a half after seeing Dr.

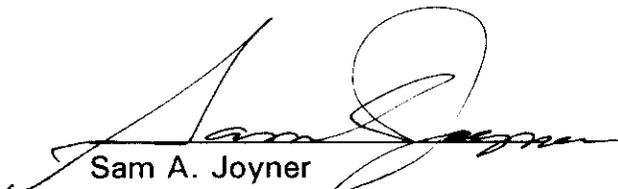
Childers. Plaintiff then appeared at Dr. Childers' office in June 1992 asking for an insurance letter and presenting with a history of arthritis. X-rays taken at that time demonstrated nothing that would account for Plaintiff's alleged pain. *R. at 183*. The ALJ concluded that these facts create serious questions regarding Plaintiff's overall credibility. The Court finds no basis with which to disagree with the ALJ's ultimate decision to find Plaintiff's subjective complaints about pain not fully credible. See Hamilton v. Secretary of Health & Human Services, 961 F.2d 1495 (10th Cir. 1992) (credibility determinations by the ALJ are given great deference by the Court).

#### **CONCLUSION**

The undersigned finds that the ALJ's determination that Plaintiff could perform his past work as a janitor is supported by substantial evidence. Consequently, the Commissioner's decision to deny Disability Insurance Benefits and Supplemental Security Income is **AFFIRMED**.

IT IS SO ORDERED.

Dated this 23 day of December 1996.

  
Sam A. Joyner  
United States Magistrate Judge

IN THE UNITED STATES DISTRICT COURT  
FOR THE NORTHERN DISTRICT OF OKLAHOMA

12-26-96  
**FILED**  
DEC 24 1996  
Phil Lombardi, Clerk  
U.S. DISTRICT COURT

PIERRE BUTLER, an individual, )  
 )  
 Plaintiff, )  
 )  
 vs. )  
 )  
 UNITED PARCEL SERVICE, INC., )  
 a Delaware Corporation, )  
 )  
 Defendant. )

Case No. 96-C-422 K ✓

**JOINT STIPULATION OF DISMISSAL WITH PREJUDICE**

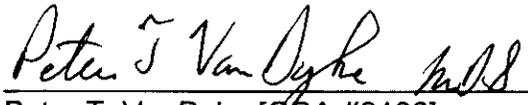
COME NOW the parties, Pierre Butler, plaintiff, and United Parcel Service, Inc., defendant, through counsel, and stipulate that the above-styled and numbered cause, be and hereby is, dismissed with prejudice.

Dated this 23<sup>rd</sup> day of December, 1997.



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No c/s

IN THE UNITED STATES DISTRICT COURT  
FOR THE NORTHERN DISTRICT OF OKLAHOMA

13-26-96

AUSTIN TED FLAGG, )  
)  
Plaintiff, )  
)  
v. )  
)  
J. C. PENNEY CO. INC., )  
VOLUNTARY EMPLOYEES )  
BENEFICIARY ASSOCIATION, )  
)  
Defendant. )

No. 96CV 169H ✓

FILED

DEC 24 1996

Phil Lombardi, Clerk  
U.S. DISTRICT COURT

JOINT STIPULATION  
OF DISMISSAL WITH PREJUDICE

It is hereby stipulated that the above-entitled action may be dismissed with prejudice, pursuant to Rule 41(a)(1) of the Federal Rules of Civil Procedure.

DATED this 20th day of December, 1996.

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CPM

12-26-96

UNITED STATES DISTRICT COURT  
FOR THE NORTHERN DISTRICT OF OKLAHOMA

FILED

DEC 24 1996

Phil Lombardi, Clerk  
U.S. DISTRICT COURT

C.A. No. 94-C439-H

SUN COMPANY, INC. (R&M), et al.,

Plaintiffs,

v.

MALLINCKRODT GROUP INC., et al.,

Defendants.

**STIPULATION OF DISMISSAL**

Pursuant to Rule 41(a) of the Federal Rules of Civil Procedure, IT IS HEREBY STIPULATED by Plaintiff Sun Company, Inc. (R&M) on its own behalf and on behalf of Sun Company, Inc., Sun Oil Company of Pennsylvania, and Sun Refining and Marketing Company, and by Mallinckrodt Group Inc. on its own behalf and on behalf of International Minerals & Chemicals Corporation, IMCERA Group Inc., Great Lakes Container Corporation (Delaware), Great Lakes Container Corporation (Michigan), Great Lakes Container Corporation of Oklahoma, Inc., Container Products of Oklahoma, Inc. and Container Products, Inc., that the captioned action and all claims, counterclaims and cross claims made therein shall be dismissed with prejudice, each party to bear its own attorneys fees and costs.

**SUN COMPANY, INC. (R&M)**

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MALLINCKRODT GROUP INC.**

UNITED STATES DISTRICT COURT FOR THE  
NORTHERN DISTRICT OF OKLAHOMA **FILED**

DEC 23 1996

Phil Lombardi, Clerk  
U.S. DISTRICT COURT  
NORTHERN DISTRICT OF OKLAHOMA

TIMOTHY EDWARD DURHAM, )  
 )  
 Plaintiff, )

vs. )

STANLEY GLANZ, in his official capacity as )  
 the Sheriff of Tulsa County, )

Defendant. )

Case No. 92-C-1171-E ✓

ENTERED ON DOCKET  
DATE DEC 24 1996

**REPORT & RECOMMENDATION**

Defendant Stanley Glanz filed a Motion to Dismiss Plaintiff's Third Amended Complaint or in the Alternative a Motion for Summary Judgment on August 17, 1995. [Doc. Nos. 58-1, 58-2]. By Order dated November 17, 1995, the District Court denied the Motion to Dismiss and stayed, pending the completion of discovery, Plaintiff's due date to file a Response to the Motion for Summary Judgment. [Doc. No. 71-1]. Defendant amended his previously filed Motion for Summary Judgment by brief filed January 2, 1996. [R. at 78-1]. Plaintiff filed his Response to Defendant's Motion for Summary Judgment on June 17, 1996. [Doc. No. 100-1]. Defendant's Reply was filed June 24, 1996. [Doc. No. 103-1]. By minute order dated July 23, 1996, this case was referred to the United States Magistrate Judge for all further proceedings.

**PROCEDURAL BACKGROUND**

Plaintiff filed this action on December 22, 1992, against numerous Defendants. [Doc. No. 1-1]. The Defendants filed a Motion for Summary Judgment on April 6,

1993. [Doc. No. 8-1]. Defendants' Motion was granted with respect to all Defendants except Stanley Glanz on March 31, 1994. [Doc. No. 26-1].

Plaintiff filed his first amended complaint on June 27, 1994. [Doc. No. 32-1]. Defendant Stanley Glanz filed a Motion to Dismiss on August 8, 1994. [Doc. No. 33-1]. Plaintiff filed a second amended complaint on April 17, 1995 [doc. no. 43-1], and on May 12, 1995, Defendant filed a Motion to Dismiss the second amended complaint. [Doc. No. 45-1]. On July 31, 1995, Plaintiff filed a third amended complaint. [Doc. No. 55-1]. And, on August 17, 1995, Defendant filed a Motion to Dismiss Plaintiff's third amended complaint, or in the alternative, a Motion for Summary Judgment. [Doc. Nos. 58-1, 58-2]. Defendant's Motion to Dismiss was denied on November 11, 1995. [Doc. No. 71-1]. Defendant's Motion for Summary Judgment is currently before this Court. [Doc. No. 58-2].

#### **FACTUAL BACKGROUND**

Plaintiff was arrested and charged with several counts of rape and lewd molestation of an eleven year old girl. Plaintiff was initially incarcerated in the Tulsa City Jail where he remained from December 19, 1991, until December 23, 1991. Plaintiff asserts that when he was processed at the Tulsa City Jail the intake officer suggested to him that he should seek protective custody, and that Plaintiff agreed with the intake officer. According to Plaintiff, individuals accused of sexually related crimes against minors are confronted with an increased risk of harm from other prisoners. In addition, Plaintiff notes that he is five feet four inches tall and weighs 120 pounds, and was therefore concerned for his safety.

Plaintiff asserts that on December 23, 1991, over his objection, he was moved from the Tulsa City Jail and placed in the Tulsa County Jail. According to Plaintiff, rather than being placed in a cell with other similarly-charged inmates, he was placed in a cell with ten to fifteen other inmates<sup>1/</sup> all of whom were known by the Defendant to be violent offenders. Plaintiff claims that within a few hours of being placed in the Tulsa County Jail cell he was violently and viciously attacked by the other inmates. An incident report notes that "Timothy Durham was lying on his bed asleep when someone, unknown to Timothy, pulled him off his bed and into [sic] the floor. Once he was in [sic] the floor several inmates started beating and stomping his head, face, and body." See Exhibit "6," attached to Plaintiff's Response to Defendant's Motion for Summary Judgment [Doc. No. 100-1].

Plaintiff was taken to Hillcrest Medical Center for treatment. Plaintiff claims that his face was swollen, that both of his eyes were blackened, that a gash on his head required six stitches, that he suffered a concussion, and that his entire body was bruised as a result of kicks he received while he was on the floor.

After receiving treatment at Hillcrest, Plaintiff was initially transported back to the Tulsa County Jail. Plaintiff protested, and requested that he be permitted to speak to the desk sergeant. According to Plaintiff, an officer informed Plaintiff's escorting officer that Plaintiff was to be returned to the Tulsa City Jail. Plaintiff was returned

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<sup>1/</sup> The incident report indicates eleven other inmates were in the cell at the time of the incident. See Exhibit "6," of Plaintiff's Response to Defendant's Motion for Summary Judgment [Doc. No. 100-1].

to Tulsa County and placed in the cell from which he had been removed earlier that morning.

The record contains an affidavit from Mr. Charles Goudeau who states that he was in the Tulsa County Jail cell when Plaintiff was returned. Mr. Goudeau states that "I noticed that Tim had a bandage on that was blood-stained and covered most of his head. He had two black eyes; his face was swollen and discolored and it looked like he had golf balls in his mouth. . . . I [also] noticed that his back and rib area was badly bruised and his skin was several different colors -- black, blue, and yellow." See Affidavit of Charles Goudeau [Doc. No. 4-1]. An affidavit submitted by Mr. Brian D. Dubuc contains similar information. See Affidavit of Brian D. Dubuc [Doc. No. 5-1].

Plaintiff additionally contends that on September 9, 1994, he was transferred back to the Tulsa County Jail.<sup>2/</sup> Plaintiff states that although the Tulsa County Jail should have known that he needed protection, no precautions were taken to protect him. Plaintiff contends that he was placed in a cell with other inmates who were known violent offenders.

On September 16, 1994, while in the Tulsa County Jail, Plaintiff states that he was again beaten by several inmates. According to Plaintiff he received a black eye and had numerous bruises due to kicks delivered to his body. Plaintiff contends that his injuries resulted in the passing of blood in his urine. Plaintiff states that he received

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<sup>2/</sup> Plaintiff states that he was convicted of the charges against the eleven year old. However, Plaintiff states that he was transferred back to Tulsa County Jail as a "pre-trial detainee." The record is not clear as to the date on which Plaintiff was convicted.

no medical treatment for his injuries, but was merely transferred to the Department of Corrections.

Plaintiff contends that the conditions at the Tulsa County Jail during his incarceration were "an abomination." According to Plaintiff, any employee of the Sheriff's Department was permitted to transfer an "inmate" at any time, and the Sheriff's employees ignored and were deliberately indifferent to the threats of violence and the conditions at the jail. Plaintiff states that beatings were common at the Tulsa County Jail yet the Sheriff chose to ignore jail conditions, refused to train officers, and neglected to establish effective policies. Plaintiff contends that the Sheriff and/or employees of the Sheriff's Department were deliberately indifferent with respect to Plaintiff's cell assignment on two separate occasions, ignored his requests for a transfer, and were deliberately indifferent to Plaintiff's need for medical assistance after Plaintiff was beaten in September of 1994.

The record additionally contains an affidavit by Michael Eugene Price. [Doc. No. 16-1]. Mr. Price states that he was incarcerated in the Tulsa County Jail from October 1991 until May 1992. [Doc. No. 16-1]. According to Mr. Price, "[t]he Officers would come back and let us know we was going to get a white man or two with a rape case, or killing or raping kids, and to 'get them' after shift change, but not on the same shift. . . . If an Officer did not like an inmate, black or white, he would come back and let us know that one is going to be coming back that is 'running his mouth to an Officer, and none of the Officers can touch the inmate.' The Officers would bring the inmate in before shift change. Right after shift change, the rest of us would pull cards to find

out who would start the beating. Low card sometimes or high card would hit the inmate. Then, the rest of the inmates would all start hitting and kicking the inmate until he was knocked out, or his head was busted open so bad that the blood was all over the inmate and he is no longer moving."

Defendant asserts that Plaintiff has failed to produce the existence of any policy or custom which condones or encourages assaults against inmates. According to Defendant, the Sheriff's office has sufficient policies to protect against incidents. Defendant also argues that Plaintiff cannot establish that individuals within the Sheriff's Department lack any necessary training. Defendant requests that the Court grant summary judgment in favor of the Defendant because Plaintiff cannot meet the requisite constitutional standards of deliberate indifference.

## DEFENDANT'S MOTION FOR SUMMARY JUDGMENT

### Standard

A court may grant summary judgment only when the materials of record "show that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(c). The threshold inquiry is whether the pleadings present "any genuine factual issues that properly can be resolved only by a finder of fact because they may reasonably be resolved in favor of either party." Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 250 (1986). While conducting this analysis, the court resolves all doubt in favor of the plaintiff, the non-

moving party. Conaway v. Smith, 853 F.2d 789, 792 n. 4 (10th Cir. 1988); Norton v. Liddel, 620 F.2d 1375, 1381 (10th Cir. 1980).

To survive a motion for summary judgment, the plaintiff "must establish that there is a genuine issue of material facts. . . ." Matsushita v. Zenith, 475 U.S. 574, 585 (1986). "By its very terms, this standard provides that the mere existence of some alleged factual dispute between the parties will not defeat an otherwise properly supported motion for summary judgment; the requirement is that there be no genuine issue of material fact." Anderson, 477 U.S. at 248. The substantive law determines which facts are material. Id. And the plaintiff "must do more than simply show that there is some metaphysical doubt as to the material facts." Matsushita v. Zenith, 475 U.S. 574, 585 (1986). In addition, the evidence and inferences therefrom must be viewed in a light most favorable to the nonmoving party. Conaway v. Smith, 853 F.2d 789, 792 n. 4 (10th Cir. 1988). Unless the moving party can demonstrate their entitlement beyond a reasonable doubt, summary judgment must be denied. Norton v. Liddel, 620 F.2d 1375, 1381 (10th Cir. 1980).

#### **Due Process, the Eighth Amendment, and Pre-Trial Detainee Status**

Plaintiff was a pre-trial detainee at the time of the first incident. Plaintiff was convicted of those charges and placed in the custody of the Department of Corrections. Prior to the second incident, Plaintiff was transferred by the Department of Corrections to the Tulsa County Jail as a "pre-trial" detainee on additional charges. Although Plaintiff was a pre-trial detainee with respect to these additional charges, Plaintiff was also a convicted felon.

With respect to the determination of the potential violation of asserted constitutional rights, pre-trial detainees are protected by the Fourteenth Amendment's due process standard. The Eighth Amendment does not apply until after conviction of a crime. See Garcia v. Salt Lake City, 768 F.2d 303, 307 (10th Cir. 1985). Courts addressing the issue have recognized that the due process rights of a pretrial detainee are at least as great as the Eighth Amendment rights of convicted prisoners. See, e.g., Bell v. Wolfish, 441 U.S. 520, 535-37 (1979); Garcia v. Salt Lake County, 768 F.2d 303, 307 (10th Cir. 1985).

#### **Deliberate Indifference Standard**

Plaintiff asserts that he was subject to vicious and brutal attacks on two separate occasions while he was in the Tulsa County Jail. Plaintiff alleges that beatings in the jail were common-place, that the Defendant knew that Plaintiff's risk of injury was increased due to the nature of the charges against him, that the Defendant placed Plaintiff in a cell with known violent offenders, that Defendant refused to institute, implement, or enforce policies to protect inmates, that Defendant failed to adequately train deputies, that any employee was permitted to transfer an inmate, and that Plaintiff was injured due to the actions and inactions of the part of Defendant.

Within the context of state prisoner civil complaints, Federal courts can address such complaints only if the asserted conduct or incident constitutes a violation of the inmate's Federal Constitutional rights. The Eighth Amendment to the Constitution provides certain rights to an individual to be free from "cruel and unusual" punishment.

The courts have concluded that inmates do have a right to be reasonably protected from threats of violence and attacks by other inmates. See Ramos v. Lamm, 639 F.2d 559 (10th Cir. 1980), cert. denied, 450 U.S. 1041 (1981). Deliberate indifference on the part of corrections officials to inmate safety and the probability of violent attacks violates a convicted prisoner's Eighth Amendment rights. Berry v. City of Muskogee, 900 F.2d 1489, 1494-95 (10th Cir. 1990).

However, under the deliberate indifference standard, "a prison official may be held liable under the Eighth Amendment for denying humane conditions of confinement only if he knows that [an] inmate[] face[s] a substantial risk of serious harm and disregards that risk by failing to take reasonable measures to abate it." Farmer v. Brennan, 114 S. Ct. 1970, 1984 (1994); see also MacKay v. Farnsworth, 48 F.3d 491, 493 (10th Cir. 1995) (the requisite mental state is that of deliberate indifference). The Court in Farmer additionally noted that an official's "failure to alleviate a significant risk that he should have perceived but did not, while no cause for commendation, cannot under our cases be considered as the infliction of punishment." Farmer, 114 S. Ct. at 1979.

The Seventh Circuit Court of Appeals recently explained deliberate indifference to inmates' safety as follows:

If [prison employees] place a prisoner in a cell that has a cobra, but they do not know that there is a cobra there (or even that there is a high probability that there is a cobra there), they are not guilty of deliberate indifference even if they should have known about the risk, that is, even if they were negligent--even grossly negligent or even reckless in the tort sense--in failing to know. But if they know that

there is a cobra there or at least that there is a high probability of a cobra there, and do nothing, that is deliberate indifference.

Billman v. Indiana Dept. of Corrections, 56 F.3d 785, 788 (7th Cir. 1995).

Defendant initially asserts that summary judgment in favor of Defendant is proper because Defendant has written policies which address the needs of inmates and cell locations and classifications. See Defendant's Brief [Doc. No. 58-2] at 11. The first incident occurred on December 19, 1991, and the second incident on September 16, 1994. Defendant acknowledges that these written policies were not implemented until at least March 25, 1994, and therefore were not in effect prior to the first incident. Regardless, the mere existence of these policies, alone, is an insufficient basis for the grant of a motion for summary judgment.

Defendant asserts, with respect to the second incident, that although Plaintiff was a "convicted sex offender," he was transferred to Tulsa County Jail on charges which were not "sexual offenses." Therefore, Plaintiff was not placed in "protective custody," and Defendant was not aware that Plaintiff should be placed in protective custody. According to Defendant, because the classification was made in "good faith" and was based on "insufficient information," the failure to properly "classify" Plaintiff cannot constitute a constitutional violation.

Plaintiff submits the deposition transcript of Sheriff Walker who acknowledges that "one of the problems that we had is that the history of inmates was not kept, the history of those incidents or any incidents a person may have been involved in. And what we try to do was develop a database or classification system when someone

was brought to jail, that a person would be classified according to his past behavior, as well as the crime for which he was charged." See Exhibit "1," at 16, Plaintiff's Response to Defendant's Motion for Summary Judgment [Doc. No. 100-1]. Plaintiff additionally asserts that Defendant acknowledges that it is "common knowledge" that individuals accused of sexually related crimes against minors are at risk of harm from other inmates. See, e.g., Exhibit "3," at 51-52, Deposition of Captain Jerry Griffin, Plaintiff's Response to Defendant's Motion for Summary Judgment [Doc. No. 100-1]. Furthermore, Plaintiff submitted an affidavit by a prisoner alleging that "officers" would inform the prisoners when an individual accused of certain types of crimes were going to be transferred to the prisoners' cells and "encourage" the prisoners to beat the transferee. [Doc. No. 16-1]. Based on the facts presented by Plaintiff, a factual issue exists as to whether the failure to obtain sufficient information and/or properly classify inmates constitutes deliberate indifference. Consequently, summary judgment is inappropriate.

Defendant additionally asserts that proof of a "single incident" is insufficient to impose liability. Plaintiff does not assert a "single incident," but alleges that Defendant had a practice and policy of ignoring obvious threats of harm and violence to inmates.

Plaintiff asserts that Defendant knew of the risk of violence to Plaintiff, that Defendant placed Plaintiff in a cell with "violent" offenders, and that Defendant was deliberately indifferent to Plaintiff's risk of harm. Plaintiff has alleged and presented sufficient facts to create a factual issue as to whether Defendant's actions violated

Plaintiff's constitutional rights. The United States Magistrate Judge recommends that Defendant's Motion for Summary Judgment with respect to this issue be **DENIED**.

**"Right" to a Particular Facility**

Defendant contends that Plaintiff has failed to establish that he has a right to be "housed in a particular location **within** a prison facility." Defendant's Motion for Summary Judgment at 13. Defendant is correct that generally an individual does not have a constitutional right to be incarcerated in a particular cell or facility. *See, e.g., Olim v. Wakinekona*, 461 U.S. 238, 245 (1983); *Meachum v. Fano*, 427 U.S. 215, 224 (1976); *Moody v. Dagget*, 429 U.S. 78, 88 n.9 (1976) **LOOK AT THESE CASES**. However, Plaintiff's argument is that Defendant violated his constitutional right due to Defendant's deliberate indifference to the risk of harm to Plaintiff.

**Failure to Adequately Train**

Defendant alleges that Oklahoma statutes provide the "minimum standards" for the training of jail personnel, and that Plaintiff has failed to establish that Defendant has not met those minimum standards. Defendant does not explain how meeting the minimum standards requires a finding that Defendant was not deliberately indifferent. Defendant also presents nothing to indicate whether or not Defendant complies with the minimum standards.

**Denial of Medical Treatment**

A State has an obligation to provide medical care for those whom it incarcerates. The failure to provide adequate medical care to a prisoner is a violation

of the Eighth Amendment's prohibition of cruel and unusual punishment.<sup>3/</sup> To establish such a violation, the prisoner must demonstrate that the prison officials were deliberately indifferent to the prisoner's serious illness or injury. Estelle v. Gamble, 429 U.S. 97 (1976).

Estelle requires a two pronged analysis. First, the objective component, requires that the prisoner's illness or injury be serious. Second, the subjective component, requires that the defendant act with a culpable state of mind. Mere inadvertence or negligence on the defendant's part is not sufficient. The prisoner must establish that the defendant acted with deliberate indifference. Deliberate indifference requires more than negligent conduct, but less than intentional conduct. Estelle, 429 U.S. at 103-105; Wilson v. Seiter, 501 U.S. 294, 111 S. Ct. 2321, 2323-24 (1991); Hardy v. Price, 996 F.2d 1064, 1066-67 (10th Cir. 1993).

The Court in Estelle recognized that not only deprivations of medical care that produce physical torture or death are actionable. Less serious denials which cause or perpetuate pain are also actionable. "To assert otherwise would be inconsistent with contemporary standards of human decency. It is clear from this principle that a constitutional claim is stated when prison officials intentionally deny access to medical

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<sup>3/</sup> Plaintiff alleges a denial of medical care only with respect to the second incident, which occurred in September of 1994. At the time of that incident, Plaintiff was incarcerated within the Oklahoma Department of Corrections, but had been transported to the Tulsa County Jail on other pending charges. Plaintiff notes that he was a pre-trial detainee in the Tulsa County Jail on the "new" charges. The Court declines to inquire further into Plaintiff's status at this stage. Whether "labeled" a pre-trial detainee or a convicted felon, Plaintiff is at least entitled to the "degree of protection against denial of medical attention which applies to convicted inmates." Garcia v. Salt Lake County, 768 F.2d 303 (10th Cir. 1985).

care or interfere with prescribed treatment.” Todaro v. Ward, 565 F.2d 48, 52 (2d Cir. 1977).

In addition, for Defendant to be held liable in his official capacity, Plaintiff must demonstrate that a policy or custom of the Tulsa County Jail played a part in the violation of his constitutional rights. See Kentucky v. Graham, 473 U.S. 159 (1985); Polk County v. Dodson, 454 U.S. 132 (1981).

Defendant presents only two limited arguments in his Motion for Summary Judgment on this issue. Defendant initially asserts that Plaintiff has “admitted” that Defendant was not deliberately indifferent to Plaintiff’s medical needs after the first incident (December 19, 1991) because Plaintiff acknowledges that he was taken to the hospital after this incident. However, in his Third Amended Complaint, Plaintiff limits his deprivation of medical treatment claim to the second incident, and does not allege that Defendant deprived him of necessary medical treatment with respect to the first incident.

With respect to the second incident, (September 9, 1994), Plaintiff asserts that although he was severely beaten, received a black eye, and passed blood in his urine, Defendant did not allow him to be treated in a hospital for these injuries, but merely transferred him to the Department of Corrections. Defendant asserts that in regard to this Plaintiff only states that the Defendant failed to take Plaintiff to the hospital. Defendant requests that the Court grant summary judgment because Plaintiff “submits no medical evidence whatsoever that indicates there was a need for more medical

attention than that which he received in the jail." Defendant's Brief in Support of Summary Judgment [Doc. No. 58-2] at 15.

First, Defendant's argument **suggests** that Plaintiff received some form of medical treatment while he was at Tulsa County Jail. However, Defendant does not refer to anything in the record which **references** any such treatment. Plaintiff states that he was denied treatment, and Defendant offers nothing to counter Plaintiff's contentions. Second, Defendant **apparently** is asserting that an individual must present medical evidence establishing that he or she needs medical treatment before the failure to provide such treatment **is** actionable. However, the Court is uncertain how an individual could obtain such "medical evidence" (which would indicate that the individual needs medical treatment) **if the individual was deprived** of medical attention. Based on the arguments advanced on this issue by Defendant, the Magistrate Judge recommends that Defendant's Motion for Summary Judgment with respect to the denial of medical treatment be **DENIED**.

#### **Qualified Immunity**

Defendant asserts, in his "Amendment to His Motion For Summary Judgment" [Doc. No. 78-1], that the Defendant **should** be granted qualified immunity based on Defendant's good faith belief that **his actions** did not violate the law.

Under the doctrine of **qualified immunity**, a defendant cannot be held **personally liable** unless the plaintiff can **establish** that the defendant's actions violated "clearly established statutory or constitutional **rights** of which a reasonable person would have known." Harlow v. Fitzgerald, 457 U.S. 800, 818 (1982). See also Pueblo

Neighborhood Health Centers, Inc. v. Losavio, 847 F.2d 642, 645 (10th Cir.1988). When the qualified immunity defense is raised in a motion for summary judgment, a plaintiff must show (1) that the defendant's conduct violates the law as it now exists, and (2) that the law was clearly established at the time of the alleged unlawful conduct. Cummins v. Campbell, 44 F.3d 847, 850 (10th Cir.1994); Albright v. Rodriguez, 51 F.3d 1531, 1534 (10th Cir.1995). If a plaintiff fails to carry either part of this burden, the defendant is entitled to qualified immunity. Id. at 1535; Thompson v. City of Lawrence, 58 F.3d 1511, 1515 (10th Cir.1995).

"The key to the [qualified immunity] inquiry is the objective reasonableness of the official's conduct in light of the legal rules that were clearly established at the time the action was taken." Laidley v. McClain, 914 F.2d 1386, 1394 (10th Cir.1990). Establishing that the right exists at a general level is not sufficient. The inquiry must be more particularized -- was the right clearly established under the particular factual situation presented by the case at hand? See Anderson v. Creighton, 483 U.S. 635 (1987). For the law to be clearly established, "there must be a Supreme Court or Tenth Circuit decision on point, or the clearly established weight of authority from other courts must have found the law to be as the plaintiff maintains." Medina v. City and County of Denver, 960 F.2d 1493, 1498 (10th Cir. 1992).

In this case, however, Plaintiff, as evident in his Third Amended Complaint (filed July 26, 1995) sued Stanley Glanz in his official capacity as the Sheriff of Tulsa County. Defendant's argument on qualified immunity applies only if Defendant is sued in his personal capacity, and does not present a basis for a motion for summary

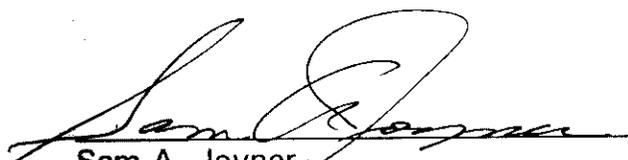
judgment against Defendant in his "official capacity." The Court therefore declines, at this time, to address this argument on the merits. The United States Magistrate Judge recommends that Defendant's Motion for Summary Judgment based on the argument of "qualified immunity" be **DENIED**.

### **RECOMMENDATION**

The United States Magistrate Judge recommends that the District Court **DENY** Defendant's Motion for Summary Judgment.

The parties must file with the Clerk of the Courts any objection to this Report and Recommendation within ten days after being served with a copy. **Failure to file objections within the specified time will result in a waiver of the right to appeal the District Court's order.** See Moore v. United States, 950 F.2d 656 (10th Cir. 1991).

Dated this 23 day of December 1996.

  
Sam A. Joyner  
United States Magistrate Judge

IN THE UNITED STATES DISTRICT COURT  
FOR THE NORTHERN DISTRICT OF OKLAHOMA

**F I L E D**

DEC 20 1996

Phil Lombardi, Clerk  
U.S. DISTRICT COURT

BIZJET INTERNATIONAL SALES &  
SUPPORT, INC.,

Plaintiff,

v.

LAICO, INC.,

Defendant.

Case No. 96-CV-720-BU

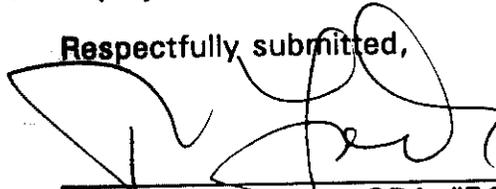
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12-24-96

**STIPULATION OF DISMISSAL**

Plaintiff, BizJet International Sales & Support, Inc., and defendant, LaiCo, Inc., pursuant to Rule 41(a)(1) of the Federal Rules of Civil Procedure, hereby stipulate to the dismissal of this proceeding without prejudice to the refileing of same.

Respectfully submitted,



Thomas M. Ladner, OBA #5161  
NORMAN & WOHLGEMUTH  
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Tulsa, Oklahoma 74103

**ATTORNEYS FOR PLAINTIFF, BIZJET  
INTERNATIONAL SALES & SUPPORT, INC.**



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- and -

Robert J. Valerian  
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**ATTORNEYS FOR DEFENDANT, LAICO, INC.**

ctf

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11/25/96

IN THE UNITED STATES DISTRICT COURT  
FOR THE NORTHERN DISTRICT OF OKLAHOMA

DEC 29 1996

MELVA WRIGHT, )  
)  
Plaintiff, )  
)  
vs. )  
)  
CITY OF SAPULPA and STATE OF )  
OKLAHOMA ex rel., OKLAHOMA )  
DEPARTMENT OF TRANSPORTATION, )  
)  
Defendants. )

Case No. 95-C-593-H

**FILED**

DEC 19 1996

Phil Lombardi, Clerk  
U.S. DISTRICT COURT  
NORTHERN DISTRICT OF OKLAHOMA

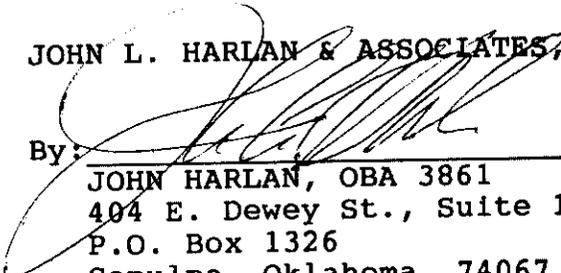
JUDGMENT

Judgment is hereby entered in favor of the Defendant City of Sapulpa and against the Plaintiff. Any issues relating to the recovery of costs or attorney fees have already been resolved by the parties.

  
SVEN ERIK HOLMES  
U.S. District Court Judge

APPROVED AS TO FORM AND CONTENT:

JOHN L. HARLAN & ASSOCIATES, P.C.

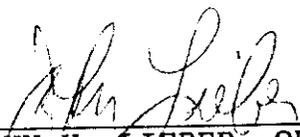
By: 

JOHN HARLAN, OBA 3861  
404 E. Dewey St., Suite 106  
P.O. Box 1326  
Sapulpa, Oklahoma 74067

ATTORNEY FOR PLAINTIFF

28

ELLER AND DETRICH  
A Professional Corporation

By: 

JOHN H. LIEBER, OBA #5421  
2727 East 21st Street  
Suite 200, Midway Building  
Tulsa, Oklahoma 74114  
(918) 747-8900

ATTORNEY FOR DEFENDANT  
CITY OF SAPULPA

3.MAG\WRIGHT\Judgment

IN THE UNITED STATES DISTRICT COURT  
FOR THE NORTHERN DISTRICT OF OKLAHOMA

MELVA WRIGHT,  
  
Plaintiff,  
  
vs.  
  
CITY OF SAPULPA and STATE OF  
OKLAHOMA ex rel., OKLAHOMA  
DEPARTMENT OF TRANSPORTATION,  
  
Defendants.

DEC 28 1996

Case No. 95-C-593-H

FILED

DEC 13 1996

Phil Lombardi, Clerk  
U.S. DISTRICT COURT  
NORTHERN DISTRICT OF OKLAHOMA

ORDER

This matter comes before the Court on the Motion for Summary Judgment of Defendant City of Sapulpa and the Motion for Partial Summary Judgment of Defendant City of Sapulpa.

Melva Wright, a citizen of Sapulpa, brought this action against the City of Sapulpa, claiming that the City violated the provisions of the Americans with Disabilities Act, 1990, 42 U.S.C. § 12101 et seq. The Defendant City of Sapulpa has filed a Motion for Summary Judgment, asserting that Plaintiff's lawsuit is barred by the statute of limitations. In a separate Motion for Partial Summary Judgment, the City has asserted that it is in compliance with the requirements of the Americans with Disabilities Act.

After reviewing the briefs and hearing argument of counsel, the Court finds and orders as follows:

1. To the extent that any of Plaintiff's claims arise from the resurfacing of Dewey Street by the State Highway Department in 1992, those claims are barred by the statute of limitations;

2. Based on the undisputed facts as set forth in the briefs, and based upon the joint report recently filed by the parties, and without making a finding whether the City of Sapulpa was or was not

5/25/96

✓

in compliance with the Americans With Disabilities Act when this lawsuit was filed, the Court finds that the City of Sapulpa is now or in the near future will be in compliance with the requirements of the Americans With Disabilities Act. The Court finds that these materials demonstrate the City's commitment to compliance with the Act. Curb ramps are already in existence throughout much of the downtown area, and along Plaintiff's route from home to work. Other curb ramps will be constructed by the City in the near future. Plaintiff has available to her, upon reasonable notice, a van which can transport her throughout the city. Installation of curb ramps in the areas described by the pleadings, together with the availability of rolling stock, satisfies the requirements of 28 C.F.R. § 35.150;

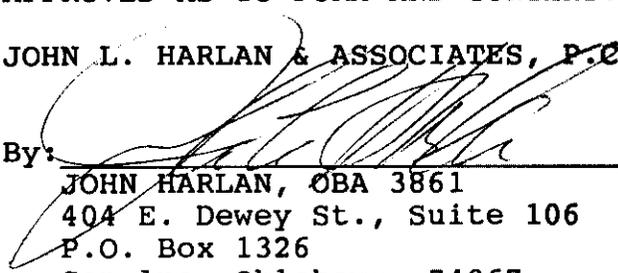
3. The Court finds and orders that no damages should be awarded to Plaintiff.

4. The Court finds and orders that there are no further issues to be decided in this case and that summary judgment should, accordingly, be entered in favor of the Defendant and against the Plaintiff.

  
SVEN ERIK HOLMES  
U.S. District Court Judge

APPROVED AS TO FORM AND CONTENT:

JOHN L. HARLAN & ASSOCIATES, P.C.

By: 

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ATTORNEY FOR PLAINTIFF

ELLER AND DETRICH  
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By:   
\_\_\_\_\_  
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ATTORNEY FOR DEFENDANT  
CITY OF SAPULPA

J.MAG\WRIGHT\Order

IN THE UNITED STATES DISTRICT COURT FOR THE  
NORTHERN DISTRICT OF OKLAHOMA

RICKY D. TEETS, )  
 )  
 Plaintiff, )  
 )  
 v. )  
 )  
 SHIRLEY S. CHATER, )  
 COMMISSIONER OF SOCIAL )  
 SECURITY,<sup>1</sup> )  
 )  
 Defendant. )

**F I L E D**

DEC 20 1996

Phil Lombardi, Clerk  
U.S. DISTRICT COURT

Case No. 95-C-791-W

ENTERED ON DOCKET

DATE 12/23/96

**ORDER**

Plaintiff brought this action pursuant to 42 U.S.C. § 405(g) for judicial review of the final decision of the Secretary of Health and Human Services ("Secretary") denying plaintiff's application for disability insurance benefits under §§ 216(i) and 223 and supplemental security income under §§ 1602 and 1614(a)(3)(A) of the Social Security Act, as amended.

The procedural background of this matter was summarized adequately by the parties in their briefs and in the decision of the United States Administrative Law Judge Richard J. Kallsnick (the "ALJ"), which summaries are incorporated herein by reference.

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<sup>1</sup>Effective March 31, 1995, the functions of the Secretary of Health and Human Services in social security cases were transferred to the Commissioner of Social Security. P.L. No. 103-296. Pursuant to Fed.R.Civ.P. 25(d)(1), Shirley S. Chater, Commissioner of Social Security, is substituted for Donna E. Shalala, Secretary of Health and Human Services, as the Defendant in this action. Although the court has substituted the Commissioner for the Secretary in the caption, the text of this Order will continue to refer to the Secretary because she was the appropriate party at the time of the underlying decision.

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The only issue now before the court is whether there is substantial evidence in the record to support the final decision of the Secretary that claimant is not disabled within the meaning of the Social Security Act.<sup>2</sup>

In the case at bar, the ALJ made his decision at the fifth step of the sequential evaluation process.<sup>3</sup> He found that claimant had the residual functional capacity to perform the physical exertional and nonexertional requirements of work, except for lifting greater than 20 pounds at a time, occasionally, or 10 pounds at a time, frequently, or work requiring fine vision. The ALJ concluded that claimant had no

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<sup>2</sup>Judicial review of the Secretary's determination is limited in scope by 42 U.S.C. § 405(g). The court's sole function is to determine whether the record as a whole contains substantial evidence to support the Secretary's decisions. The Secretary's findings stand if they are supported by "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." Richardson v. Perales, 402 U.S. 389, 401 (1971) (citing Consolidated Edison Co. v. N.L.R.B., 305 U.S. 197, 229 (1938)). In deciding whether the Secretary's findings are supported by substantial evidence, the court must consider the record as a whole. Hephner v. Mathews, 574 F.2d 359 (6th Cir. 1978).

<sup>3</sup>The Social Security Regulations require that a five-step sequential evaluation be made in considering a claim for benefits under the Social Security Act:

1. Is the claimant currently working?
2. If claimant is not working, does the claimant have a severe impairment?
3. If the claimant has a severe impairment, does it meet or equal an impairment listed in Appendix 1 of the Social Security Regulations? If so, disability is automatically found.
4. Does the impairment prevent the claimant from doing past relevant work?
5. Does claimant's impairment prevent him from doing any other relevant work available in the national economy?

20 C.F.R. § 404.1520 (1983). See generally, Talbot v. Heckler, 814 F.2d 1456 (10th Cir. 1987); Tillery v. Schweiker, 713 F.2d 601 (10th Cir. 1983).

past relevant work, his residual functional capacity for the full range of light work was reduced by his inability to do work requiring fine vision, he was 37 years old, which is defined as a younger individual, he had a high school education, and he did not have any acquired work skills which were transferable to the skilled or semiskilled work functions of other work. The ALJ found that, although the claimant's additional nonexertional limitations did not allow him to perform the full range of light work, there were a significant number of jobs in the national economy which he could perform, such as cafeteria counter attendant, food preparation, hand packaging, grader/sorter (not small objects), and arcade attendant. Having determined that there were a significant number of jobs in the national economy that claimant could perform, the ALJ concluded that he was not disabled under the Social Security Act at any time through the date of the decision.

Claimant now appeals this ruling and asserts alleged errors by the ALJ:

- (1) The ALJ erred in relying on the medical-vocational guidelines in finding that claimant was not disabled.
- (2) The ALJ failed to consider all of claimant's nonexertional impairments in determining that he could do certain jobs.
- (3) The ALJ erred when he posed an improper question to the vocational expert.

It is well settled that the claimant bears the burden of proving disability that prevents any gainful work activity. Channel v. Heckler, 747 F.2d 577, 579 (10th Cir. 1984).

The claimant met the disability insured status requirements of the Social Security Act on July 15, 1979, the date he stated he became unable to work, and continued to meet them through June 30, 1986, but not thereafter. (TR 21). Therefore, the only evidence that was relevant to the ALJ's decision regarding benefits under §§ 216(i) and 223 was evidence prior to that date, but the evidence up to the date of the Secretary's decision was relevant to the decision regarding supplemental security income.

The claimant has had diabetes mellitus, treated with insulin, diet and exercise, for many years. This has resulted in hemorrhages and cataracts in his eyes and early diabetic renal failure.

Early medical records dated February 7, 1979 showed that claimant's father was instructed to bring claimant in for a blood sugar test. (TR 166). The doctor stated: "If this doesn't straighten out, may hospitalize for evaluation and regulation of diabetes. Father stated that he has preached for years and years for the son to eat a regular diet and take care of his diabetes, but he doesn't do it." (TR 166). In September of 1979, he was hospitalized for an acute intestinal infection and diabetes. (TR 161).

Claimant was hospitalized again in May of 1980 for gastroenteritis after eating a "large and greasy fish meal" and diabetes. (TR 175-177). He told the doctor that he was allergic to seafood. (TR 175). The doctor noted that he had a longstanding family history of diabetes mellitus on both sides of his family and had been taking

insulin since age eleven. (TR 175). He left the hospital against medical advice and was told that he could no longer be a patient as a result. (TR 155).

There are no further records from before June 30, 1986, the date the claimant last met the disability insured status requirements. Claimant was hospitalized in September of 1987 for abdominal cramps, nausea, and vomiting. (TR 184). His doctor reported: "patient states that he has not taken any of his oral medicines . . . for approximately the last 2 weeks . . . . Patient has a longstanding history of noncompliance, periodically forgetting to take his medicine or refusing to take his medication and having multiple E.R. visits and subsequent hospitalizations." (TR 184).

On April 11, 1989, Dr. Robert McBratney reported that claimant's vision was starting to fluctuate with changes in blood sugar. (TR 229). An examination showed acuities of 20/63 in both eyes, healthy extraocular structures and anterior segments in both eyes, a small stromal corneal scar in the left eye, and clear vitreous in the right eye but a cell in the anterior portion of the left vitreous and posteriorly. (TR 229). The posterior segment showed pink optic nerves, but the blood vessels showed venous beading with venous dilation and neovascularization in the temporal arcades, bilaterally. The maculas showed background diabetic retinopathy changes, consisting of microaneurysms and hemorrhages. (TR 229).

Claimant underwent his first laser treatment for proliferative diabetic retinopathy on April 14, 1989. (TR 286). Dr. Christian Hanson put him on a 2000 calorie diet and mild exercise program on April 19, 1989, noting that "his blood sugar

has not been very well controlled. **Recently, within the last two to three days, he has developed 'blocked vision' in his left eye.**" (TR 223). The doctor noted that he was smoking 1 ½ packs of cigarettes daily, had smoked for over 15-16 years, and also occasionally used alcohol and marijuana. (TR 224).

By April 21, 1989, Dr. Hanson reported that claimant's blood sugar was significantly improved "with compliance of diet therapy and insulin program." (TR 216). On May 31, 1989, Dr. McBratney found that claimant's visual acuity was "pinhole to 20/32 and J1, O.U.," and his right eye was stabilized. (TR 228). He had a left eye small vitreous hemorrhage which had occurred recently. (TR 228). When he saw his doctor on July 13, 1989, he reported that his blood sugar was "reasonably well controlled." (TR 212). The doctor emphasized that, while anti-anxiety drugs had been prescribed for him in the past, no more would be prescribed because the doctor did not want to "contribute to his problems with drugs." (TR 212-213). On July 27, 1989, a pan retinal Argon green fundus photocoagulation was performed on his left eye. (TR 190).

Claimant was seen in endocrine follow-up on January 8, 1990. (TR 198). He had received additional laser therapy to his left eye and was anticipating obtaining laser therapy to his right eye. (TR 198). He still had some hazy or blurring vision. (TR 198). Claimant told the doctor that his finger stick blood sugars were "doing all right," but that he was not checking them very often. (TR 198). He had occasional hypoglycemic episodes, but these responded appropriately to therapy, and he had no polydipsia, polyuria, polyphagia, or parenthesis. (TR 198). A physical examination

was essentially normal with the exception of demonstrated significant retinopathy. (TR 198). The doctor concluded that claimant's blood sugar "is only moderately well controlled." (TR 198).

By October 24, 1990, claimant's doctor reported that his visual acuity remained stable at 20/25, O.D.; 20/32, O.S. and he had "no evidence of recurrent disease, and is currently stable." (TR 227). A year later on May 8, 1991, the doctor stated that his visual acuity was stable at 20/32, O.U., "with no evidence of any abnormal neovascularization present." (TR 226). On August 19, 1992, the doctor found that claimant's visual acuity was 20/50 OU, with a pinhole improvement in his left eye to 20/40, but advancing posterior subcapsular cataracts affected both eyes. (TR 226). His diabetic retinopathy was stable in both eyes, and cataract surgery was recommended. (TR 226).

On January 6, 1993, claimant had a Kelman phacoemulsification with intraocular artificial lens implant in his right eye. (TR 231). On February 17, 1993, claimant was seen in follow-up and his corrected acuity OD was 20/30-2 in his right eye and 20/40 in his left eye. (TR 271). He was told to return in six months. (TR 271). He had cataract surgery on June 4, 1993. (TR 270). By September 3, 1993, his visual acuities were 20/50 with pinhole to 20/32 in his right eye and 20/32 in the left. (TR 268). The diabetic retinopathy was stable, but there was subretinal exudate in the perifoveal area of the right eye. (TR 268). The doctor recommended angiography to look at the lesion because of its proximity to center vision and to assure stability. (TR 268).

On March 4, 1994, tests showed normal serum creatines, but urine protein was over twice the normal value. (TR 287). The tests showed that claimant was very near diabetic renal failure and a possible candidate for dialysis within two years. (TR 287). His blood sugar was "chronically elevated i.e. poorly controlled." (TR 287). The doctor concluded that with the disabilities and impending increase in disability, he was not employable and never would be. (TR 287).

There is no merit to claimant's contentions. The ALJ did not rely on the medical-vocational guidelines ("grids") in finding that claimant was not disabled, but only used them as a framework for decisionmaking. (TR 22). The grids were developed by the Social Security Administration to determine a claimant's ability to work by relating his age, education, and job experience with his ability to engage in work in the national economy at various levels of exertion. If a claimant has both exertional and nonexertional impairments, an ALJ must use the guidelines first to determine if the claimant is disabled by reason of the exertional impairment alone, and, if he is not, the ALJ must then make a second individualized determination using the guidelines only as a framework for consideration of how much the individual's work capability is further diminished in terms of jobs that would be contraindicated by the nonexertional limitations. Thompson v. Sullivan, 987 F.2d 1482, 1492 (10th Cir. 1993).

The ALJ properly used the guidelines as a framework in finding that claimant was not disabled. The ALJ found claimant could do light work, except for lifting more than 20 pounds at a time, occasionally, lifting 10 pounds at a time frequently,

or work requiring fine vision. (TR 21). Since claimant was 37 years old, had a high school education, and had no acquired work skills, the grids directed a finding of "not disabled."

The ALJ then relied on the testimony of the vocational expert, who concluded that claimant could perform such jobs as cafeteria counter attendant, food preparation, hand packaging, grader/sorter, and arcade attendant, to find that he was not disabled. (TR 22).

There is also no merit to claimant's contention that the ALJ did not consider all of claimant's non-exertional impairments, such as fatigue, disorientation, vomiting, dehydration, poor circulation, poor grip strength, and shoulder pain, in determining that he could do certain jobs. The ALJ noted that claimant had testified that he had poor circulation, but concluded that it was not severe because there was no evidence of diabetic neuropathy or referral to a neurologist. (TR 19-20). The court can find only medical evidence of stomach problems to support claimant's testimony regarding vomiting and dehydration prior to June 30, 1986, even though claimant testified at the hearing on October 3, 1994, that he was having the other problems in 1979 (TR 42-45, 47-49, 51, 53-54, 56-58, 159-166, 175-177). After June 30, 1986, there is no medical evidence of shoulder problems, disorientation, or poor grip strength.

Finally, there is no merit to claimant's contention that the ALJ erred when he posed an improper hypothetical question to the vocational expert. It is true that "testimony elicited by hypothetical questions that do not relate with precision all of a claimant's impairments cannot constitute substantial evidence to support the

Secretary's decision." Hargis v. Sullivan, 945 F.2d 1482, 1492 (10th Cir. 1991) (quoting Ekeland v. Bowen, 899 F.2d 719, 722 (8th Cir. 1990)). However, in forming a hypothetical to a vocational expert, the ALJ need only include impairments if the record contains substantial evidence to support their inclusion. Evans v. Chater, 55 F.3d 530, 532 (10th Cir. 1995); Talley v. Sullivan, 908 F.2d 585, 588 (10th Cir. 1990).

Initially the ALJ established that the vocational expert had been present for all of the testimony and studied the record. (TR 64). The ALJ was only able to elicit testimony by the vocational expert that claimant could not perform any jobs in the national economy by asking the expert to assume that all of claimant's testimony at the hearing was credible. (TR 68-69). This opinion, based on complaints not reflected in the medical records, was not binding on the ALJ. Gay v. Sullivan, 986 F.2d 1336, 1341 (10th Cir. 1993). It was proper for the ALJ to ask hypothetical questions including only those impairments which were actually supported in the record. Jordan v. Heckler, 835 F.2d 1314, 1316 (10th Cir. 1987).

Claimant is not "blind" as defined by the Social Security Act, which is central visual acuity of 20/200 or less in the better eye after best correction with a lens. 20 C.F.R. Ch. III, Pt. 404, Subpt. P, App. 1, Section 2.02. The court finds it significant that claimant has a long history of non-compliance with his medical treatment. The unjustified refusal of a prescribed course of treatment which can be expected to restore the ability to work is grounds for denial of disability benefits and can be a reason to discredit subjective complaints. Pacheco v. Sullivan, 931 F.2d 695, 697-98

(10th Cir. 1991); Diaz v. Secretary of Health & Human Servs., 898 F.2d 774, 777 (10th Cir. 1990).

In 1979, claimant's doctor noted that he had not properly followed the diet which was crucial to his treatment of diabetes. (TR 166). In May of 1980, he was told that he could not return to his treating physician's clinic because he had left hospital care "against medical advice" while they were attempting to regulate his acute gastroenteritis and diabetes. (TR 155). While he had been hospitalized for nausea after having eaten a greasy fish meal, he stated that he was allergic to seafood. (TR 175-177). In September of 1987, his doctor concluded that he had "a longstanding history of non-compliance, periodically forgetting to take his medicine or refusing to take his medication and having multiple E.R. visits and subsequent hospitalizations." (TR 184). Another report noted that he is a diabetic with somewhat poor compliance on his insulin therapy. (TR 188). In 1989, Dr. Hanson stated that he smoked 1 ½ packs of cigarettes a day and used alcohol and marijuana (TR 224) and Dr. McBratney suggested that he had a drug problem. (TR 212-213).<sup>4</sup>

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<sup>4</sup> It is significant that Public Law Number 104-121, 110 Stat. 847 (1996), was enacted by Congress on March 29, 1996. Section 105 of that law amended certain provisions of the Social Security Act and provides, in pertinent part, that: "[a]n individual shall not be considered to be disabled for purposes of this title if alcoholism or drug addiction would (but for this subparagraph) be a contributing factor material to the Commissioner's determination that the individual is disabled." P.L. No. 104-121, § 105(a)(1). The amendment applies to any individual who applies for, or whose claim is finally adjudicated by the Commissioner of Social Security with respect to, benefits under Title II of the Social Security Act based on disability on or after the date of the enactment of the Act. Thus, if the ALJ or this court determined that drug or alcohol abuse was material to claimant's disability, he would not be considered to be disabled under the new law.

In 1990, claimant admitted that he **did not** check his blood sugars very often. (TR 198).

The decision of the ALJ is **supported** by substantial evidence and is a correct application of the regulations. The decision is affirmed.

Dated this 20<sup>th</sup> day of December, 1996.



JOHN LEO WAGNER  
UNITED STATES MAGISTRATE JUDGE

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IN THE UNITED STATES DISTRICT COURT  
FOR THE NORTHERN DISTRICT OF OKLAHOMA

**FILED**

DEC 20 1996

Phil Lombardi, Clerk  
U.S. DISTRICT COURT

CHARLES ROBERT TAYLOR  
and GEORGIA L. TAYLOR,

Plaintiffs,

vs.

Case No. 95-C-820-B

MARTIN EDWARD GUSS, JR.,  
M.T. FARMS, INC., a foreign  
corporation, MARTIN GUSS,  
d/b/a MARTIN TRUCK REPAIR,  
KEVIN SCHREINER, SUNNY  
ACRES, INC. and NORTHLAND  
INSURANCE COMPANIES,

Defendants.

ENTERED ON RECORD

DATE DEC 23 1996

AMENDED JUDGMENT

Pursuant to the Jury's Verdict herein filed of record on November 21, 1996, and this Court's order of the date hereon, it is hereby **ADJUDGED** and **DECREED** that Plaintiff, Charles Robert Taylor, recover \$93,500.00 in actual damages against the Defendants, Martin Guss, Jr., M.T. Farms, Inc., Martin Guss, doing business as Martin Truck Repair, Northland Insurance Companies, Kevin Schreiner and Sunny Acres, Inc.; and that Plaintiff, Georgia L. Taylor, recover \$63,000.00 in actual damages from said Defendants. Pre-judgment interest at the rate of 9.55 percent per annum from August 23, 1995, until November 21, 1996, is assessed against the Defendants Martin Edward Guss, Jr., M. T. Farms, Inc., Martin Edward Guss, d/b/a Martin Truck Repair and Northland Insurance Companies. Pre-judgment interest is assessed at the rate of 9.55 percent per annum from October 10, 1995, until November 21, 1996, against the Defendants, Kevin Schreiner and Sunny Acres, Inc.

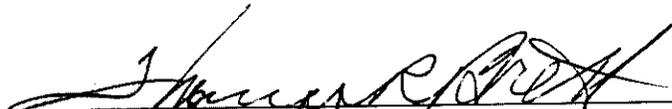
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Post judgment interest is assessed at the rate of 5.49 percent per annum from the date of November 21, 1996, until paid.

It is further ADJUDGED and DECREED that Plaintiffs, Charles Robert Taylor and Georgia L. Taylor, recover nothing from said Defendants by way of their claim for alleged punitive damages and that said Defendants are hereby granted judgment on Plaintiffs' claims for punitive damages.

Costs are assessed against the Defendants and may be awarded upon timely application pursuant to local Rule 54.1. Each party is to pay their own respective attorneys' fees.

IT IS SO ORDERED, this 20<sup>th</sup> day of December, 1996.

  
THOMAS R. BRETT  
UNITED STATES DISTRICT JUDGE

IN THE UNITED STATES DISTRICT COURT  
FOR THE NORTHERN DISTRICT OF OKLAHOMA

**F I L E D**

DEC 20 1996

Phil Lombardi, Clerk  
U.S. DISTRICT COURT

CHARLES ROBERT TAYLOR )  
and GEORGIA L. TAYLOR, )

Plaintiffs, )

vs. )

No. 95-CV-820-B ✓

MARTIN EDWARD GUSS, JR., )  
M. T. FARMS, INC., a foreign )  
corporation, MARTIN GUSS, )  
d/b/a MARTIN TRUCK REPAIR, )  
KEVIN SCHREINER, SUNNY )  
ACRES, INC., and NORTHLAND )  
INSURANCE COMPANIES, )

Defendants. )

ENTERED ON THE CLERK'S  
DEC 23 1996

ORDER

The Court has for decision various post-jury trial motions filed by Defendants. Therein, the Defendants seek the following: (1) to amend the judgment (docket # 82 and 84) regarding the operative pre-judgment interest date to February 19, 1996, instead of August 23, 1995; (2) seek judgment as a matter of law under Fed.R.Civ.P. 50(b) on the issue of punitive damages awarded Plaintiffs (docket #78); and (3) seek a new trial under Fed.R.Civ.P. 59, or in the alternative a remittitur regarding the compensatory damage award to Plaintiff, Georgia L. Taylor in the amount of \$63,000.00 (docket #76 and 80).

- I. Defendants' request to amend the judgment regarding the operative pre-judgment interest date to February 19, 1996, instead of August 23, 1995.

Plaintiffs commenced the action against the Defendants, Martin Edward Guss,

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Jr., and M.T. Farms, Inc., on August 23, 1995. On October 10, 1995, the named Defendants, Martin Edward Guss, Jr., and M.T. Farms, Inc., commenced a third-party action against Kevin Schreiner and Sunny Acres, Inc., seeking indemnity if Third-Party Plaintiffs were determined liable to Plaintiffs. On February 19, 1996, Plaintiffs filed their first amended complaint adding Martin Guss, d/b/a Martin Truck Repair and Northland Insurance Companies, each of whom were in privity with the original Defendants, and also added as parties defendant, the Third-Party Defendants, Kevin Schreiner and Sunny Acres, Inc. The action was clearly commenced as to Martin Edward Guss, Jr., and M.T. Farms, Inc., on August 23, 1995. Additional Defendants, Martin Guss, d/b/a Martin Truck Repair and Northland Insurance Companies, were persons or entities in privity with the original Defendants so application of the pre-judgment interest provisions of Okla. Stat. tit. 12, § 727 should relate back to the original filing date of August 23, 1995. Fed.R.Civ.P. 15(c). As for the Defendants, Kevin Schreiner and Sunny Acres, Inc., they were first joined as Third-Party Defendants on October 10, 1995, and then subsequently named as additional Defendants on February 19, 1996, by Plaintiffs' first amended complaint. Ultimately, all Defendants were found jointly and severally liable to Plaintiffs. Thus, for purposes of pre-judgment interest, the action was commenced under Okla.Stat. tit. 12, § 727 against Martin Edward Guss, Jr., M. T. Farms, Inc., Martin Guss, d/b/a Martin Truck Repair and Northland Insurance Companies on August 23, 1995, and against the Defendants, Kevin Schreiner and Sunny Acres, Inc., on October 10, 1995. See, Land v. Transport Indemnity Company, 791 P.2d 118 (Okla. App. 1990).

Thus, the motion to amend judgment of Martin Edward Guss, Jr., M. T. Farms, Inc., Martin Guss, d/b/a Martin Truck Repair and Northland Insurance Companies regarding pre-judgment interest is hereby denied. Defendants', Kevin Schreiner and Sunny Acres, Inc., motion to amend judgment concerning the pre-judgment interest is hereby granted as stated above.

II. Defendants' Rule 50(b) motion for judgment as a matter of law regarding punitive damages.

Following a review of the record, the Court concludes the punitive damages award should be set aside and Defendants' awarded judgment on Plaintiffs' claim for punitive damages. This is based on the Court's conclusion that Defendants' conduct directly causing the subject accident is properly characterized as negligent, and not conduct characterized as "... wanton or reckless disregard for the rights of another, oppression, fraud or malice, actual or presumed," required for the award of punitive damages under Okla. Stat. tit. 23, § 9 (November 1, 1986). Cox v. Theus, 569 P.2d 447 (Okla. 1977); Galt-Brown Co. v. Lay, 183 Okla. 87, 80 P.2d 567 (1938); Oller v. Hicks, 441 P.2d 356, 360 (Okla. 1967); and Wilson v. Merrell Dow Pharmaceutical, Inc., 893 F.2d 1149, 1154 (10th Cir. 1990).

In other words, regarding Plaintiffs' claim of punitive damages, the Court should have sustained Defendants' motion for a directed verdict at the conclusion of the evidence, and not submitted the issue to the jury.

III. Defendants' motion for a new trial pursuant to Fed.R.Civ.P. 59, or in the alternative, a remittitur, concerning Plaintiff, Georgia L. Taylor's award of \$63,000.00 in

compensatory damages.

The evidence revealed that when driver Guss, Jr., negligently lost control of his tractor semi-trailer on the wet, slushy snow bridge surface, a violent collision ensued when it struck the Volkswagen in which Georgia L. Taylor was a passenger. As a result, she suffered massive bruises and contusions of her head, face, and body. The photographs in evidence clearly reflect the seriousness of her traumatic experience. She incurred medical expenses of \$2,554.00. She made no claim for permanent disability but the jury could infer considerable mental and physical pain and anguish, as well as temporary disability, from the objective injuries revealed by the photographic evidence. The Court instructed the jury under Oklahoma law that in arriving at a reasonable sum of compensatory damages for the Plaintiff, Georgia L. Taylor, it could consider her past medical expenses, past physical pain and suffering, past mental pain and suffering, her age, her physical condition before and after the accident, the nature and extent of her injuries, as well as any loss of consortium she might have sustained as a result of injuries to her spouse, the Plaintiff, Charles Robert Taylor. (Oklahoma Uniform Jury Instructions 4.1 and 4.7). The Court is of the view that the award of \$63,000.00 compensatory damages to the Plaintiff, Georgia L. Taylor, is not unreasonable under the facts and circumstances presented in this record. Therefore, Defendants' motion for new trial or in the alternative, a remittitur, is hereby overruled.

The Court will enter an Amended Judgment in keeping with the above.

IT IS HEREBY SO ORDERED this 20<sup>th</sup> day of December, 1996.



THOMAS R. BRETT  
UNITED STATES DISTRICT JUDGE

IN THE UNITED STATES DISTRICT COURT FOR THE  
NORTHERN DISTRICT OF OKLAHOMA

**F I L E D**

PATSY G. REDFEARN, )  
)  
Plaintiff, )  
)  
v. )  
)  
SHIRLEY S. CHATER, )  
COMMISSIONER OF SOCIAL )  
SECURITY,<sup>1</sup> )  
Defendant. )

DEC 20 1996

Phil Lombardi, Clerk  
U.S. DISTRICT COURT

Case No. 94-C-1063-W

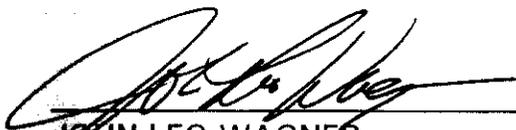
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DATE 12/23/96

**ORDER**

This case is remanded to the agency for further development of the record. The ALJ should consider whether Ms. Redfearn suffers from an affective disorder or a nonexertional mental impairment. Her mental impairments, if any, must then be evaluated in combination with her physical impairments and any nonexertional limitations. The ALJ should consider her mental impairments, if any, in completing the PRT form, in evaluating her residual functional capacity, and, if necessary, in framing a revised hypothetical question to the vocational expert.

Dated this 20<sup>th</sup> day of December, 1996.



JOHN LEO WAGNER  
UNITED STATES MAGISTRATE JUDGE

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<sup>1</sup>Effective March 31, 1995, the functions of the Secretary of Health and Human Services in social security cases were transferred to the Commissioner of Social Security. P.L. No. 103-296. Pursuant to Fed.R.Civ.P. 25(d)(1), Shirley S. Chater, Commissioner of Social Security, is substituted for Donna E. Shalala, Secretary of Health and Human Services, as the Defendant in this action. Although the court has substituted the Commissioner for the Secretary in the caption, the text of this Order will continue to refer to the Secretary because she was the appropriate party at the time of the underlying decision.

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IN THE UNITED STATES DISTRICT COURT FOR THE  
NORTHERN DISTRICT OF OKLAHOMA

**F I L E D**

PATSY G. REDFEARN,

Plaintiff,

v.

SHIRLEY S. CHATER,  
COMMISSIONER OF SOCIAL  
SECURITY,

Defendant.

DEC 20 1996

Phil Lombardi, Clerk  
U.S. DISTRICT COURT

Case No. 94-C-1063-W

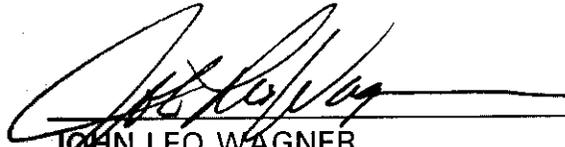
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DATE 12/23/96

**JUDGMENT**

Judgment is entered in favor of the plaintiff, Patsy G. Redfearn, in accordance with this court's Order filed December 20, 1996.

Dated this 20<sup>th</sup> day of December, 1996.



JOHN LEO WAGNER  
UNITED STATES MAGISTRATE JUDGE

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ENTERED ON DOCKET

DATE 12/23/96

IN THE UNITED STATES DISTRICT COURT FOR THE  
NORTHERN DISTRICT OF OKLAHOMA

WARREN C. CHAPPELL,

Plaintiff,

v.

SHIRLEY S. CHATER,  
COMMISSIONER OF SOCIAL  
SECURITY,

Defendant.

**F I L E D**

DEC 20 1996

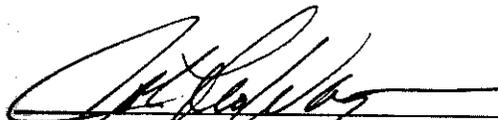
Phil Lombardi, Clerk  
U.S. DISTRICT COURT

Case No. 94-C-9-W ✓

**JUDGMENT**

Judgment is entered in favor of the plaintiff, Warren C. Chappell, in accordance  
with this court's Order filed December 20<sup>th</sup>, 1996.

Dated this 28<sup>th</sup> day of December, 1996.



JOHN LEO WAGNER  
UNITED STATES MAGISTRATE JUDGE

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ENTERED ON DOCKET

DATE 12/23/96

IN THE UNITED STATES DISTRICT COURT FOR THE  
NORTHERN DISTRICT OF OKLAHOMA

**F I L E D**

DEC 20 1996

Phil Lombardi, Clerk  
U.S. DISTRICT COURT

WARREN C. CHAPPELL, )  
)  
Plaintiff, )  
v. )  
)  
SHIRLEY S. CHATER, )  
COMMISSIONER OF SOCIAL )  
SECURITY,<sup>1</sup> )  
Defendant. )

Case No. 94-C-9-W ✓

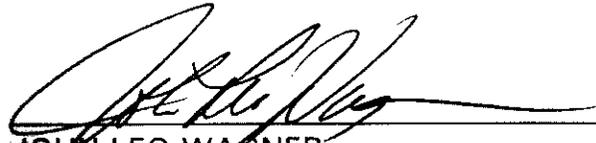
**ORDER**

This case is remanded to the agency for further development of an adequate record and to make the required findings about the pertinent demands of plaintiff's past relevant work. The ALJ may elicit information about the demands of the past work from a variety of sources, such as information from plaintiff about the demands of his work as he actually performed it, information supplied by a vocational expert, or information contained in the Dictionary of Occupational Titles concerning the demands of such work as it is generally performed in the national economy. The ALJ should clearly indicate the source of the information upon which he relies in making the required findings. Because the record contains several references to the MMPI that plaintiff took, the results of which may reflect a mental impairment, the ALJ is also to make reasonable efforts to obtain the results of the MMPI.

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<sup>1</sup>Effective March 31, 1995, the functions of the Secretary of Health and Human Services in social security cases were transferred to the Commissioner of Social Security. P.L. No. 103-296. Pursuant to Fed.R.Civ.P. 25(d)(1), Shirley S. Chater, Commissioner of Social Security, is substituted for Donna E. Shalala, Secretary of Health and Human Services, as the Defendant in this action. Although the court has substituted the Commissioner for the Secretary in the caption, the text of this Order will continue to refer to the Secretary because she was the appropriate party at the time of the underlying decision.

Dated this 20<sup>th</sup> day of December, 1996.

A handwritten signature in black ink, appearing to read "John Leo Wagner", written over a horizontal line.

JOHN LEO WAGNER  
UNITED STATES MAGISTRATE JUDGE

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12-23-96

IN THE UNITED STATES DISTRICT COURT  
FOR THE NORTHERN DISTRICT OF OKLAHOMA

CRAIG W. HUNTLEY, )  
)  
Plaintiff, )  
)  
vs. )  
)  
BALL-FOSTER GLASS CONTAINER )  
CO., L.L.C., a Delaware )  
Corporation, )  
)  
Defendant. )

No. 96-C-890-K

**FILED**

DEC 20 1996

Phil Lombardi, Clerk  
U.S. DISTRICT COURT

**FILED**

DEC 20 1996

Phil Lombardi, Clerk  
U.S. DISTRICT COURT

**ORDER**

Before the Court is the motion of the Plaintiff to remand proceedings to state court pursuant to 28 U.S.C. § 1447.

Plaintiff commenced this action on August 30, 1996 by filing a petition in the District Court of Creek County, Oklahoma. The facts of the petition allege that Plaintiff was terminated from his employment in violation of Oklahoma public policy, and that his termination constituted a breach of contract. Plaintiff demanded in excess of \$10,000 in compensatory damages. Plaintiff additionally asserted that the Defendant's conduct was such that he was entitled to exemplary damages in excess of \$10,000.

Defendant removed the claim to federal court asserting that the amount in controversy "upon information and belief" exceeded \$50,000. Plaintiff disputes that the amount in controversy meets the jurisdictional requirements of diversity jurisdiction, and filed a motion to remand.

To address the Plaintiff's motion, the Court must determine three issues: (1) who bears the burden of establishing the amount in controversy; (2) what level of proof is required; and (3) whether

the amount in controversy meets the jurisdictional prerequisite.

Initially, the Court notes the presumption against removal jurisdiction. *Laughlin v. Kmart Corp.*, 50 F.3d 871, 873 (10th Cir. 1995). Because of this presumption, the party seeking removal bears the burden of establishing that removal is proper, thus the burden in this motion is to be borne by the Defendant. *Id.*

The burden of proof applied in removal actions depends upon whether or not the plaintiff has specified an amount of damages to which he claims entitlement. In this case, Plaintiff has not enumerated a particular figure, but rather has merely stated that the damages sought exceed \$20,000. When a plaintiff fails to specify damages, courts have applied varying standards with regard to a defendant's burden of proof to establish jurisdiction. Some courts have required Defendant's to show to a legal certainty that the amount exceeds \$50,000. *See*, Charles A. Wright, *et al.*, 14A *Federal Practice and Procedure* 180 (West Supp. 1996) and cases cited therein. Others demand that a defendant prove that the jurisdictional requirement is met by a preponderance of the evidence. *Id.* A third standard merely imposes upon a defendant the obligation to show a reasonable probability that the damages will exceed \$50,000. *Id.* In addition to these standards, some courts apply no standard at all, or adhere to a standard which requires that a defendant show that it does *not* appear to a legal certainty that the amount in controversy falls below the jurisdictional amount required. This is sometimes referred to as the "inverted legal certainty" standard. *Id.*

Defendant here urges the Court that "it must appear . . . to legal certainty that the claimed amount is less than the required jurisdictional amount" citing *Perrin v. Tenneco Oil Co.*, 505 F. Supp.

23, 25 (W.D. Okla. 1980).<sup>1</sup> The Defendant thus either appears to be requesting that this Court place the burden upon the Plaintiff to prove that the amount in controversy does not meet the jurisdictional prerequisite, or, at the very least, the Defendant is seeking application of the inverted legal certainty standard.

This issue has recently been addressed by a number of federal appellate courts. Of particular note is *Sanchez v. Monumental Life Ins. Co.*, 95 F.3d 856 (9th Cir. 1996), which addressed the applicability of the legal certainty test in cases where the plaintiff's complaint is not specific as to amount of damages. The *Sanchez* court determined that the legal certainty test, which is derived from the Supreme Court case, *St. Paul Mercury Indem. Co. v. Red Cab Co.*, 303 U.S. 283, 288-90, 58 S. Ct. 586, 590-91, 82 L.Ed. 845 (1938), applies only in two types of cases: (1) those which are initially brought in federal court in which the plaintiff has alleged to have met the jurisdictional amount in controversy; and (2) those brought in state court where the plaintiff has alleged an amount in excess of the jurisdictional minimum for federal court jurisdiction. *Sanchez*, 95 F.3d at 860. Other federal appellate courts have agreed with this analysis. See, *Tapscott v. MS Dealer Serv. Corp.*, 77 F.3d 1353, 1357 n.8 (11th Cir. 1996); *De Aguilar v. Boeing Co.*, 47 F.3d 1404, 1409 (5th Cir. 1995) cert. denied, — U.S. —, 116 S. Ct. 180, 133 L.Ed.2d 119 (1995); *Gafford v. General Elec. Co.*, 997 F.2d 150, 160 (6th Cir. 1993). Likewise, the *Sanchez* court rejected the inverse legal certainty standard on the grounds that such a standard would unnecessarily expand federal diversity jurisdiction. *Sanchez*, 95 F.3d at 861. Indeed, the federal appellate courts addressing the issue of the proper standard to apply have concluded that the proper balance between a plaintiff's choice of forum and

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<sup>1</sup>The *Perrin* court relies on *St. Paul Mercury Indemnity Co. v. Red Cab Co.*, 303 U.S. 283, 58 S. Ct. 586, 82 L.Ed. 845 (1938) and *A.C. McKoy, Inc. v. Schorwald*, 341 F.2d 737 (10th Cir. 1965) in applying the legal certainty standard.

a defendant's right to remove is properly struck by requiring the defendant to prove that the jurisdictional prerequisite is met by a preponderance of the evidence. *See, Tapscott*, 77 F.3d at 1357. This Court agrees, and adopts the reasoning of the cases cited above. The Defendant in this case must establish that it is more likely than not that the Plaintiff's claim for relief exceeds \$50,000 in damages.

The amount in controversy is usually determined by the allegations in the complaint, or where they are not dispositive, by the allegations in the notice of removal. *Laughlin*, 50 F.3d at 873. The Defendant must produce facts in support of the assertion that the Plaintiff's claim exceeds \$50,000, and must go beyond mere conclusory allegations that the complaint exceeds such amount. *Id.*; *see also, Asociacion Nacional de Pecaodores a Qequena Escala O Artesnales de Colombia v. Dow Quimica de Columbia S.A.*, 988 F.2d 559, 566 (5th Cir. 1993) (finding that the defendants had not met their burden where they offered only a conclusory statement in their notice of removal that was not based on direct knowledge that the plaintiff's claim exceeded \$50,000); *Shaw v. Dow Brands, Inc.*, 994 F.2d 364 (7th Cir. 1993) (declining to remand for further fact-finding where defendant's "good faith belief" that the amount in controversy exceeded \$50,000 was not disputed by the plaintiff).

In this case, the Defendant avers that the Plaintiff's claim meets the jurisdictional prerequisite because Oklahoma Uniform Jury Instructions ("OUJI") allow recovery in wrongful discharge cases for back pay, future earnings, and emotional distress. Defendants have provided evidence that the Plaintiff's monthly salary at the time he was terminated was \$4,570.00 per month, and thus claim that

an award of back pay alone would meet the jurisdictional amount in controversy.<sup>2</sup> While this claim appears compelling at first glance, a thorough reading of the applicable OUII indicates that any award of back pay or future pay must be reduced by the amount the Plaintiff has earned since his discharge. Given the want of evidence on the record regarding the Plaintiff's loss of income or lack thereof, there is really no evidence, beyond speculation, of *what* Plaintiff's damages might be.

The Court finds that Defendant has not established by a preponderance of the evidence that the amount in controversy exceeds \$50,000. This Court is without jurisdiction in this matter.

For the foregoing reasons, the Motion to Remand is hereby GRANTED without prejudice. Pursuant to 28 U.S.C. § 1447(c), this action is hereby remanded to the District Court of Creek County, State of Oklahoma.

ORDERED this 19<sup>th</sup> day of DECEMBER, 1996.

  
TERRY C. KERN  
UNITED STATES DISTRICT JUDGE

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<sup>2</sup> Defendant additionally indicates that the average recovery in employment cases from April 1995 to March 1996 as determined from a survey of Oklahoma Trial Reports exceeds the jurisdictional amount. The Court declines to review these reports as supporting Defendant's burden. Indeed, if the Court were to consider such evidence, it is apparent that the reports do nothing to support the Defendant's assertions. Of the fourteen employment-related cases cited, six resulted in Plaintiff's verdicts of less than \$50,000, seven resulted in verdicts in excess of \$50,000, and one resulted in a defense verdict. This hardly establishes that it is more likely than not that the Plaintiff's claim is worth the jurisdictional amount in controversy.

**UNITED STATES DISTRICT COURT FOR THE  
NORTHERN DISTRICT OF OKLAHOMA**

JERRY FULTZ,

Plaintiff,

vs.

SHIRLEY S. CHATER, Commissioner of the  
Social Security Administration,

Defendant.

ENTERED ON DOCKET

DATE 12/23/96

Case No. 96-CV-570-J ✓

**F I L E D**

DEC 20 1996 *SL*

Phil Lombardi, Clerk  
U.S. DISTRICT COURT

**ORDER**

On June 25, 1996, Plaintiff filed this Social Security Appeal, pursuant to 42 U.S.C. § 405(g). On November 13, 1996, the Commissioner filed an out of time motion to remand this case so that the Commissioner could locate Plaintiff's claim file. Plaintiff did not object. The Court granted the motion to remand on November 14, 1996. The Court remanded the case to the Commissioner and Ordered that the Commissioner inform the Court within 30 days, whether Plaintiff's claim file had been found. [Doc. No. 7].

Plaintiff filed its "Answer and Motion to Withdraw Motion to Remand" on December 11, 1996. [Doc. No. 8]. The Commissioner requests that the Court withdraw her motion to remand because the claim file has been located. The Court cannot withdraw a motion to remand that has already been granted. The Commissioner's motion to withdraw is, therefore, **DENIED**. [Doc. No. 8].

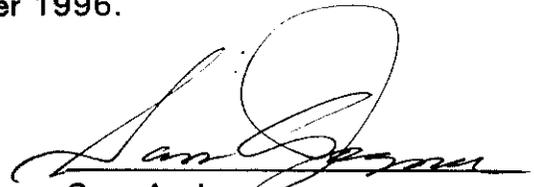
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The Court will treat the Commissioner's motion to withdraw as the response required by the Court's November 14, 1996 Order. This case shall be reopened and it shall proceed in accordance with the following schedule:

1. Within sixty (60) days from the date the Commissioner's Answer and the transcript were filed, Plaintiff shall file a brief which shall comply with the following:
  - A. **CONTENTS**
    - Section I:** Concise Statement of Facts.
    - Section II:** List each specific error relied upon with specific reference to related transcript page(s). Case citations to very recent cases of which the court may not yet be aware, and cases which are directly or closely on point with respect to a specifically alleged error.
    - Section III:** A description of the relief sought.
  - B. **FORMAT** -- Briefs shall not exceed five (5) pages, exclusive of the signature block and certificate of service.
2. Within sixty (60) days after the filing of Plaintiff's brief, the Commissioner shall file a response brief complying with the above requirements. This brief must respond to Plaintiff's claimed errors and relief sought.

IT IS SO ORDERED.

Dated this 20 day of December 1996.

  
Sam A. Joyner  
United States Magistrate Judge