ATTACHMENT A

THE PROPOSED DECISION

BEFORE THE
BOARD OF ADMINISTRATION
CALIFORNIA PUBLIC EMPLOYEES' RETIREMENT SYSTEM
STATE OF CALIFORNIA

In the Matter of the Appeal of Reinstatement

from Industrial Disability Retirement of:

JACQUELYN K. VANZANT, Respondent,

and CALIFORNIA CORRECTIONAL INSTITUTION, CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION, Respondent.

Agency Case No. 2023-0841

OAH No. 2023120564

PROPOSED DECISION

Julie Cabos-Owen, Administrative Law Judge (ALJ), Office of Administrative Hearings (OAH), State of California, heard this matter by videoconference on February 15, 2024. Sharon Hobbs (Complainant), Chief of the Disability and Survivor Benefits Division, California Public Employees' Retirement System (CalPERS), was represented by Bryan R. Delgado, Staff Attorney. Jacquelyn K. Vanzant (Respondent) represented herself. Angela Witworth represented the California Correctional Institution, California Department of Corrections and Rehabilitation (CDCR).

Testimony and documents were received in evidence. The record closed and the matter was submitted for decision on February 15, 2024.

FACTUAL FINDINGS

Parties

1. Complainant filed the Statement of Issues in her official capacity as Chief of the Disability and Survivor Benefits Division of CalPERS.

2. Respondent was employed by CDCR as a Supervising Correctional Cook (SCC). By virtue of her employment, Respondent is a safety member of CalPERS.

Procedural Background

3. On February 5, 2018, Respondent signed and subsequently filed an application for industrial disability retirement based on neurological (migraines and cervical spine) conditions.

4. By letter dated September 18, 2018, CalPERS informed Respondent and CDCR that Respondent was approved for industrial disability retirement based on her neurological conditions.

5. Respondent retired for industrial disability in 2018.

6. The Accusation, paragraphs IV and V, alleges the following procedural facts which were uncontested by Respondent:

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> By letter dated September 23, 2020, CalPERS informed Respondent her industrial disability retirement benefits were under review to determine if she continued to meet the qualifications to receive industrial disability retirement benefits.
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> By letter dated June 23, 2021, CalPERS informed Respondent that it had determined she continued to be disabled or incapacitated from the performance of her duties as an SCC on the basis of a neurological (migraine headache) condition.

(Exhibit 1, p. A2.)

7. By letter dated July 12, 2022, CalPERS informed Respondent her industrial disability retirement benefits were under review to determine if she continued to meet the qualifications to receive industrial disability retirement benefits. The letter instructed Respondent to provide specified information to CalPERS by August 11, 2022, including documentation from the physician(s) treating her neurological condition.

8. By letter dated August 12, 2022, CalPERS informed Respondent her industrial disability retirement benefits remained under review. The letter reminded Respondent she had not provided the required information to CalPERS by August 11, 2022, including medical records and a current re-evaluation of her neurological condition by her treating physician.

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9. On February 15, 2023, Respondent underwent an independent medical examination (IME) with William Hammesfahr, M.D. Respondent was 35 years old on that date. Dr. Hammesfahr issued an IME report following the IME.

10. CalPERS received medical reports concerning Respondent's neurological (migraines and related cervical spine) condition from various medical personnel, including Dr. Hammesfahr. After review of the reports, CalPERS determined that Respondent is no longer disabled or incapacitated from the performance of her duties as an SCC.

11. By letter dated March 27, 2023, CalPERS notified Respondent and CDCR of its determination and informed both parties of their right to appeal this determination.

12. By letter dated April 13, 2023, Respondent filed a timely appeal and requested an administrative hearing.

13. This appeal is limited to the issue of whether Respondent remains substantially incapacitated from the performance of her usual duties as an SCC for CDCR due to neurological (migraines and related cervical spine) condition.

Job Description and Physical Requirements

14. According to the SCC Essential Functions List, Respondent was responsible for "planning, organizing, and supervision of the rank-and-file food service staff, [and] service of food to inmates in the correctional facility." (Exhibit 13, p. A87.) The SCC is required to perform essential functions under extreme emergency conditions, including lockdown, escape, and catastrophic natural disaster. The list of essential functions included: moving around the institution grounds on varied surfaces

and grades throughout the day; pushing and pulling carts to load and transport food; opening and closing heavy gates/doors; loading and unloading trays, pots, pans, canned goods, and other items from various sources; lifting, carrying, and moving items such as culinary utensils and food items. (*Ibid.*) An SCC also:

> Must have mental capacity to be aware and alert, at all times, in order to be aware of surroundings while working in a correctional setting around inmates;
>
> Maintains order and supervises the conduct of inmates;
>
> Protects and maintains the safety of persons and property;
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> Prevents escapes and injury by inmates to themselves or others or to property; Maintains security of working areas and work materials;
>
> Inspects premises and searches work areas and inmates for contraband, such as weapons or illegal drugs;
>
> Must have and maintain sufficient strength, agility and endurance to perform during stressful (physical, mental and emotional) situations without compromising health and well-being of self or others;
>
> Must remain alert, focused to effectively evaluate and respond to dangerous or emergency situations to detect danger; may involve physical defense of self or others[.]

(Exhibit 13, p. A87.)

15. According to a CalPERS document entitled "Physical Requirements of Position/Occupational Title," which Respondent and her supervisor completed on November 22, 2017, the physical requirements of Respondent's job as an SCC included frequent (three to six hours) standing and walking. The physical requirements also included occasional (up to three hours): walking on uneven ground; exposure to excessive noise; exposure to dust, gas, fumes, or chemicals; squatting; bending at the neck and waist; twisting at the neck and waist; reaching above and below the shoulder; pushing and pulling; power grasping; and lifting and carrying up to 50 pounds.

History of Injury and Pre-Retirement Treatment

16. The incident giving rise to Respondent's disability status occurred on December 16, 2015. While escorting two inmate workers from the kitchen to the laundry, Respondent slipped on black ice, fell to the ground, and hit the back of her head. Immediately thereafter, she experienced right leg pain, left hand pain and numbness, head and neck pain, and tinnitus. She tried to remain at work but after vomiting twice, she went home. She eventually went to the hospital where a CT scan of her head was performed. She was diagnosed with a concussion.

17. Respondent continued to experience chronic headaches, sensitivity to light, tinnitus, and numbness in her left hand.

18. Respondent's post-injury, pre-retirement treatment records (12/26/15 – 9/18/18) were not submitted in evidence. In his IME Report, Dr. Hammesfahr summarized the treatment records he reviewed. Since Dr. Hammesfahr's summary did not apparently contain direct quotes from those records, it is unclear what Respondent's treating doctors specifically stated in those records. However, the

summary of Respondent's post-injury treatment set forth below provides a general background regarding her condition prior to her industrial disability retirement.

19. According to Dr. Hammesfahr's summary, on November 28, 2017, Respondent's physician, Rahila Tricia Andrews-Steele, M.D., treated Respondent for ongoing headache and vision change. Dr. Andrews-Steele diagnosed Respondent with post-concussion syndrome, headache, vision disorder, cervical radiculopathy, neck muscle strain, and left shoulder pain. Dr. Andrews-Steele found Respondent to be "substantially permanently incapacitated from performance of the usual duties of the position for their current employer." (Exhibit 11, p. A73.)

20. According to Dr. Hammesfahr's summary, on January 19, 2018, Dr. Andrews-Steele re-examined Respondent, who reported an increase in vertigo, severe migraines twice per week to once every two weeks, and neck pain that was aggravated by noise and relieved by medication. At that time Respondent was using ice packs for prevention and relief, and medication including butalbital, which she prefers over sumatriptan. She had previously received two cervical epidural steroid injections (CESI). Dr. Andrews-Steel's treatment plan included: "Propranolol dose 80 mg a day, Imitrex or Fioricet as needed for acute migraine, Effexor for mood, amitriptyline and naproxen daily for pain. Follow up with . . . Pain Management for possible third CESI. Home exercise program for left shoulder per [physical therapist]. Vision – time, glasses, Neurology evaluation." (Exhibit 11, p. A74.)

21. According to Dr. Hammesfahr's summary, on April 12, 2018, Dr. Andrews-Steele re-examined Respondent who reported that she was beginning to wake up with migraines again. She was sore after traveling the prior day, and she requested a Toradol injections. Respondent understood she may need to continue medication indefinitely, but she was interested in weaning due to the possibility of becoming

pregnant. Dr. Andrews-Steele diagnosed Respondent with headache, vision disorder, post-concussion syndrome, left shoulder joint pain, neck muscle strain, and left scapulalgia. Dr. Andrews-Steel's treatment plan included: propranolol, Imitrex (brand name for generic sumatriptan) or Fioricet as needed for acute migraine, Effexor (brand name for generic venlafaxine) for mood, amitriptyline and naproxen daily for pain, butalbital-acetaminophen-caffeine, and a ketorolac injection.

22. According to Dr. Hammesfahr's summary, on June 11, 2018: Dr. Andrews-Steele re-examined Respondent who rated her neck pain as 5/10, which had increased from 3/10 at the last appointment, and described it as a dull ache to throbbing several times per week since her injury. Dr. Andrews-Steele diagnosed Respondent with headache, vision disorder, post-concussion syndrome, left shoulder joint pain, neck muscle strain, and left scapulalgia. Dr. Andrews-Steel's treatment plan included propranolol, Effexor (brand name for generic venlafaxine) for mood, amitriptyline and naproxen daily for pain, butalbital-acetaminophen-caffeine, and camphor-methyl-salicylate menthol topical patch. Respondent was to follow up with pain management doctor and would request a third CESI. Respondent started physical therapy for vertigo.

Pre-Retirement IME

23. According to Dr. Hammesfahr's summary, on August 11, 2018, David Pingitore, Ph.D., conducted a Neuropsychological IME of Respondent. At that time, Respondent complained of: short-term memory problems including problems with concentration, recall of information, and problems such as a traveling in the community; neurological symptoms including dizziness and vertigo; tinnitus, which is described as persistent ringing in her ears; executive function problems or everyday solving problems including distractibility and difficulty with multitasking; migraine

symptoms which are persistent, once or twice per week, which included problems with vision, tinnitus, dizziness, and vomiting; and anxiety attacks and/or symptoms of panic resulting from migraine episodes. Dr. Pingitore diagnosed Respondent with Mild Neurocognitive Disorder due to Traumatic Brain Injury and Adjustment Disorder with mixed anxiety and depressed mood. He found Respondent permanently incapacitated based on her diagnosed conditions.

Post-Retirement IMEs and Treatment

24. After Respondent retired for disability, CalPERS informed her in September 2020 that her industrial disability retirement benefits were under review to determine if she continued to meet the qualifications to receive industrial disability retirement benefits.

25. On November 23, 2020, Penelope S. Suter, OD, examined Respondent. On February 22, 2021, Charles Filanosky, Jr., Ph.D., conducted a Neuropsychological IME. On May 26, 2021, Perminder Bhatia, M.D., conducted a Neurological IME.

26. According to Dr. Hammesfahr's summary, Dr. Bhatia noted Respondent's back, shoulder, and arm pain had improved slowly with physical therapy. Tinnitus and cervical injury and had improved but were not fully resolved. However, Respondent's daily headaches were not subsiding. Respondent complained of pain on the back of her head, throbbing pain on the top of her head, light sensitivity, and aversion to loud sounds. Her pain ranged from 3/10 to 8/10, with two to three days in the severe range. Her daily headaches caused eye fatigue, inability to focus, and occasional vomiting. Respondent reported her symptoms were sometimes so severe she had to remain in bed. Respondent reported taking multiple medications without any relief. She was being prescribed propranolol and Effexor (venlafaxine), and she had been taking over-

the-counter naproxen. However, at the time of evaluation, Respondent was taking only over-the-counter magnesium and prenatal vitamins because she was pregnant.

27. According to Dr. Hammesfahr's summary, Dr. Bhatia answered questions posed by CalPERS regarding Respondent's disability status at that time. Dr. Bhatia noted that Respondent's vertigo, memory loss, and vision had improved, and she did not have any nerve damage. However, she had some disc impairment in the cervical region. Physical examination revealed tenderness in the right cervical area. Respondent's history was consistent with somebody having continuous migraine headaches which are possible after traumatic brain injury. Dr. Bhatia opined Respondent could not function in the presence of the continuous migraines, and at that time, the incapacity seemed to be permanent.

28. According to Dr. Hammesfahr's summary, Dr. Bhatia also opined as follows: Respondent did not receive all possible effective preventative medications to treat her headaches, and at the time of the evaluation, she was pregnant and could not take any medications. If Respondent was given proper treatment, her incapacity may be temporary and may not be permanent. She should be considered temporarily incapacitated for about 15 months -- three months for her pregnancy and one year to undergo recommended treatments -- then be re-evaluated. New medications could include CGRP inhibitors, Botox, and occipital nerve blocks.

29. In June 2021, after re-evaluating Respondent's industrial retirement benefits, CalPERS informed Respondent that she continued to be incapacitated from the performance of her duties as a SCC on the basis of a neurological (migraine headache) condition. The letter did not specifically address Respondent's related cervical spine condition. However, according to Dr. Bhatia's summary, that condition

had improved. Nevertheless, it remained an occasional trigger for Respondent's migraines.

30. According to Dr. Hammesfahr's summary, on August 25, 2022, Dr. Andrews-Steele issued a Physician's Report on Disability, diagnosing Respondent with post-concussion syndrome, vision disorder, bilateral subjective tinnitus, neck pain, cervical spine pain, left shoulder joint pain, and left scapulalgia. Dr. Andrews-Steele found Respondent was substantially permanently incapacitated from performance of her usual duties.

Dr. Hammesfahr's IME and Testimony

31. Dr. Hammesfahr conducted the February 15, 2023 IME of Respondent at the request of CalPERS. He also testified at the hearing as CalPERS's expert witness, and he expounded on the IME findings and opinions set forth in his report as detailed below.

32. In his IME Report, Dr. Hammesfahr documented Respondent's reported state of injury as follows:

> Her current headache[s] are severe right-sided temple headache and originate on the left temple. She also has right occipital nerve distribution pain. The pain is often blinding, and she has trouble getting out of bed……. The headaches are present all the time, but with episodes of severe spiking pain with minimal activity like playing with the kids, but at other times, comes without warning.

She is currently raising three children, and does all the activities with her kids, including meal prep, etc. She uses blackout curtains at her house, she avoids socializing with friends or family as those activities causes headaches. She "preps" for meeting people outside of the house, like drinking water, not overly exerting herself prior to leaving the house. She starts to "prep" herself the week before expected activities. She is also careful to plan her schedule around weather and barometric pressure changes as these trigger her headaches.

The severe headaches are 10/10 and she wants to go to the hospital. She has not gone to the hospital or urgent care in the last year as she states that it is pointless to go to the ER. She has trouble getting there with three children. There is an Urgent Care 90 minutes away associated with Kaiser, and this is farther than the hospital.

[Respondent] states that going outside causes pain due to brightness of lights. She states that she [has not gone] to grocery stores for the last two years, as the noise and fluorescent lights triggers migraines. She does not drive more than an hour as it otherwise triggers migraines.

Her balance is not a problem as long as she does not move quickly. She cannot do bicycles, trampolines, and swing sets as they trigger dizziness. She used to fall to the right, but

this is no longer a problem, and she has not fallen in the last year.

She often wakes up at night, frequently with a headache. She currently sleeps only 3 hours per night. (She goes to bed at 9PM and wakes up at 8AM, but fitness/sleep tracker identifies that she actually only sleeps three hours per night.)

[Respondent] has pain in both sides of her jaw with tension and "locking" of her jaw. She has not seen a doctor for this problem. This has been present all along. She does not eat cereal as it triggers her headaches as well as "locking" up her jaw.

Neck pain causes increased migraines.

Concentration and memory have improved over the last couple of years, but is poor when she has a migraine. [¶]

Activities that tighten her neck and shoulder muscles trigger headaches, such as sweeping, mopping, trying to clean windows, putting dishes away over her head, etc. She notes that her neck pain is generally a 6/10, aggravated by bending, twisting, lifting, etc. She also notes that she did try a cervical steroid trigger point injection and that helped her pain..... She denies symptoms of concussion including irritability, memory loss (except episodically with her

migraines), balance disorder (except episodically with her migraines), etc.

(Exhibit 11, pp. A71, A72.)

33. Dr. Hammesfahr's examination of Respondent yielded results he described as normal. At the time of the examination, Respondent complained of a bad headache, and she demonstrated some light sensitivity (e.g. squinting), which is typical with migraines. However, she was not wearing sunglasses to avoid the light in his office, did not ask to have the lights turned off, and she had no problem with the flashlight beams aimed at her eyes during the examination. Dr. Hammesfahr noted Respondent was able to sit and to stand for over 10 minutes without discomfort or having to change position. Her cognition and reflexes were normal, and she did not demonstrate any dizziness or loss of balance. Given the findings, Dr. Hammesfahr determined Respondent was experiencing only very minor symptoms in his office.

34. Dr. Hammesfahr explained that there is a difference between migraines and headaches. He acknowledged that a headache can be a symptom of a migraine. However, a migraine is a condition where blood vessels narrow and reduce blood flow to the brain. As a migraine progresses, blood pressure and pulse increase, balance and reflexes are affected, and the patient may experience headache and vertigo. Given these changes, a patient experiencing a migraine develops abnormal neurological findings detectable on examination. However, Respondent did not have the progression or neurological symptoms to corroborate her having a migraine. Dr. Hammesfahr determined Respondent's condition was not severe.

35. In his report, Dr. Hammesfahr listed Respondent's "current medications" as "Venlafaxine 2 per day for migraine and mood disorder. Propranolol. 2 per day for

migraines." (*Id.* at p. A72.) However, Dr. Hammesfahr understood Respondent was not taking her prescribed medications because she was breast feeding, and she was in the process of weaning her two-year-old.

36. Dr. Hammesfahr acknowledged Respondent has a migraine disorder. However, he opined her migraine disorder is easily remediable and not disabling. Dr. Hammesfahr opined Respondent "has not availed herself of standard medical regimens that are likely to resolve her headaches." (Exhibit 11, p. A80.) These medical regimens include: CGRP inhibitors; occipital nerve blocks; Botox; ACE inhibitors such as low dose lisinopril for short-period migraine control; Depakote; Calcium Channel blockers; more mild approaches such as Fioricet and similar medications; and natural solutions such as chiropractic manipulation and magnesium (oral/IM/IV). Dr. Hammesfahr noted Respondent had also suffered a cervical spine injury that tends to trigger migraines. He suggested Respondent could get relief with CESIs and other medications like Torodal. Dr. Hammesfahr testified, if Respondent had tried the treatments Dr. Bahtia recommended (Botox and occipital nerve blocks), "she would have improved." Dr. Hammesfarh is certain Respondent's condition can be controlled with the treatment options he suggested and with necessary adjustments to the dosage(s) and combinations of medications. However, Respondent has not tried all available therapies.

37. Dr. Hammesfahr concluded: "[A]s [Respondent] has not yet undergone common safe medical regimens to treat post-concussive migraine headaches, it is not appropriate to consider her as permanently disabled for the purposes of this evaluation. With appropriate treatment, it is likely that the headache condition will essentially resolve within 1-2 months of starting treatment. [¶] [T]hus, she does not

have an impairment that arises the level of substantial incapacity to perform their usual job duties." (Exhibit 11, pp. A81-A82.)

38. Based on the lack of findings on examination, combined with Respondent's failure to try available therapies, Dr. Hammesfahr testified that Respondent is no longer substantially incapacitated from performance of her usual job duties as an SCC.

Respondent's Return to Work December 2023

39. After CalPERS notified Respondent of its determination that she was no longer incapacitated from the performance of her duties as an SCC, and while Respondent was awaiting this appeal hearing, Respondent erroneously believed she was required to return to work.

40. In December 2023, Respondent reported to work at CDCR. She worked on December 4, 5, 8, 9, 10, 11, and 12, 2023. She discontinued working after that.

41. The evidence did not establish what tasks Respondent completed during her workdays in December 2023. Respondent's supervisor, CDCR Assistant Correctional Food Manager, Gerardo Castaneda, testified credibly at the hearing. He noted that, as a returning employee, Respondent would have been shadowing another employee for about a month, so she was not working alone at any point. Consequently, Mr. Castaneda did not know whether Respondent was capable of working a shift by herself. He did not receive any reports that Respondent was unable to complete the job duties she was given during her brief return to work.

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Respondent's Testimony and Documentary Evidence

42. Respondent continues to employ different methods to avoid triggering her headaches. To address triggers such as light and sound, Respondent added blackout curtains to her home, replaced the television and computer with a projector, and uses noise-canceling headphones. She rarely leaves her home.

43. Respondent testified she currently takes the following medications: oral magnesium; Effexor (venlafaxine); gabapentin "for nerves;" propranolol; and cyclobenzaprine for neck pain.

44. The only current medical report Respondent offered in evidence was a January 31, 2024 report from optometrist, Penelope S. Suter, O.D. Dr. Suter reported, "[Respondent's] current medications at the time of this evaluation are venlafaxine, propranolol, [magnesium], prenatal vitamins, lysine and melatonin." (Exhibits K, p. B11.) This list differs from the medications Respondent listed at hearing.

45. Dr. Suter noted Respondent's vision improvements with therapy. She specifically documented:

> At this evaluation [Respondent] presented with chief complaints of difficulty reading, photophobia and continued headaches. She states that she reads subtitles on a large screen TV for practice reading. It takes about an hour for her to be too fatigued to do that. She notes that since beginning her vision therapy she has decreased stress and fatigue, increased visual comfort, improved balance, and increased spatial awareness.

(Exhibit K, p. B11.)

46. Dr. Suter further noted, "[Respondent's] history that reading causes increased headache or migraine 'spikes' implies that her binocular deficits are contributing to her headache. This is markedly improved, but not yet resolved." (Exhibit K, p. B12.) Dr. Suter recommended additional vision therapy.

47. Dr. Suter did not opine about whether Respondent's condition(s) rendered her substantially incapacitated from performance of her usual job duties as a SCC.

48. Respondent has received approval for another round of vision therapy with Dr. Suter. She has also been approved to be seen by a neurology specialist.

LEGAL CONCLUSIONS

1. The Public Employees' Retirement Law (Retirement Law) governs disability retirement and reinstatements and grants sole jurisdiction to CalPERS to make such determinations. (See Gov. Code, §§ 20026, 20125, 21154, 21156, 21190, 21192, and 21193.)

2. In an administrative hearing concerning retirement benefits, the party asserting the affirmative has the burden of proof by a preponderance of the evidence. (*McCoy v. Board of Retirement* (1986) 183 Cal.App.3d 1044, 1051, fn. 5.)

3. According to the Administrative Procedure Act (APA) (Gov. Code, §§ 11340 et seq.), the burden of proof flows from the type of process initiated. If CalPERS initiates the process to take away a person's right (e.g. involuntarily discontinuing disability retirement), an Accusation is filed, and CalPERS has the burden of proving

that the person is no longer disabled. (*In the Matter of the Application for Reinstatement from Industrial Disability of Willie Starness*, CalPERS Precedential Decision 99-03.) Where CalPERS grants or denies a benefit to a member/applicant and either the member/applicant or another respondent appeals CalPERS' decision, the proceeding is initiated by a Statement of Issues, and the appealing respondent has the burden of proof that the determination was incorrect. (See also, Evid. Code, § 500.) In this case, CalPERS has the burden of producing the evidence to support its determination that Respondent is no longer incapacitated for performance of her duties as an SCC. If this burden is met, then the burden shifts to Respondent to show that CalPERS' determination was incorrect and that Respondent is still incapacitated for performance of her duties as an SCC. CalPERS has met its burden, and Respondent has not.

4. Government Code Section 21192 provides:

> The [CalPERS] board, or in case of a local safety member, other than a school safety member, the governing body of the employer from whose employment the person was retired, may require any recipient of a disability retirement allowance under the minimum age for voluntary retirement for service applicable to members of his or her class to undergo medical examination, and upon his or her application for reinstatement, shall cause a medical examination to be made of the recipient who is at least six months less than the age of compulsory retirement for service applicable to members of the class or category in which it is proposed to employ him or her. The board, or in

case of a local safety member, other than a school safety member, the governing body of the employer from whose employment the person was retired, shall also cause the examination to be made upon application for reinstatement to the position held at retirement or any position in the same class, of a person who was incapacitated for performance of duty in the position at the time of a prior reinstatement to another position. The examination shall be made by a physician or surgeon, appointed by the board or the governing body of the employer, at the place of residence of the recipient or other place mutually agreed upon. Upon the basis of the examination, the board or the governing body shall determine whether he or she is still incapacitated, physically or mentally, for duty in the state agency, the university, or contracting agency, where he or she was employed and in the position held by him or her when retired for disability, or in a position in the same classification, and for the duties of the position with regard to which he or she has applied for reinstatement from retirement.

5. Government Code section 20026, states, in pertinent part:

"Disability" and "incapacity for performance of duty" as a basis of retirement, mean disability of permanent or extended and uncertain duration, as determined by the board . . . on the basis of competent medical opinion.

6. "Incapacitated for the performance of duty," means the "substantial inability of the applicant to perform [their] usual duties," as opposed to mere discomfort or difficulty. (*Mansperger v. Public Employees' Retirement System* (1970) 6 Cal.App.3d 873, 877; *Hosford v. Board of Administration* (1978) 77 Cal.App.3d 854.) The increased risk of further injury is not sufficient to establish current incapacity; the disability must exist presently. Restrictions which are imposed only because of a risk of future injury are insufficient to support a finding of disability. (*Hosford*, *supra*, 77 Cal.App.3d 854, 862 -863.)

7. Respondent retired for disability in 2018 due to a neurological (cervical and migraine) condition arising from a fall in December 2015. In 2020/2021, Respondent was re-evaluated, and CalPERS determined that she continued to be substantially incapacitated for performance of her duties as an SCC. However, in 2021, Dr. Bhatia noted that Respondent's cervical spine condition had improved and her incapacity from migraines may not be permanent if she was given proper treatment. Dr. Bhatia recommended treatment and re-evaluation in 15 months. In 2023, Respondent was re-evaluated, and Dr. Hammesfahr determined Respondent's neurological (migraine disorder and related cervical spine) condition is not severe or disabling and is easily remediable with available treatment options which Respondent has not yet tried. Dr. Hammesfahr opined Respondent is no longer substantially incapacitated from performance of her usual job duties as an SCC. No physician provided any current opinion that Respondent continues to be unable to perform her usual work duties.

8. The potential for exacerbation or escalation of her migraine symptoms when placed in her former position is a prospective possibility, not a medical certainty, and is insufficient to support a finding of Respondent's inability to perform her usual

and customary duties. As noted in *Hosford*, *supra*, a disability cannot be premised on a fear of further injury, and the fact that someone may feel discomfort is insufficient to grant or continue industrial disability retirement. Respondent must be unable to perform her usual and customary duties. While Respondent is concerned about triggers such as light and sound, these potential triggers in themselves do not establish that she would be unable to perform her duties with the use of appropriate treatments. When she last worked as an SCC in December 2023, Respondent was able to report to work for several days, and her supervisor received no information that Respondent was substantially unable to perform any of the duties she was assigned, although she may arguably have been uncomfortable doing so.

9. The totality of the evidence established that Respondent is no longer substantially incapacitated from performing her usual duties as an SCC.

ORDER

The appeal of Respondent, Jacquelyn Vanzant, is denied.

DATE: 03/11/2024

Julie Cabos-Owen

JULIE CABOS-OWEN
Administrative Law Judge
Office of Administrative Hearings