ATTACHMENT E

THE PROPOSED DECISION

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

In the Matter of the Application for Disability Retirement of:

DAWN J. CALES and COUNTY OF SISKIYOU, Respondents

Agency Case No. 2021-1039

OAH No. 2023010241

PROPOSED DECISION

Administrative Law Judge Coren D. Wong, Office of Administrative Hearings, State of California, heard this matter by videoconference on May 17, August 9, and December 14, 2023, from Sacramento, California.

Helen L. Louie, Nhung Dao, and Bryan Delgado, Staff Attorneys, represented the California Public Employees' Retirement System (CalPERS).

Respondent Dawn J. Cales represented herself.

No one appeared for or on behalf of respondent the County of Siskiyou (County). Its default was entered, and this matter proceeded as a default proceeding pursuant to Government Code section 11520 as to the County only.

Evidence was received, the record closed, and the matter submitted for decision on December 14, 2023.

FACTUAL FINDINGS

Jurisdiction

PRIOR EMPLOYMENT

1. Respondent worked for the County as a Behavioral Health Services Crisis Worker I. She is a local miscellaneous member of CalPERS subject to Government Code section 21150 by virtue of her former employment. She has the minimum service credit necessary to qualify for retirement.

APPLICATION FOR RETIREMENT

2. Respondent signed a Disability Retirement Election Application seeking a service pending disability retirement on March 19, 2021, which CalPERS received three days later. She identified her specific disability as posttraumatic stress disorder (PTSD), neck trauma, traumatic brain injury (TBI), hearing loss, tinnitus, post-concussion syndrome, chronic migraines, and thoracic pain.

3. Respondent described suffering her disability on October 24, 2018, when a client physically assaulted her at work. The client punched her in the back of the head, knocked her to the ground unconscious, and continued to assault her as she lay motionless. Respondent "separated from [her] job [because] they would not help [her] feel safe."

4. A month after submitting her application, respondent notified CalPERS she no longer wished to pursue a disability retirement based on her orthopedic (neck and thoracic spine), otolaryngologic (hearing loss and tinnitus), or neurological (migraines) conditions. Therefore, CalPERS evaluated her eligibility for a disability

retirement based solely on her neuropsychological (PTSD, TBI, and post-concussion syndrome) conditions.

5. On August 24, 2021, CalPERS notified respondent it had completed reviewing the medical evidence submitted in support of her application. It determined her neuropsychological conditions were not disabling and she was not substantially incapacitated for the performance of her usual duties as a Behavioral Health Services Crisis Worker I with the County. Therefore, CalPERS granted her a service retirement but denied her a disability retirement. Respondent service retired effective February 23, 2021, and she has been receiving a service retirement allowance since then.

6. Respondent timely appealed CalPERS's denial of a disability retirement. Not only did she ask CalPERS to reevaluate her eligibility based on her neuropsychological conditions, but she also asked it to evaluate her previously identified orthopedic, otolaryngologic, and neurological conditions. Furthermore, respondent asked CalPERS to evaluate a newly identified vision loss condition.

7. CalPERS responded to respondent's appeal and explained she needed to amend her application and submit supporting medical records before it could evaluate her eligibility for a disability retirement due to a vision loss condition. It further explained it needed additional medical information about her orthopedic, otolaryngologic, and neurological conditions.

8. CalPERS received some, but not all, of the information requested. On February 7, 2022, it sent respondent correspondence acknowledging receipt of a Physician's Report on Disability from her primary care physician, otolaryngologist, and neuropsychologist. However, it explained she did not submit sufficient medical records supporting her orthopedic, neurological, or otolaryngologic conditions. Additionally,

respondent did not submit an amended application or medical records to support her vision loss condition. CalPERS requested that she submit all supporting documentation by March 9, 2022.

9. Ten months later, CalPERS sent respondent correspondence explaining its previous decision to deny her application based her neuropsychological conditions remained unchanged after reviewing the additional medical information. CalPERS also explained it reviewed additional medical information regarding her otolaryngologic conditions and determined she was not substantially incapacitated based on those conditions. Lastly, CalPERS stated it never received an amended application and the medical information respondent submitted was insufficient for it to determine if she was substantially incapacitated due to orthopedic, neurologic, or vision conditions.

10. CalPERS notified respondent of her right to appeal its determinations. It explained she did not need to submit a new appeal if she wanted to appeal only the determination regarding her alleged otolaryngologic conditions.

11. On January 10, 2023, Keith Riddle, Chief of CalPERS's Disability and Survivor Benefits Division, signed the Statement of Issues solely in his official capacity. The Statement of Issues states respondent's appeal "is limited to whether at the time of the filing of the application for disability retirement, on the basis of neuropsychological (PTSD, [TBI], and post-concussion syndrome) and otolaryngologic (hearing loss and tinnitus) conditions, respondent Cales [was] substantially incapacitated from the performance of her duties as a Behavioral Health Services Crisis Worker I for respondent County of Siskiyou."

Physical Requirements of Position/Occupational Title

12. A management analyst with the County completed a Physical Requirements of Position/Occupational Title for Respondent's former position as a Behavioral Health Services Crisis Worker I. The analyst itemized the physical requirements of the position and indicated the frequency with which respondent was required to perform them during a typical shift.

13. Respondent testified that the management analyst completed the form without her input. She disagreed with the frequencies indicated for some of the duties. The persuasive evidence established that the physical requirements of respondent's former position and the frequency with which she performed them were:

> Constantly (more than 5 hours): interacting/communicating face-to-face with public, by telephone with public, and with co-workers; lifting/carrying up to 50 pounds; sitting; bending and twisting (neck); bending and twisting (waist); reaching (below shoulder); pushing and pulling; fine fingering (pinching, picking); computer use (keyboard, mouse); walking on an even ground; exposure to excessive noise; exposure to extreme temperature; and exposure to dust, gas, fumes, or chemicals.
>
> Frequently (2.5 to 5 hours): interacting/communicating with inmates, patients, or clients; supervising staff; standing; walking; power grasping; handling (holding, light grasping); and driving.

Occasionally (31 minutes to 2.5 hours): kneeling and reaching (above shoulder).

Never: lifting/carrying more than 50 pounds; running; crawling; climbing; squatting; and operating hazardous machinery.

CalPERS's Medical Evidence

CHARLES A. FILANOSKY, PH.D., A.B.P.P.

14. Charles A. Filanosky, Ph.D., A.B.P.P., is a neuropsychologist to whom CalPERS referred respondent for an independent medical evaluation (IME) of her neuropsychological (PTSD, TBI, and post-concussion syndrome) conditions. He earned a Bachelor of Arts in psychology from Syracuse University, College of Arts and Sciences, in 1992. He earned his Master of Education from Boston University, School of Education, three years later. Between 2002 and 2005, Dr. Filanosky earned his Master of Science in clinical psychology, a certificate in neuropsychological assessment, and a Doctor of Philosophy in clinical psychology from Pacific Graduate School of Psychology.

15. The American Board of Professional Psychology certified Dr. Filanosky in rehabilitation psychology. The California Board of Psychology issued him a license to practice clinical psychology in 2009. He has been a staff neuropsychologist with The Permanente Medical Group in Vacaville and Vallejo since October 2016. He is also co-director of The Permanente Medical Group's Sports Concussion Clinic.

16. Dr. Filanosky performed his IME of Respondent on July 26, 2021. He documented his findings and conclusions in a written report, which was introduced into evidence.

17. Respondent's chief complaint was about continuing cognitive and emotional deficits caused by a client physically assaulting her at work on October 24, 2018. She described interviewing a client and feeling increasingly threatened by him. The client attacked her from behind when she tried to leave the interview room.

18. During and immediately after the assault, respondent experienced "intermittent blackouts" and her ear was "split open." She had no feeling below her neck, and her head felt like "it was going to slide off her shoulders." She recalled crying.

19. Respondent was taken to the hospital by ambulance. She received stitches to her ear and was released the same day. She began experiencing weakness in her shoulder, numbness in her arm, trouble seeing, headaches, and ear pain. Respondent returned to work three or four days after the assault, but she described an inability to function due to feeling "terrified" at work.

20. Respondent received subsequent treatment through the workers' compensation system. She was not approved to see a psychiatrist, but she was approved to see a therapist, which she said was "somewhat helpful." Ongoing symptoms included forgetting or not understanding conversations, entering a room but forgetting why, inability to multitask, discomfort in crowds, and needing her husband to go places with her.

21. Respondent denied any history of mental health issues or psychiatric hospitalization. She described some suicidal ideation, but she denied any intent, plan,

or history of suicide. She denied any current abuse or history of abusing alcohol or prescription medications. She has never used illicit drugs.

22. Respondent described meeting all developmental milestones in a timely fashion as a child. She was raised by both parents in the family home. She is the youngest of several children. She described some physical, emotional, and sexual abuse during childhood.

23. Respondent reported having a normal social development. She had normal friendships and participated in age-appropriate activities such as sports. She did not describe any history of conduct disturbance or behavioral problems.

24. Respondent is in her second of two marriages. She has been married to her husband for more than nine years, and she described their relationship as "excellent." She has two adult daughters with whom she remains close. Respondent described adequate social support beyond her immediate family.

25. Respondent described the duties she performed as a Behavioral Health Services Crisis Worker I consistently with the job description and the Physical Requirements of Position/Occupational Title the County sent Dr. Filanosky prior to the IME. She described her main duties as providing paraprofessional and treatment support and services to clients, such as skills building, crisis intervention, harm reduction, guidance, and education.

26. Dr. Filanosky administered numerous psychological tests designed to assess respondent's mental status. Testing her orientation as to person, time, place, and circumstances indicated she was properly oriented as to the first three. However, Dr. Filanosky noted respondent was asked, but unable, to describe a current event she

recently heard, read about, or saw. He described her inability to do so as "quite atypical in a non-demented adult."

27. Testing respondent's functional abilities revealed she was able to use the telephone and manage her health care by herself. However, anxiety made traveling alone difficult, and memory lapses made shopping, meal preparation, and household chores challenging. She was able to perform activities of daily living independently.

28. Respondent's baseline intellectual functioning was average and within normal limits. Her attention as measured by her ability to repeat strings of numbers told to her was impaired. Testing of her basic verbal learning, visual memory, and remote learning also showed signs of significant impairment.

29. Testing of respondent's processing speed was average, but with no errors. Her performance solving math word problems was low average. Her reasoning and concept formation showed signs of impairment. However, she "did quite well" during testing of executive functioning.

30. Respondent's mental flexibility was low average. Her drawing of a clock included all the necessary numbers in proper sequence and properly spaced. She appropriately distinguished between the hour and minute hands, and she correctly set both to the requested time. The shape of the clock's face was more oblong than circular. She wrote the wrong month and day when asked to write her name and the date on the picture.

31. Overall, respondent's mood during examination was largely within normal limits and showed no clear signs of psychopathy. She reported severe symptoms of depression and anxiety and described some suicidal ideation. She also described the severity of her PTSD as extremely high and reported unusual symptoms.

Respondent provided infrequent and unusual responses to measures of personality and psychotherapy.

32. Dr. Filanosky discussed the validity of neuropsychological assessments.

> Within the field of neuropsychological assessment, it is standard of practice to analyze factors related to effort when making determinations in regard to the validity of neuropsychological testing performance as well as credibility of what are ultimately subjective psychological complaints and symptoms. Standalone and embedded measures are utilized, along with behavioral observations made during the interview and testing process, and even during breaks, and concordance of history and symptom report within provided medical and other records are considered together for patterns suggestive of credible reporting vs. simulation.
>
> In this specific case, Ms. Cales' indicators consistently support the presence of an adequate effort or feigning/simulation of cognitive and emotional impairment. This includes performance on standalone and embedded measures of effort on cognitive testing as well as report of extreme or atypical symptomology during psych testing.

33. Dr. Filanosky explained:

> Ms. Cales was referred for a neuropsychological evaluation by CalPERS and seen on 07/26/2021. She completed the

evaluation but validity indicators reliably support less than optimal effort on cognitive testing, interpreted to be a reflection of amplification or simulation in this context, with similar results on psychological testing. For example, her performance on a test of memory was quite well below 100% of a sample of individuals with moderate and severe TBI, including persons who were in a coma, persons with significant structural brain changes on imaging, etc. This performance is implausible as a consequence of a mild concussive injury. Findings are more likely than not an underrepresentation of actual cognitive abilities and an overrepresentation of psychological symptomology.

Given what is considered to be a performance aimed to simulate or substantially magnify cognitive or emotional complaints, no diagnosis can be offered at a confidence level of more likely than not in this case.

Medical records indicate diagnoses of concussion/traumatic brain injury and PTSD by her providers. Given the description of the incident, these should be considered reasonable diagnoses. However, to the extent Ms. Cales' report of her symptoms is a factor in such decision making the likelihood of confidence in accuracy is decreased.

[¶] . . . [¶]

> I do note that medical records indicate that she had been previously able to return to work. With these results, there may be some temptation to yet again retest in this case. This is not recommended, as in such a future exam it would be difficult to confidently distinguish genuine impairment, if indeed present, versus more informed or sophisticated simulation behavior.

34. Dr. Filanosky commented upon the Comprehensive Initial Neuropsychological Agreed Medical Evaluation Richard Alloy, Ph.D., performed on February 18, 2020, in respondent's workers' compensation matter, which CalPERS had provided prior to the IME.

> Previous neuropsychological evaluation was conducted by Dr. Alloy 2/18/20. It is notable on his exam that she was "impaired on all 7 measures" of the Word Memory Test, a well validated cognitive effort test. He then opines this performance to be typical of persons with "genuine memory deficits" but I would respectfully disagree with this interpretation. Similarly, when describing her performance on the MMPI-2 he describes her symptom reporting as including "an excessive number of rare and unusual responses" which he then notes ". . . invalidates this profile for interpretive purposes" though he continues on to interpret it. Given what in my opinion would also appear to be an examination that is well documented to capture feigning of cognitive and emotional impairment, I would

disagree with the basis for his findings and subsequent opinions on diagnosis, causation, as well as other opinions resting on this.

35. Dr. Filanosky concluded respondent was not substantially incapacitated for the performance of her usual duties as a Behavioral Health Services Crisis Worker I with the County due to neuropsychological (PTSD, TBI, and post-concussion syndrome) conditions when she applied for a disability retirement. He testified consistently with his IME report at hearing.

36. Additionally, Dr. Filanosky explained that determining the validity of neuropsychological testing is important because, although it is impossible for one to perform better than her true ability, it is entirely possible for her to intentionally perform worse. respondent's score on the Test of Memory Malingering (TOMM), a common test for validity used by neuropsychologists, was "substantially" lower than that typically seen by patients with severe dementia or a substantial TBI.

37. Respondent's overall performance during testing was "implausibly poor." She performed "way, way below expectation." Dr. Filanosky described her inability to describe a current event "odd," because the event patients described most often at the time was either the COVID-19 pandemic or a mass shooting. Respondent's reported difficulty performing household chores due to forgetfulness was unusual because memory issues rarely affect one's ability to perform such tasks.

38. Brain injuries affect one's ability to learn new things, not recall things previously learned. Testing of remote learning measured respondent's ability to recall things she learned in high school and before. Dr. Filanosky described her test results as consistent with someone who: (1) has severe, end-stage dementia; (2) dropped out of

school in the second grade; or (3) was not educated in the United States. Her overall learning was, at best, lower than 98 percent of the general population. Ms. Cale's attention span measured worse than 99 percent of the general population.

39. CalPERS sent Dr. Filanosky additional medical records after he completed his IME. He reviewed those records and prepared a supplemental IME report. He explained, "There is no new data included in any of the provided medical records to warrant update or change to any of my opinions as provided in my previous examination; the above may be considered a clarification but not a change." The "clarification" to which Dr. Filanosky referred was the following:

> [N]one of Dr. Alloy's testing nor my own can determine an examinee's motivation when they fail effort testing or symptom validity scores or measures in psychological testing. For the most part, this is interpreted based on the context or purpose of the examination, that is, what the individual is seeking to obtain or seeking to avoid based on the outcome or findings of the exam. Instead, our exams are designed to evaluate credibility of neuropsychological complaints; ultimate credibility is respectfully deferred to the trier of fact.

GEOFFREY A. SMITH, M.D., F.A.C.S.

40. Geoffrey A. Smith, M.D., F.A.C.S., is an otolaryngologist to whom CalPERS referred Respondent for evaluation of her otolaryngologic (hearing loss and tinnitus) conditions. He earned his Bachelor of Arts in bacteriology from the University of California, Los Angeles, in 1968. He earned his medical doctorate from the University

of California, Davis, Medical School four years later. He performed his medical residency in head and neck surgery at the UCLA Medical Center from 1972 through 1976, and he served as the Chief Resident of head and neck surgery at the same hospital the following year.

41. The American Board of Otolaryngology and The American Board of Cosmetic Plastic Surgery have certified Dr. Smith as an otolaryngologist and plastic surgeon, respectively. The California Medical Board issued him a license to practice medicine in 1973. Dr. Smith retired from actively treating patients, but he continues to work as a qualified medical examiner and forensic consultant.

42. Dr. Smith performed his IME of respondent on July 15, 2022. He documented his findings and conclusions in a written report, which was admitted into evidence at hearing.

43. Respondent arrived wearing a hearing aid in her left ear only and explained she recently lost the one for the right. Sometimes she appeared unable to hear during the IME with or without the hearing aid. Other times, she was able to hear and respond appropriately.

44. Respondent described being assaulted at work by a mentally ill client on October 24, 2018. He initially attacked her from behind, she fell to the ground, and he continued to attack her while she lay on the ground. At some point, she lost consciousness, but she did not know for how long.

45. Respondent said she suffered diminished hearing after the assault. She initially had difficulty sleeping and could not hear people because of constant ringing in her ears. She had dizzy spells, which eventually resolved with physical therapy. She obtained hearing aids through the workers' compensation system in 2020.

46. A hearing test was administered. Dr. Smith wrote the following about the results:

> Audiometrics, a copy of which is enclosed, demonstrate a flat/more comfort level of hearing response, with diminished word recognition and poor pure tone to speech reception threshold correlation. This is an indication of a functional (exaggerated) loss of hearing. Additionally, the level of response when talking with her about events, and prior to and after the physical examination and audiometric examination portion, was a different experience than talking with her before when she indicated she was not able to hear or understand me when I was talking with her.

47. Dr. Smith concluded respondent was not substantially incapacitated for the performance of her usual duties as a Behavioral Health Services Crisis Worker I with the County due to otolaryngologic (hearing loss and tinnitus) conditions when she applied for a disability retirement. He testified consistently with his IME report at hearing.

48. Additionally, Dr. Smith explained he was interested in determining if respondent could "hear and respond normally to normal conversations." He started his IME by engaging in simple conversation to get her more comfortable providing information during the actual examination. At times, she appeared to be unable to hear him. Other times, she said she had trouble hearing him. But respondent and Dr. Smith were able to engage in back-and-forth conversations, "particularly as she spent more time with him in the office."

49. Dr. Smith concluded respondent exaggerated her hearing loss during testing. Their numerous conversations throughout the IME showed that she was able to hear "considerably better than what she had tested." Additionally, they showed she was able to understand words better in real life than during testing. Lastly, Dr. Smith observed respondent throughout the third day of hearing, and he noted she appeared to have been hearing and responding well.

Respondent's Evidence

50. Respondent testified at hearing and introduced Michael D. Staszel, D.O.'s, Dr. Alloy's, and Richard Shearer, M.D.'s, Physician's Report on Disability. None of her physicians testified.

TESTIMONY

51. Respondent had been working as a Behavioral Health Services Crisis Worker I less than two months when she was assaulted by a mentally ill client on October 24, 2018. It was her first time evaluating a client by herself. She was escorting the client to her office when he asked, "Have you ever seen anyone dead?" She was able to redirect the conversation as they continued walking to her office. Respondent's plan was to have the client sit in her office while she went to get a coworker to help her.

52. As Respondent and the client approached her office, he asked, "Have you seen anyone dead, how many, one, two, tell me?" At that point, she felt she was in imminent danger. As they entered her office, the client put his hand on the wall to prevent respondent from leaving. He then demanded, "If you have anything to say, you will stand right there and ask me!" She was able to distract him by explaining she had forgotten something, and he dropped his hand long enough for her to escape.

53. Respondent went to an office two doors down and began asking her coworker for help when the client came from behind and punched her in the back of the head. The blow forced her head into the metal doorjamb, and she fell to the ground unconscious. The client continued to punch her in the head as she lay motionless.

54. Respondent cut her ear during the assault and required stitches. She injured her cervical spine at C4-C5 and C5-C6. She was told the only treatment option is spinal fusion. However, that is not an option because she is blind in her left eye and needs to be able to rotate her head to see on that side.

55. Respondent also suffered nerve damage from her neck to her fourth and fifth digits in both arms. She has severe PTSD, a moderate TBI, constant ringing in her ears, and a loss of hearing in both ears. She suffers from depression, anxiety, and night terrors. She is in constant pain.

56. Respondent returned to work against medical advice four or five days after the assault because she had not accrued enough sick leave to continue missing work. She found it extremely difficult to work because she had the constant fear someone would come from behind and kill her. She despised having people approach her from behind and not being able to hear them. Respondent eventually felt she had no choice and applied for retirement.

MEDICAL REPORTS

57. Respondent's medical reports need not be discussed in detail because they were admitted solely as administrative hearsay, and there was no direct medical evidence she was substantially incapacitated for the reports to supplement or explain. Furthermore, Dr. Shearer did not offer an opinion about substantial incapacity. He also

indicated he did not consider the physical requirements respondent performed in her former position. Dr. Alloy wrote the same.

Analysis

EVIDENCE OF THE PHYSICAL REQUIREMENTS OF RESPONDENT'S FORMER POSITION

58. The County's management analyst did not testify at hearing and was not subject to cross-examination. Respondent did testify and was subject to cross-examination. To the extent respondent disagreed with the management analyst, respondent provided more persuasive evidence of the physical requirements of her former position and the frequency with which she performed them.

EVIDENCE OF SUBSTANTIAL INCAPACITY

59. Respondent has the burden of producing competent medical evidence that she was substantially incapacitated for the performance of her usual duties as a Behavioral Health Services Crisis Worker I with the County due to neuropsychological (PTSD, TBI, and post-concussion syndrome) and otolaryngologic (hearing loss and tinnitus) conditions when she applied for a disability retirement. She did not meet her burden.

60. Respondent's only medical evidence was Drs. Staszel's, Alloy's, and Shearer's Physician's Report on Disability. But the evidence was admitted as administrative hearsay. (See Gov. Code, § 11513, subd. (d) ["Hearsay evidence may be used for the purpose of supplementing or explaining other evidence but over timely objection shall not be sufficient in itself to support a finding unless it would be

admissible over objection in civil actions"].) There was no direct medical evidence of her substantial incapacity for the records to supplement or explain.

61. Additionally, Dr. Shearer offered no opinion on substantial incapacity. Furthermore, neither he nor Dr. Alloy considered the physical requirements of respondent's former position. Dr. Alloy provided no foundation for his conclusion that she was substantially incapacitated for the performance of her usual duties. Also, he has questionable credibility for the reasons Dr. Filanosky articulated.

62. On the other hand, CalPERS produced persuasive evidence that respondent was not substantially incapacitated when she applied for disability retirement. Drs. Filanosky's and Smith's opinions were based on physical examination and objective testing. They persuasively explained the reasons for their conclusions in their IME reports and at hearing.

LEGAL CONCLUSIONS

Applicable Burden/Standard of Proof

1. Respondent has the burden of proving she qualifies for disability retirement by a preponderance of the evidence. (*McCoy v. Bd. of Retirement* (1986) 183 Cal.App.3d 1044, 1051-1052, fn. 5 ["As in ordinary civil actions, the party asserting the affirmative at an administrative hearing has the burden of proof, including both the initial burden of going forward and the burden of persuasion by a preponderance of the evidence"].) This evidentiary standard requires respondent to produce evidence of such weight that, when balanced against evidence to the contrary, is more persuasive. (*People ex rel. Brown v. Tri-Union Seafoods, LLC* (2009) 171 Cal.App.4th 1549, 1567.) In other words, she needs to prove it is more likely than not she was

substantially incapacitated for the performance of the usual duties of a Behavioral Health Services Crisis Worker I with the County due to neuropsychological (PTSD, traumatic brain injury, and post-concussion syndrome) and otolaryngologic (hearing loss and tinnitus) conditions when she applied for disability retirement.

Applicable Law

2. Government Code section 21150, subdivision (a), provides that "a member incapacitated for the performance of duty shall be retired for disability . . . if . . . she is credited with five years of state service, regardless of age." Respondent satisfies the jurisdictional requirements for disability retirement.

3. To qualify for disability retirement, respondent must prove, at the time she applied for a disability retirement, she was "incapacitated physically or mentally for the performance of . . . her duties." (Gov. Code, § 21156, subd. (a).) Government Code section 20026 defines "disability" and "incapacity for performance of duty" as a "disability of permanent or extended duration, which is expected to last at least 12 consecutive months or will result in death, as determined by the board . . . on the basis of competent medical opinion."

4. The courts have interpreted the phrase "incapacitated for the performance of duty" to mean "the substantial inability of the applicant to perform [her] usual duties." (*Mansperger v. Public Employees' Retirement System* (1970) 6 Cal.App.3d 873, 877.) It is not necessary that the person be able to perform all duties since public policy supports employment and utilization of the disabled. (*Schrier v. San Mateo County Employees' Retirement Assn.* (1983) 142 Cal.App.3d 957, 961.) Instead, the frequency with which the duties she cannot perform are usually performed as well as the general composition of duties she can perform must be considered.

(*Mansperger v. Public Employees' Retirement System*, *supra*, 6 Cal.App.3d at pp. 876-877 [while applicant was unable to lift or carry heavy objects due to his disability, "the necessity that a fish and game warden carry a heavy object alone is a remote occurrence"].)

5. Discomfort, which may make it difficult for one to perform her duties, is insufficient to establish permanent incapacity. (*Smith v. City of Napa* (2004) 120 Cal.App.4th 194, 207 [mere discomfort which makes it difficult to perform one's job does not constitute a permanent incapacity]; citing *Hosford v. Bd. of Admin.* (1978) 77 Cal.App.3d 854, 862.) Furthermore, an increased risk of further injury is insufficient to constitute a present disability, and prophylactic restrictions on work duties cannot form the basis of a disability retirement. (*Hosford v. Board of Admin.*, *supra*, 77 Cal.App.3d. at p. 863.)

Conclusion

6. Respondent did not produce competent medical evidence that she was substantially incapacitated for the performance of her usual duties as a Behavioral Health Services Crisis Work I with the County due to neuropsychological (PTSD, TBI, and post-concussion syndrome) and otolaryngologic (hearing loss and tinnitus) conditions when she applied for disability retirement. Therefore, her application for disability retirement should be denied. However, her previously granted service retirement is unaffected.

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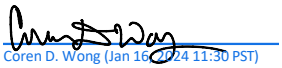
ORDER

Respondent Dawn J. Cales's application for a disability retirement is DENIED.

DATE: January 16, 2024



COREN D. WONG

Administrative Law Judge

Office of Administrative Hearings