ATTACHMENT A

THE PROPOSED DECISION

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

In the Matter of the Application for Industrial Disability Retirement of:

TUONG-VI DANG DINH and CALIFORNIA STATE PRISON – SOLANO, CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION, Respondents

Agency Case No. 2021-0396

OAH No. 2021090609

PROPOSED DECISION

Jessica Wall, Administrative Law Judge (ALJ), Office of Administrative Hearings (OAH), State of California, heard this matter by videoconference on November 17, 2022, and April 13, 2023, from Sacramento, California.

Helen Louie, Attorney, represented the California Public Employees' Retirement System (CalPERS).

Richard E. Elder, Jr., Attorney at Law, represented respondent Tuong-Vi Dang Dinh (respondent).

Respondent California State Prison – Solano, California Department of Corrections and Rehabilitation (CDCR) did not appear at hearing. CDCR was duly served with a Notice of Hearing. The matter proceeded as a default against CDCR under Government Code section 11520, subdivision (a).

Evidence was received, the record closed, and the matter submitted for decision on April 13, 2023.

ISSUE

Was respondent substantially incapacitated from the performance of her usual and customary duties as a Supervising Correctional Cook for CDCR based on orthopedic (shoulders, neck, arms, hands, elbows, and low back) conditions at the time she filed her application for industrial disability retirement (IDR)?

FACTUAL FINDINGS

Jurisdictional Matters

1. Respondent was employed by CDCR at California State Prison – Solano as a Supervising Correctional Cook. By virtue of her employment, respondent is a state safety member of CalPERS.

2. On October 27, 2020, respondent signed and later filed an IDR application. Her stated disabilities were orthopedic (shoulders, neck, arms, hands, elbows, and low back) conditions. She wrote that her limitations were "no repetitive use of the arms, hands and no lifting, pushing, pulling over 5 lbs."

3. In January 2021, CalPERS sent a letter directing respondent to undergo an Independent Medical Examiner (IME) evaluation with Robert Henrichsen, M.D. Following receipt of Dr. Henrichsen's IME report, CalPERS denied respondent's application for IDR on March 19, 2021. CalPERS reviewed the medical evidence and found that respondent's orthopedic conditions did not render her substantially incapacitated from performing her usual duties as a Supervising Correctional Cook at CDCR.

4. Respondent timely appealed CalPERS's denial of her IDR application. On August 6, 2021, Keith Riddle, Chief of CalPERS's Disability and Survivor Benefits Division, filed a Statement of Issues for purposes of the appeal. The matter was set for an evidentiary hearing before an ALJ of the OAH. This hearing followed.

Respondent's Work Injuries at CDCR

5. Respondent began working at CDCR in 2009. She worked as a Supervising Correctional Cook from August 2014 through December 2018. In an attachment to her IDR application, respondent listed the four injuries that caused her disability as: (1) an inmate pushed a cart into her, resulting in an injury to her right shoulder (January 2013); (2) she tripped on pallets, resulting in an injury to her left shoulder, left arm, left hand, and low back (June 2016); (3) boxes fell on her left arm and hand (April 2017); and (4) a coworker pushed a pallet jack with boxes through the refrigeration unit and a box fell on respondent, injuring her head, neck, and right shoulder (December 2018). Additionally, in other medical records, respondent reported the following additional work injuries: she tripped on a box and fell on her right side (2010), a can opener fell on her right wrist (2011), and she cut her right index finger on a freezer door (2014).

Supervising Correctional Cook Job Requirements

6. As set forth in the Duty Statement, a Supervising Correctional Cook at CDCR's Solano facility oversees and supervises the preparation, cooking, and serving of approximately 17,000 meals per day. The Duty Statement breaks down the role's duties into percentages, as follows:

- 35 percent: Maintaining food quality standards by assigning the preparation and production of food items for the daily meal plans and supervising the inmates during their work shifts.
- 25 percent: Supervising the "break out" of delivered food and documenting the amount of food produced by inmates.
- 15 percent: Training cooks to ensure that subordinates follow procedures.
- 15 percent: Ensuring that the health and safety codes are strictly followed.
- 10 percent: Drafting daily, weekly, and monthly reports.

7. On October 20, 2020, respondent signed the Physical Requirements of Position/Occupational Title form (Physical Requirements form) for her position of Supervising Correctional Cook. Her employer signed it on November 5, 2020. The form states a Supervising Correctional Cook constantly (more than 5 hours) interacts with inmates and coworkers, lifts or carries up to 10 pounds, bends at the neck, and twists at the neck and waist; frequently (2.5 to 5 hours) supervises staff, stands, and walks; occasionally (31 minutes to 2.5 hours) sits, bends at the waist, reaches above and below the shoulder, power grasps, handles, uses fine fingering, uses a computer, and walks on uneven ground; and never or rarely (less than 5 minutes) lifts or carries more than 11 pounds, runs, crawls, kneels, climbs, squats, and pushes or pulls.

Testimony of Carl H. Shin, M.D.

8. Respondent's treating physician, Carl H. Shin, M.D., testified in support of her application. Dr. Shin graduated from Loma Linda University School of Medicine in 1995. He completed his residency in Physical Medicine and Rehabilitation at Loma Linda University Medical Center in 1999. He then completed an Interventional Spine fellowship at University of Pennsylvania in 2000. Dr. Shin has been licensed for 26 years and is board-certified by the American Board of Physical Medicine and Rehabilitation. He specializes in non-operative management of injuries. Ninety percent of his patients are under the workers' compensation system, including respondent. At present, Dr. Shin's office manages four of respondent's workers' compensation cases. He also serves as a qualified medical evaluator (QME) for the State of California.

DR. SHIN'S TREATMENT OF RESPONDENT

9. When Dr. Shin began treating respondent, he drafted a Pain Management New Patient Consultation. He noted that she underwent left shoulder surgery in August 2017 and had a left carpal tunnel release in June 2018. On February 21, 2019, he physically examined respondent and found she had near full range of motion in her cervical spine. Respondent achieved functionally normal range of motion (150 degrees of abduction and flexion) in her right shoulder when encouraged and had nearly full range of motion in her left shoulder. She frequently complained of pain and tenderness, reporting her pain was 7-out-of-10 when she was inactive. When she was active, her pain was 9-out-of-10.

10. Dr. Shin saw respondent at another appointment on March 8, 2019. That day, respondent expressed her pain was "very mild," 5-out-of-10 unmedicated and 3-out-of-10 with ibuprofen. She had full range of motion in her left shoulder, left elbow,

and both wrists and fingers. Nevertheless, she reported tenderness around her left shoulder and elbow.

11. Dr. Shin examined respondent again on May 14, 2019. She reported her pain was 5-out-of-10 that day, but 2-out-of-10 with medication. Again, respondent had full range of motion in her left shoulder and cervical spine. On May 20, 2019, Dr. Shin examined respondent again. She reported about the same level of pain as the prior week. Dr. Shin examined her right shoulder and found she now had limited abduction (90 degrees) and slightly limited flexion (120 degrees). Her left shoulder had full range of motion. Dr. Shin reviewed notes from a March 2019 magnetic resonance imaging (MRI) report. That report found respondent had a tendon and cartilage tear in her right shoulder.

12. Dr. Shin testified that he last saw respondent in February 2022. The last report of him examining her was on May 20, 2019. After that date, other doctors and a physician assistant (PA) at his practice examined respondent. In November 2019, Timothy Yoon, M.D., found respondent had slightly limited range of motion in her left shoulder. She underwent a right shoulder surgery in January 2020. In respondent's July 2020 visit with PA Jason Packer, her range of motion in the right shoulder was only 90 degrees. By September 2020, her range of motion in the right shoulder increased to 160 degrees. The following month, she was able to exceed functionally normal range of motion in both shoulders (160/170 degrees [Right/Left]). She also began to report stiffness in her cervical spine in October and November 2020.

13. In October 2021, respondent began to complain of hypersensitivity in her left hand and forearm. From November 2021 through April 2022, respondent visited four times. She reported tenderness in her left elbow and pain of 7-or-9-out-of-10. No range of motion examinations took place in this period.

PHYSICIAN'S REPORT ON DISABILITY

14. Dr. Shin filled out respondent's Physician's Report on Disability (Physician's Report) for her IDR application. The report asked if respondent was substantially incapacitated from the performance of the usual duties of her position as a Supervising Correctional Cook. Dr. Shin selected "No." He had not reviewed the Duty Statement and Physical Requirements form for respondent's position. His examination findings for respondent were "chronic pain, multiple industrial injury claims." He diagnosed her with "lateral epicondylitis-left," based on her complaints of tenderness, and "[right] shoulder pain." Lateral epicondylitis, colloquially known as "tennis elbow," is a condition that occurs when repetitive motions of the wrist and arm overload the elbow tendons. Dr. Shin listed the following diagnostic tests: a June 2019 electromyography (EMG) and a March 2019 MRI. He said she could not use her left upper extremity repetitively, lift over five pounds, or reach overhead.

HEARING TESTIMONY

15. Shortly before the hearing, Dr. Shin reviewed respondent's Duty Statement and Physical Requirements form. He still believes respondent should not reach above her shoulders, lift 30 pounds or more, constantly bend and twist her neck, and twist at her waist. He also thinks she should be restricted from lifting over 10 pounds from the floor because of her back condition. Nevertheless, Dr. Shin agreed that respondent is physically able to lift 35 pounds a couple times a day. He opined she could push up to 60 pounds if she used a dolly and could lift 50 pounds if assisted by a coworker.

16. Dr. Shin did not know what an IME was and was unfamiliar with the legal standards CalPERS applies in IDR cases. Nevertheless, he disagreed with Dr.

Henrichsen's conclusions. Dr. Shin explained that respondent's primary diagnosis is chronic pain syndrome. Her prior surgeries created "neuroplastic pain." "Neuroplastic pain" is brain-generated pain that occurs in the absence of injury. He does not rely on objective findings, which he said were "unreliable" because some people experience "pain without pathology." He believes that respondent should be restricted from performing her job duties because of the risk of pain. Dr. Shin acknowledged that treating physicians can be biased in their opinions because they may advocate for their patients. However, he does not think that respondent is exaggerating her complaints.

Respondent's Testimony

17. Interpreter Mike Nguyen provided Vietnamese language interpretation services during respondent's testimony. Respondent waived her right to Vietnamese language interpretation during all other parts of the hearing. Respondent was born in Saigon, Vietnam, and moved to the United States in 1992. She started working at CDCR as a correctional cook (CC) in July 2009. In August 2014, she was promoted to Supervising Correctional Cook. She worked in that role until her last day of work on December 8, 2018. In 2017 and 2018, she worked a 10-hour shift, four days per week.

18. In her role as a Supervising Correctional Cook, respondent supervised 20 CCs in four kitchens. The CCs, in turn, monitored and supervised inmate cooks. The kitchens had two-and-a-half to three hours to finish meals. The meals had to be timely or risk negatively affecting other prison programs. During lockdowns, inmate cooks could not assist. This meant fewer workers in the kitchen. There were always at least five CCs working with respondent on weekdays and at least three on weekends. If a staff member were late, respondent would perform their duties to ensure meals would be on time. She said that the role of Supervising Correctional Cook was more

physically difficult than her prior role as a CC because she was responsible for more kitchens.

19. Respondent was the only person with a key to 14 walk-in freezers and refrigerators (walk-in units). She reports that the CCs had to watch the inmates, so she would move things in and out of the walk-in units. She would not allow inmates in the walk-in units because they might steal food or make weapons. She can no longer operate the heavy sliding doors on the walk-in units because of her orthopedic conditions.

20. Respondent explained that she signed the Physical Requirements form when it was blank. She disagrees with how CDCR reported her job duties on the form. Respondent believes her role was more physically arduous than supervisory. Specifically, she argues she lifted items weighing more than 11 pounds constantly during her shift. She recalled regularly lifting 50-pound boxes of sugar, rice, and frozen foods. She also reported pushing carts of meals weighing more than 50 pounds. Respondent said that she would spend two hours per shift lifting around 50 pounds and three to four hours lifting around 30 pounds. She estimated she spent seven to eight hours of her shift lifting. She then spent the remaining two to three hours on the computer. She also believes that she reached above her shoulders more than two-and-a-half hours each shift. These descriptions were contrary to her description in her November 2020 QME evaluation, where respondent said her supervisory duties (e.g., working at a computer, placing orders, and calling vendors) comprised half to two-thirds of her work shift.

21. Respondent said her most challenging work duties were opening doors with keys, standing and walking on rough ground, and sitting at a computer to make schedules and orders. She also testified she was unable to work in a hot kitchen

because the heat would make her pass out. Upon further questioning, respondent admitted that she has never passed out because of the kitchens' heat. Her concern was based on a medication unrelated to her orthopedic conditions.

22. Respondent recalled walking five to seven hours per shift. She can no longer do this because her lower back hurts. She is unable to use a computer for 31 minutes to two-and-a-half hours per shift because her hands and wrists hurt, her fingers stick together, and she cannot use a mouse. Respondent also stated that her neck hurts when she looks at a computer monitor. She can only spend 10 to 15 minutes on a computer. She reported her neck and back pain prevent her from twisting and bending at the neck and waist. However, during part of CalPERS's closing argument, respondent shook her head vigorously in disagreement.

IME Evaluation by Robert Henrichsen, M.D.

23. Dr. Henrichsen has been a licensed physician for 54 years. He is board-certified in orthopedic surgery and has extensive experience in treating orthopedic conditions, including conditions affecting the cervical spine, upper extremities, and lumbar spine. Dr. Henrichsen was in private practice with Auburn Orthopaedic Medical Group from 1973 until 2011. He performed many surgeries during that period. Currently, he performs IME evaluations for CalPERS and serves as a QME.

24. As part of his evaluation, Dr. Henrichsen reviewed respondent's records, including her treatment records, the Duty Statement and Physical Requirements form, and IDR application. He also interviewed respondent and performed a physical examination. Dr. Henrichsen prepared an initial report dated February 16, 2021. Subsequently, he prepared three supplemental reports on March 2, 2021; June 17, 2022; and July 1, 2022. He testified at hearing consistent with those reports.

INTERVIEW AND PHYSICAL EXAMINATION

25. Dr. Henrichsen met respondent for her evaluation on February 16, 2021, and asked her questions through the assistance of a Vietnamese language interpreter. Respondent told him about eight work-related injuries. She explained her work duties were: standing and walking (2.5 hours); sitting (up to 2.5 hours); bending at the neck (5 hours) and waist (2.5 hours); lifting one to 10 pounds (5 hours); lifting 10 to 50 pounds (5 minutes); climbing, squatting, kneeling, twisting, pushing, pulling, driving, and stooping (5 minutes). This description of work duties aligns with the Physical Requirements form. She reported her current symptoms as pain in her neck with motion, weakness in her left shoulder, reduced mobility in her right shoulder, sharp pain in her left and right elbows, sensitive skin around her carpal tunnel release incision area, and intermittent right ring trigger finger. Respondent said pain is generally 7-or-8-out-of-10, but it sometimes rises to 9-out-of-10.

26. On his physical examination, Dr. Henrichsen evaluated respondent's shoulders, neck, arms, hands, elbows, and low back. He observed that respondent did not have muscle guarding or spasms. She was able to squat but complained of pain. She had less than full range of motion in her lumbar spine. Her lower extremity strength was normal. Respondent repeatedly complained of hip pain during the lower body examination. Dr. Henrichsen explained this was not possible because pain radiates down, not up, the nervous system in the legs.

27. Respondent had less than the full range of motion in her shoulders (90/100 degrees abduction and 110/125 degrees flexion), but her muscle tone and bulk was normal. Her surgery scars were healed. There was no evidence of mechanical impingement syndrome. While respondent explained that her right shoulder had more pain and symptoms than the left, there were no specific abnormal findings.

28. Similarly, respondent complained of pain near her collarbone. Yet her tissues there were normal and showed no evidence of inflammation. She had limited rotation in her neck. Her biceps muscles appeared normal and showed no signs of biceps tendonitis. Respondent reported tenderness around her elbows but had no active olecranon bursitis or elbow tendonitis.

29. Dr. Henrichsen found respondent's wrists to be functionally normal. Still, she complained of pain in the area. There was no evidence of residual carpal tunnel symptoms. She had a two-millimeter (mm) cyst on her left ring finger, which was sensitive, but no triggering in that hand. Respondent reported a trigger finger on her right hand. On the day of the evaluation, her finger was functioning normally.

MEDICAL RECORD REVIEW

30. Dr. Henrichsen reviewed respondent's medical records related to her orthopedic condition, including reports from Dr. Shin and his colleagues; Randall Schaefer, M.D., who performed respondent's right shoulder surgery; and physical therapists who worked with respondent after her right shoulder surgery. Those reports indicate that respondent's right shoulder surgery was successful and healed without infection or complication. She had excellent range of motion in her right shoulder less than five months after the surgery.

31. Dr. Henrichsen also reviewed respondent's November 2020 QME report by Joel Renbaum, M.D. In the report, Dr. Renbaum listed respondent's prior work injuries and recorded her current complaints. In his examination of respondent, her cervical spine was normal with good range of motion. Her shoulder range of motion was slightly less than normal (140/140 degrees abduction and 140/160 flexion), and

she reported tenderness in both her spine and shoulders. Her elbows and wrists were normal.

32. Finally, Dr. Henrichsen reviewed a December 28, 2020, MRI scan summary of respondent's lumbar spine from David Hyun Min Kim, M.D. The summary reported degenerative disc disease, a 4-5 mm disc protrusion in L2-3 and L4-5, and a 2-3 mm disc bulge in L5-S1.

DIAGNOSES AND CONCLUSIONS

33. Dr. Henrichsen diagnosed respondent with: (1) multiple symptoms, (2) history of right and left shoulder arthroscopic decompression and right shoulder rotator cuff repair with biceps tenodesis; (3) symptoms of neck pain and frontal headaches; (4) symptoms poorly supported by examination findings; (5) synovial cyst, left hand; and (6) degenerative disc disease, degenerative arthritis of lumbar spine. He discussed how respondent reported a variety of contusion injuries and cuts in the workplace, but "no real serious issues have occurred from each injury."

34. Dr. Henrichsen was concerned about the stark differences between respondent's November 2020 QME evaluation and her physical examination that day. In November 2020, respondent had good, albeit not perfect, range of motion in her shoulders. Yet, only two months later, she had far more limited function. There was no record that could explain the difference. Additionally, while the MRI showed respondent had some degenerative disease, she did not have nerve impingement in her neck. Her neck had functional mobility.

35. Dr. Henrichsen found respondent did not have actual and present orthopedic impairment of her shoulders, neck, arms, hands, and elbows that substantially incapacitated her from performing her duties as a Supervising

Correctional Cook. His objective findings were that respondent had no evidence of nerve impingement, no muscle atrophy, no muscle disuse issues, and no joint contractures or joint effusion. He concluded there were no job duties that respondent would be unable to perform based on her orthopedic conditions.

SUPPLEMENTAL REPORTS

36. Dr. Henrichsen's first supplemental report addressed respondent's assertion of orthopedic impairment based on her lower back. He found that, based on his physical examination and review of respondent's MRI, her lower back condition did not substantially incapacitate her from performing her job's usual duties.

37. In the second supplemental report, Dr. Henrichsen reviewed additional medical records from Dr. Shin and his colleagues. He concluded that "some of the examinations have poor-to-no objective examination support of her multiple subjective symptoms." In his third and final report, Dr. Henrichsen gave recommendations and conclusions about respondent's lower back. He found she was not substantially incapacitated based on her lower back because her subjective symptoms, examination findings, and imaging studies did not correlate. He maintained that there were no duties she was unable to perform.

HEARING TESTIMONY

38. At hearing, Dr. Henrichsen provided examples of what activities correlated to various levels on the pain scale. Someone experiencing pain of 6-to-8-out-of-10 would take medicine to help with the pain. At 8-out-of-10, a person would go to the emergency room because the pain would be so great. A 10-out-of-10 would be the greatest pain imaginable, like being "naked in hot, burning oil." Dr. Henrichsen

opined that respondent's examination findings did not support the level of pain she reported.

39. Listening to Dr. Shin's testimony did not change Dr. Henrichsen's opinion. He noted that respondent's different findings on different days with different providers suggested that she put forth less than full effort in his examination. He also believes she has let her fear of pain restrict her mobility. After watching respondent's testimony, Dr. Henrichsen noted that her neck mobility appeared much better during the hearing than it was on the day he examined her. He noted that she was able to move her neck around without any signs of pain.

Analysis

EXPERT RELIABILITY

40. The testimony and reports of the expert witnesses conflicted. Thus, they must be evaluated to ascertain which expert was more reliable. Dr. Henrichsen and Dr. Shin both completed medical school at Loma Linda University, after which each went on to complete residency and a yearlong fellowship. Dr. Henrichsen has been a licensed physician for twice as long as Dr. Shin. Additionally, Dr. Henrichsen is board certified in orthopedic surgery, while Dr. Shin is board certified in Physical Medicine and Rehabilitation. Dr. Henrichsen performed surgeries and Dr. Shin specializes in non-surgical pain management.

41. Dr. Shin's last documented examination of respondent was in May 2019, more than a year before her IDR application. He admitted that his opinions can be biased because he is her treating physician. Dr. Shin also relied on respondent's reported pain and discomfort rather than objective tests.

42. Conversely, Dr. Henrichsen performed his physical examination of respondent in February 2021, less than four months after her application. Dr. Henrichsen's opinions were based on his independent clinical evaluation. He established that the objective criteria assessed during the physical examination did not support respondent's subjective complaints. Dr. Henrichsen explained that respondent's MRI findings were normal for her age and her carpal tunnel release surgery resolved abnormalities in the prior EMG findings. He found that respondent exaggerated her symptoms, which was consistent with respondent's testimony and behavior at the hearing.

43. Moreover, Dr. Henrichsen understood and relied on the CalPERS criteria for disability retirement. Dr. Shin admitted he was unfamiliar with the CalPERS criteria for IDR cases. Based on the foregoing, Dr. Henrichsen's opinions were more trustworthy and reliable.

DETERMINATION

44. Considering the record, respondent failed to offer sufficient competent medical evidence to establish that, when she applied for IDR, she was substantially and permanently incapacitated from performing the usual duties of a Supervising Correctional Cook. Her attempt to recharacterize her position's duties at hearing, in conflict with both the Duty Statement and Physical Requirements form, was unavailing. She cannot rely on activities outside of the usual and customary duties of her position to support her IDR application. (See *Beckley v. Board of Administration* (2013) 222 Cal.App.4th 691, 699 [relying on an employee's job classification to determine usual duties].)

45. Respondent had the burden to offer sufficient competent, objective medical evidence that she was substantially incapacitated from performing the usual and customary duties of a Supervising Correctional Cook at the time she filed her application. She did not carry her burden. Thus, her IDR application must be denied.

LEGAL CONCLUSIONS

1. As the applicant, respondent has the burden of proving by a preponderance of the evidence that her application for IDR should be granted. (Evid. Code, § 500; *McCoy v. Bd. of Retirement* (1986) 183 Cal.App.3d 1044, 1051, fn. 5.) A preponderance of the evidence means "evidence that has more convincing force than that opposed to it." (*People ex rel. Brown v. Tri-Union Seafoods, LLC* (2009) 171 Cal.App.4th 1549, 1567.)

2. To qualify for disability retirement, respondent had to prove that, when she applied, she was "incapacitated physically or mentally for the performance of [her] duties in the state service." (Gov. Code, § 21156.) Under Government Code section 20026:

> "Disability" and "incapacity for performance of duty" as a basis of retirement, mean 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, or in the case of a local safety member by the governing body of the contracting agency employing the member, on the basis of competent medical opinion.

3. The term "incapacity for performance of duty," as used in Government Code section 20026 (formerly section 21022), means "the substantial inability of the applicant to perform [her] usual duties." (*Mansperger v. Public Employees' Retirement System* (1970) 6 Cal.App.3d 873, 876.) A disability retirement determination relies on objective evidence, rather than subjective complaints of pain. (*Harmon v. Bd. of Retirement* (1976) 62 Cal.App.3d 689, 697.)

4. Prophylactic restrictions, which seek to prevent the risk of future injury or harm, are not sufficient to support a finding of disability. (*Hosford v. Bd. of Admin.* (1978) 77 Cal.App.3d 855, 863.) Rather, a disability must currently exist and not be prospective in nature. (*Ibid.*) Discomfort, which may make it difficult for an employee to perform her duties, is not sufficient to establish permanent incapacity. (*Smith v. City of Napa* (2004) 120 Cal.App.4th 194, 207.)

5. Considering the evidence in light of the above precedent, respondent did not carry her burden. As explained above, she failed to submit sufficient evidence based upon competent medical opinion that, at the time she applied for IDR, she was permanently and substantially incapacitated from performing the usual duties of a Supervising Correctional Cook for CDCR. Consequently, her IDR application is denied.

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ORDER

The appeal of respondent Tuong-Vi Dang Dinh is DENIED. CalPERS's decision to deny her application for industrial disability retirement is AFFIRMED.

DATE: May 2, 2023

Jessica Wall
Jessica Wall (May 2, 2023 16:31 PDT)

JESSICA WALL

Administrative Law Judge

Office of Administrative Hearings