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:

AMANDA L. JONES, Respondent,

and

PELICAN BAY STATE PRISON, CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION, Respondent,

Agency Case No. 2020-1013

OAH No. 2021010202

PROPOSED DECISION

This matter was heard before Administrative Law Judge Ed Washington, Office of Administrative Hearings, State of California, via videoconference from Sacramento, California, on June 24, 2021.

Staff Attorney Preet Kaur represented the California Public Employees' Retirement System (CalPERS).

Amanda L. Jones (respondent) represented herself.

CalPERS properly served Pelican Bay State Prison, California Department of Corrections and Rehabilitation (CDCR), with the Statement of Issues and Notice of Continued Hearing. CDCR made no appearance. This matter proceeded as a default against CDCR pursuant to Government Code section 11520, subdivision (a).

Evidence was received and the hearing concluded. The record remained open through June 29, 2021, to allow respondent to submit fully redacted exhibits. Respondent timely submitted fully redacted exhibits. The record was closed, and the matter was submitted for decision on June 29, 2021.

ISSUE

Was respondent permanently disabled and substantially incapacitated from performing her usual and customary duties as a correctional officer for CDCR based on orthopedic (right upper extremity, neck, and low back) conditions when she applied for industrial disability retirement?

FACTUAL FINDINGS

Jurisdictional Matters

1. Respondent worked for CDCR. On November 2, 2019, respondent signed and thereafter filed with CalPERS a Disability Retirement Election Application (application). Respondent was employed by CDCR as a correctional officer when she filed her application.

2. On her application, respondent identified "Industrial Disability Retirement" as the application type. She described her disability as "Brachial plexus

disorder and low back pain," and specified that her disability occurred on December 11, 2017. Respondent also specified that her disability occurred "during an inmate takedown, right upper extremity and low back injured."

3. Respondent described her limitations and preclusions due to this condition as: "No lifting more than 10 [pounds]. No crawling, climbing stairs/ladders." She specified that her condition affected her ability to perform her job because "[her] work restrictions are incompatible with the essential functions of [her] job." She did not describe her job duties on the application.

4. CalPERS obtained medical records and reports, including reports prepared by Brendan Morely, M.D., who completed respondent's Physician's Report on Disability, and Robert K. Henrichsen, M.D., who conducted an Independent Medical Evaluation (IME) of respondent concerning her orthopedic conditions. After reviewing the reports, CalPERS determined that respondent was not substantially incapacitated from the performance of her job duties as a correctional officer for CDCR.

5. By letter dated June 26, 2020, CalPERS notified respondent that her application for industrial disability retirement had been denied. Respondent timely appealed from the denial and this hearing followed.

Duties of Correctional Officer

6. CDCR produces a form titled "CDCR Division of Adult Institutions, Correctional Officer, Essential Functions," that identifies a correctional officer's essential job functions. Those functions include: (1) wearing personal protective equipment; (2) range qualifying with departmentally approved weapons and firing weapon in combat/emergency situations; (3) swinging a baton with force; (4) disarming, subduing and applying restraints to an inmate; (5) defending against an

inmate armed with a weapon; (6) climbing occasionally to frequently, ascending/descending or climbing a series of steps/stairs, several tiers of stairs or ladders, and climbing onto bunks/beds while involved in cell searches and carrying items while climbing stairs; (7) crawling and crouching occasionally and crouching while firing a weapon or while involved in property searches; (8) lifting and carrying 20 to 50 pounds continuously to frequently and over 100 pounds occasionally, including lifting, carrying, dragging, and physically restraining an inmate; (9) pushing and pulling while opening and closing locked gates and cell doors throughout the workday or during an altercation with or restraint of an inmate; (10) reaching occasionally to continuously overhead while performing cell or body searches; and (11) frequent to continuous hand and wrist movement for grasping and squeezing.

7. Respondent submitted a Physical Requirements of Position/Occupational Title form with her application, completed by a CDCR return to work coordinator, that details the type, duration, and frequency of physical task a correctional officer must perform. A correctional officer must occasionally (up to three hours a day) to constantly (over six hours a day), sit, stand, walk, walk on uneven ground, and drive. An incumbent must occasionally to frequently (three to six hours a day) climb, bend at the waist, reach below shoulder level, push and pull, and use a computer keyboard and mouse. A correctional officer must frequently to constantly bend at the neck, twist at the neck and waist, engage in fine manipulation of the fingers, grasp, and repeatedly use hands. A correctional officer must occasionally run, kneel, reach above shoulder level, and lift over 50 pounds. A correctional officer must also frequently lift between 26 and 50 pounds, and constantly lift up to 25 pounds.

8. The California Department of Human Resources, State Personnel Board Specification, Correctional Officer, provides, in part, that a correctional officer must be

able to subdue and apply restraints to inmates, supervise inmates at all times and escort them to and from activities. A correctional officer must stand watch on an armed post and walk or stand for long periods of time, run up or down stairs, use reasonable force to protect the safety and security of the public. A correctional officer must also conduct inmate body searches, search visitors, apply restraints, carry or lift an unconscious inmate, receive and issue firearms and ammunition, fire a weapon, use a baton, or conduct inmate cell searches.

Respondent's Evidence

RESPONDENT'S TESTIMONY

9. Respondent worked for CDCR as a Medical Technical Assistant (MTA) from 2002 to 2010 with peace officer status. In 2010 she became a correctional officer when the MTA classification was eliminated.

10. On or about December 11, 2017, an inmate became uncooperative while being escorted within the facility. Respondent and other correctional officers physically restrained the inmate by taking him to the ground. While the inmate was on the ground, respondent sat on his back and tried to handcuff the inmate as the inmate repeatedly pulled his arms away from respondent. Respondent testified that keeping her weight on the inmate as he resisted was "like riding a bull." Shortly after the inmate was restrained, respondent noticed that she had pain in her right elbow and shoulder, and her back. Her right arm and shoulder were stiff and difficult to move.

11. Respondent testified that the following morning, she discovered she could no longer extend her right arm beyond approximately 45 to 90 degrees. She saw Keven Caldwell, M.D., that same day who determined respondent suffered a right shoulder and right arm strain. Dr. Caldwell took respondent off work for approximately

six weeks and referred her to physical therapy. Respondent's physical therapist passed away unexpectedly and she had difficulty continuing treatment due to the limited number of physical therapists in her area.

12. Respondent continued to experience symptoms. In February 2018, she was referred to Todd Guthrie, M.D., an orthopedic surgeon for evaluation. Dr. Guthrie informed respondent that her ongoing symptoms may be the result of "a brachial plexus issue," because she had "signs of a positive Hawkins impingement," indicating that she had an impingement of the tendons or bursa in her shoulder. He recommended that respondent complete a nerve conduction study to better identify the issue.

13. In early 2018, respondent completed a nerve conduction study with Joseph P. Purell, D.O., at the Redding Spine and Sports Medicine. The nerve conduction study was normal and Dr. Purell could not identify a basis for respondent's symptoms.

14. Respondent continued to see Dr. Caldwell for treatment. She received an MRI on her right forearm in May 2018, the results of which showed no abnormalities. In June 2018 she had a cervical spine MRI, that showed central protrusion and central canal narrowing at C3-C4, a small disc bulge at C5-C6, and moderate narrowing at C6-C7. She was then reassigned to Dr. Morely.

15. In August 2018, Dr. Morely referred respondent to Timothy Lo, M.D., a neurologist, who recommended that respondent treat her contracture with Botox injections. Respondent declined Botox treatment and continued to see Dr. Morely every six weeks. Her symptoms did not improve.

16. On May 2, 2019, she was evaluated by a shoulder specialist, Thomas C. Degenhardt, M.D., at Santa Rosa Orthopedics. He concluded that respondent had a right elbow flexion contracture but could not identify a medical basis for respondent's symptoms.

17. Respondent continued to see Dr. Morley regularly for treatment and assessment of her condition. He periodically referred respondent to specialists to ascertain the source of her symptoms of pain and joint immobility. In January 2021, Dr. Morley referred respondent to Kai-Uwe Mazure, M.D., an orthopedic surgeon who specializes in the hand and upper extremities and degenerative disorders. Dr. Mazure was also unable to clearly identify the source of respondent's symptoms, but concluded that respondent's symptoms prevented her from performing a significant portion of her essential job functions. The source of respondent's pain and joint contractures remain undetermined.

18. Respondent asserted she could not perform the majority of her duties. She testified that she cannot sit or drive for more than six hours because her back will cramp, she will have back pain, and her right leg will "get tingly." She cannot stand for over six hours without alternating between sitting and standing, due to pain. She cannot run up to three hours without experiencing back pain. She testified that she cannot crawl because it would produce back pain and she cannot extend her arm beyond an approximately 45 degrees. She cannot squat or twist at the waist for up to three hours due to severe back pain. She added that she does not experience pain when attempting to extend her right arm. Instead, she is simply unable to extend it because "it just doesn't go." She testified that because she cannot extend her right arm, she cannot climb a ladder, cannot engage in any reaching, grasping, fine manipulation, lifting, pushing, or pulling and cannot conduct inmate body searches,

search visitors, apply restraints, carry or lift an unconscious inmate, receive and issue firearms and ammunition, safely fire a weapon, use a baton, or conduct inmate cell searches.

DOCUMENTS SUBMITTED BY RESPONDENT

19. Respondent did not call a medical expert to testify on her behalf. Instead, she submitted documents to support her application, which included: (1) a CalPERS Physician's Report on Disability, signed by Dr. Morely on October 10, 2019, which she included with her application; (2) a professional biography of Dr. Mazure, printed from the Santa Rosa Orthopedics website; and (3) an examination report prepared by Dr. Mazure on January 19, 2021. These documents were admitted into evidence as administrative hearsay and have been considered to the extent permitted under Government Code section 11513, subdivision (d).[1]

20. In this report, Dr. Morely specified that his objective findings upon examination were that an MRI of respondent's right shoulder showed mild degenerative hypertrophy of acromioclavicular joint, and that respondent could only extend her right elbow actively to about 100 degrees, and that a prior MRI of respondent's right forearm taken after her workplace incident was normal. In the

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[1] Government Code section 11513, subdivision (d), in relevant part, provides:

> 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.

comments section of his report, Dr. Morely added that respondent also had "brachial plexus disorders" and "low back pain."

21. In the "Member Incapacity" section, Dr. Morely specified that respondent was permanently and substantially incapacitated from the performance of her usual duties. He described the job duties respondent could not perform, as follows:

> Patient should be precluded from use of the right arm. Should be allowed to alternate between sitting and standing as needed by pain. No lifting more than 10 [pounds], no crawling, and no climbing of stairs and ladders.

22. According to Dr. Mazure's report, he saw respondent for pain in her right shoulder, right upper arm, and right elbow, resulting from the December 2017 workplace incident. He examined respondent's right elbow and noted it was flexed at 95 degrees of flexion and passive extension was negative 85 degrees. Flexion was normal, coordination was normal, there was no popping or clicking of the joints with movement, no swelling of the elbow, and the biceps was intact and not tender. Respondent's brachioradialis (a muscle in the lateral forearm) was prominent and contracted. Respondent's triceps was intact and her ulnar nerve and medial lateral elbow were not tender.

23. Respondent held her wrist in flexion, but passive extension allowed for normal extension. Respondent's fingers did not appear affected and had normal movement in flexion, extension, and abduction. Respondent's shoulder was contracted in adduction and was limited "for flexion-extension." There was tenderness along the anterior shoulder proximal biceps tendon. There was no swelling to the extremity,

cutaneous symptoms or nerve pain and sensation to light touch was intact throughout the shoulder.

24. Dr. Mazure reviewed respondent's diagnostic test findings and diagnosed respondent with "M25.521 Pain in right elbow; M24.521 Contracture, right elbow; and M62.838 Other muscle spasm." He included the following comments in the "Treatment Plan" section of his report:

> Right shoulder and arm strain: [Respondent] has suffered an injury to the right upper extremity. She [has] developed a secondary contracture. ... [Seven] diagnostic studies I was able to review do not explain this patient's significant symptoms. I must conclude [respondent's] symptoms are related to a neurological injury above the cervical spine similar to cerebral palsy injury where contractures of multiple muscles lead to functional loss and deformities and contractures. Alternatively, this may be a psychiatric issue, similar to clenched fist syndrome with somatization of psychiatric trauma [leads] to a clenched fist, which is non-contracted. She is not a candidate for any peripheral extremity surgical treatment until the exact origin of her pathology has been properly diagnosed. She would be a candidate for an MRI scan of her brain and potentially for selective Botox injections. ... It is unlikely she would be able to return to previous location. This is a very complex case.

Expert Opinion

25. CalPERS called Robert K. Henrichsen, M.D., as its expert at hearing. Dr. Henrichsen is a board-certified orthopedic surgeon and a certified Fellow of the American Academy of Orthopaedic Surgeons. He obtained his medical degree from Loma Linda University in 1967. He was in private practice with Auburn Orthopaedic Medical Group from 1973 until 2011. His practice currently involves performing Independent Medical Evaluations (IMEs) and Qualified Medical Evaluations for a variety of entities.

26. On May 19, 2020, Dr. Henrichsen performed an IME on respondent to determine whether she was substantially incapacitated from performing her former job duties, based on her reports of right shoulder, right upper extremity, and low back pain. Dr. Henrichsen's evaluation included interviewing respondent, physically examining respondent's spine and extremities, and reviewing her job functions and medical records. No diagnostic image studies were presented for review. Dr. Henrichsen detailed his evaluation, along with his findings and conclusions, in a 22-page IME report.

27. During the interview, respondent reported pain in right shoulder with reduced motion, pain in her right elbow with reduced motion, and having a feeling of arm spasms. She told Dr. Henrichsen that the spasm-like feeling will radiate down to her elbow. She reported right side low back pain that sometimes radiated to her hip and thigh. She reported that her symptoms have not improved in the approximately two-and-a-half-year period that has passed since incident at work. Respondent also reported that she will generally sleep on either side of her body, but has trouble sleeping and wakes up a significant amount.

28. Dr. Henrichsen's physical examination revealed that respondent had normal strength in her heels and toes and exhibited no signs of muscle weakness. Her femoral nerve traction test on the right side resulted in her heel coming within 20 centimeters of her buttock and produced some right thigh pain. On her left side, the distance between her heel and buttock was 10 centimeters, which produced low back pain.

29. Respondent stated that she was unable to lie prone for examination, but agreed to lie on her right side. She had tenderness in the right sacroiliac joint area. The left lower back was not tender and there were no trigger points, nodules, or true muscle spasms present in any part of the thoracic or lumbar spine. Respondent's shoulder and spinal musculature were not tender. There were no spasms, trigger points, or nodules. Respondent was unable to shrug both of her shoulders. She shrugged her left shoulder normally but her right shoulder did not move. According to Dr. Henrichsen, respondent did not put forth sufficient effort to allow for a scapular motor muscle evaluation.

30. There was no swelling or edema of either upper extremity around the shoulder. There was no atrophy of the right shoulder or upper extremities. Respondent reported tenderness near her right shoulder blade and in the right acromioclavicular joint. Respondent's shoulder extension measured 35 degrees on the right and 75 degrees on the left. Active shoulder flexion was 60 degrees on the right and 160 degrees on the left, active abduction was 50 degrees on the right and 160 degrees on the left, external rotation was zero degrees on the right and 90 degrees on the left. Respondent kept her right elbow flexed at approximately 100 degrees during the examination and while performing these motions.

31. Respondent's biceps bulges were normal on both sides. Her right elbow lacks 95 degrees of full extension, however, she has full extension on the left. Respondent's forearm pronation measured 90 degrees with both the right and left arms. Upon supination her range of motion measured 15 degrees on the right and 90 degrees on the left. The circumference of respondent's right and left arms measured 24 centimeters and 23 centimeters, respectively, while her forearms measured 21 centimeters and 21.5 centimeters. Sensation in both upper extremities to light touch was intact. Grip strength testing in pounds on the right measured 30, 25, 25, and 25, and on the left measured 60, 60, 55, and 50.

32. Dr. Henrichsen reviewed several medical records as part of his evaluation, covering evaluation and treatment respondent received, dating back to her December 2017 injury. These records reflected that respondent's symptoms worsened over time for undetermined reasons. The records also reflected that respondent was subjected to multiple studies by various medical providers to identify the source of her symptoms without success.

33. On February 12, 2018, Melissa McKenzie, D.O., performed a nerve conduction study of respondent's right upper extremity. The motor studies in the median and ulnar nerve at the wrist and elbow were normal.

34. During a March 22, 2018 evaluation, Dr. Guthrie opined that respondent had brachial plexus neuropathy. Upon examination he found that respondent had normal upper extremity reflexes on the right. Respondent could not perform rapid alternating movements with her hands. However, he found a positive Hoffman test on the right and left, indicating possible spinal cord compression. Dr. Guthrie found that respondent had normal strength in the right deltoid muscle, right biceps, triceps, and wrist extensors. There was some biceps tendon tenderness, but no impingement

findings. Respondent had good muscle tone in and around the shoulder area. Her right elbow had grossly intact range of motion but the last 40 degrees of elbow extension produced biceps pain.

35. On May 10, 2018, Dr. Purell performed another nerve conduction study, in conjunction with an EMG. He found that sensory delays across respondent's wrists. Ulnar nerve testing was normal and motor conduction times were normal.

36. On May 22, 2018, Dr. Guthrie evaluated respondent and reviewed MRI scans of her neck. The scan revealed that respondent had a small protrusion at C3-4 and degenerative changes at C5-6. Upon evaluation, respondent had normal sensation in both upper extremities. Her cervical spine range of motion was normal, but there was some tenderness. Strength in her upper extremities was normal and her Hoffman's sign test was negative.

37. On August 29, 2018, respondent was evaluated by Dr. Lo. At that time, respondent could no longer extend her right elbow beyond 110 degrees and she experienced biceps pain with passive attempts to extend the elbow. Reflexes in respondent's upper and lower extremities were normal. Dr. Lo noted that he did not have a good explanation for respondent's contraction or inability to fully extend her right elbow or fully move her right shoulder. He reviewed respondent's cervical spine MRI scans and found no evidence of spinal cord compression.

38. On September 27, 2018, respondent had an MRI shoulder scan and a right shoulder x-ray from three views. The MRI revealed that respondent's rotator cuff was intact, there was no muscle atrophy, and the biceps tendon was normal. The acromioclavicular joint showed some degenerative arthritis. The x-ray also revealed that respondent had some mild acromioclavicular joint arthritis.

39. On May 25, 2019, respondent had another nerve conduction study with EMG. The results of the study were that the sensation in respondent's extremities were intact and the reflexes in her upper extremities were normal. However, the nerve conduction study on this occasion did reveal minor ulnar neuropathy on the right forearm and across the right elbow.

40. On September 23, 2019, Amjad Rasheed, M.D., reviewed an MRI scan of respondents right brachial plexus. He found that no abnormal mass was present in respondent's right brachial plexus. A lumbar scan MRI also revealed that respondent has some degenerative disc disease in her lower back.

41. After completing the interview, physical examination and reviewing respondent's medical records, Dr. Henrichsen reached the following diagnostic impressions:

1. History of right shoulder and arm strain.

2. Cervical stenosis with disc bulging.

3. Degenerative disc disease of the lumbar spine with referred pain.

4. Symptoms greater than findings.

5. Non-explainable right shoulder, right forearm, and right elbow reduction of motion.

6. Suggestion of right elbow cubital tunnel syndrome.

7. History of psychiatric issues.

42. In the "Discussion" section of his report, Dr. Henrichsen noted that respondent has been examined by a variety of skilled physicians and no physician has been able to determine the exact cause of her symptoms. He noted that respondent reported that her condition has not improved, however, if a person suffers soft tissue strain, they would gradually improve with or without treatment over the first four to eight weeks after the injury. He could find no medical explanation for why that did not occur with respondent, and concluded his report as follows:

> My medical conclusions ... are that [respondent] has an apparent contracture of her right shoulder and elbow that is not medically explained by any evaluator, any imaging, or electrical study. She allows pain or perceived pain to restrict motion of her low back, and her right shoulder, forearm, and elbow, and she had in the past a tendency to somatization. These observations and findings again support my explanation that her symptoms are far greater than findings and some of her symptoms are not medically explainable.
>
> Therefore, from a medical aspect, [respondent] does not have nerve impingement, joint damage, permanent muscle injury, or referred pain from her neck or low back that would preclude her from her occupation. To examination, she demonstrates a marked reduction of mobility of the right shoulder, forearm, and elbow and also a significant limited amount of mobility of her low back. If one were to make conclusions based only on observation and her

> apparent self-restriction of motion of her right upper extremity, it could be concluded that she has impairment rising to the level of substantial incapacity. However, my medical opinion is that her appearance that has been present for all physicians, including myself, is that she gives in to her pain and therefore limits her motion and/or voluntarily limits the motion of the extremities. Such presentation does not rise to the level of substantial incapacity for employment.

43. At hearing, Dr. Henrichsen reiterated that respondent had a series of electrical studies to determine whether her nerve functions were normal. The results of the majority of those studies were normal. Respondent also had imaging studies and x-rays that revealed she has some minimal arthritis, that was also supported by an MRI of her shoulder. There was also evidence of mild wear and tear on respondent's low back on a degenerative basis. The MRI scan of respondent's brachial plexus was normal or "unremarkable."

44. Although respondent's May 29, 2019 nerve conduction study with EMG revealed some ulnar nerve neuropathy, those results fell only slightly below what would be considered normal, and therefore, were considered in the transitional range and not at all incapacitating. Dr. Henrichsen testified that the ulnar nerve is what most people refer to as "the funny bone," and the neuropathy described in the records would only produce a "buzzing" or intermittent tingling that could be resolved by straightening the joint. Similarly, respondent's medical records demonstrated that she has some cervical stenosis without symptoms and a mild spinal degenerative

condition. However, these findings were had minimal, if any effect, on respondent's abilities and were in no way substantially incapacitating in nature.

45. Dr. Henrichsen testified that respondent experienced an incident at work that resulted in no acute injury. She finished her work shift immediately after the injury occurred. To the extent she suffered a right shoulder and arm strain, she should have been significantly better after six to eight weeks, even without treatment. However, respondent's reported symptoms actually worsened over time. He noted that respondent has significant symptoms with inability to use her right elbow and shoulder normally. However, upon examination of her elbow and shoulder, the tissues of the muscle tone and muscle bulk do not exhibit a lack of use on a regular basis. Upon examination, her tissues looked normal, the circumference measurements were normal, and her reflexes were normal. Therefore, her symptoms were not supported by examination findings.

46. Dr. Henrichsen could not identify any medical bases that supports or even correlates with respondent's symptomology. He surmised that respondent's reported mobility limitations resulted from an unreasonable fear to activate certain muscles due to pain or her unwillingness to activate those muscles. Accordingly, he concluded that respondent was not substantially incapacitated from performing her usual and customary duties as a correctional officer for CDCR.

Analysis

47. When all the evidence is considered, respondent failed to offer sufficient competent medical evidence to establish that, when she applied for industrial disability retirement, she was substantially and permanently incapacitated from performing the usual duties of a correctional officer for CDCR. Dr. Henrichsen testified

in detail about his evaluation and review of respondent's medical history and records. His opinion that respondent was not substantially incapacitated from performing her usual job duties was persuasive. His IME report was detailed and thorough, and his testimony at hearing was clear and comprehensive. His opinions were well-supported by the evidence, including the evaluations performed by several other medical professionals since December 2017.

48. The burden was on respondent to offer sufficient competent medical evidence at hearing to support her industrial disability retirement application. Respondent did not meet her burden. Her testimony was not straightforward. She initially said very little without being directed to elaborate. And, much of the testimony respondent did provide appeared to be information she gleaned directly from Dr. Henrichsen's report. Her assertion that she could not perform certain job functions due to back pain or because she would need to change positions, does not preclude her from performing those tasks. Discomfort when performing one's job duties does not constitute an inability to perform those duties. (See, *Smith v. County of Napa* (2004) 120 Cal.App.4th 194, 207.) She testified that she could not perform several duties because she cannot straighten her right arm. However, there was no reliable evidence presented at hearing to support this stated inability.

49. Respondent did not call a medical expert to testify at hearing, nor did she provide competent medical evidence to support her claimed incapacity. While she did provide hearsay evidence from medical providers, that information did not support that she is unable to perform her usual and customary duties.

50. Because respondent failed to offer sufficient evidence at hearing to establish that, when she applied for disability retirement, she was substantially and

permanently incapacitated from performing the usual duties of a correctional officer for CDCR, her industrial disability retirement application must be denied.

LEGAL CONCLUSIONS

1. Respondent seeks disability retirement pursuant to Government Code section 21151, subdivision (a), which provides in pertinent part, that "[a]ny patrol, state safety, state industrial, state peace officer/firefighter, or local safety member incapacitated for the performance of duty as the result of an industrial disability shall be retired for disability, pursuant to this chapter, regardless of age or amount of service."

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.)

3. "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. (Gov. Code, § 20026.)

4. In *Mansperger v. Public Employees' Retirement System* (1970) 6 Cal.App.3d 873, 876, the court interpreted the term "incapacity for performance of duty" as used in Government Code section 20026 (formerly section 21022) to mean "the *substantial* inability of the applicant to perform his usual duties." (Italics in original.) The court in *Hosford v. Board of Administration* (1978) 77 Cal.App.3d 855, 863, explained that prophylactic restrictions that are imposed to prevent the risk of future injury or harm are not sufficient to support a finding of disability; a disability

must be currently existing and not prospective in nature. In *Smith v. City of Napa* (2004) 120 Cal.App.4th 194, 207, the court found that discomfort, which may make it difficult for an employee to perform his duties, is not sufficient in itself to establish permanent incapacity. (See also, *In re Keck* (2000) CalPERS Precedential Bd. Dec. No. 00-05, pp. 12-14.)

5. When all the evidence is considered in light of the analyses in *Mansperger, Hosford*, *Smith*, and *Keck*, respondent did not establish that her industrial disability retirement application should be granted. She failed to submit sufficient evidence based upon competent medical opinion that, at the time she applied for industrial disability retirement, she was permanently and substantially incapacitated from performing the usual duties of a correctional officer for CDCR. Consequently, her industrial disability retirement application must be denied.

ORDER

The application of respondent Amanda L. Jones for industrial disability retirement is DENIED.

DATE: September 14, 2021

Ed Washington
Ed Washington (Sep 14, 2021 09:27 PDT)

ED WASHINGTON
Administrative Law Judge
Office of Administrative Hearings