

ATTACHMENT A
THE PROPOSED DECISION

BEFORE THE
BOARD OF ADMINISTRATION
CALIFORNIA PUBLIC EMPLOYEES' RETIREMENT SYSTEM

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

SETH BOONE,

Respondent,

and

CALIFORNIA STATE PRISON LASSEN
COUNTY,

Respondent.

Case No. 2010-0006

OAH No. 2012040704

PROPOSED DECISION

On November 15, 2012, in Sacramento, California, Ann Elizabeth Sarli, Administrative Law Judge, Office of Administrative Hearings (OAH), State of California, heard this matter.

Wesley E. Kennedy, Senior Staff Counsel, represented the California Public Employees' Retirement System.

Matthew C. Watkins, Attorney at Law, represented respondent Seth Boone.

Respondent California State Prison Lassen County did not appear.¹

Evidence was received. The matter was submitted and the record was closed on November 15, 2012.²

¹ California State Prison Lassen County was duly served with a Notice of Hearing. The matter proceeded as a default against this respondent, pursuant to California Government Code section 11520, subdivision (a).

² The record was reopened on December 13, 2012 to admit Dr. Branscum's report in evidence as administrative hearsay. The exhibit had been pre-marked as Exhibit 12, but that designation was changed to Exhibit E to reflect the fact that respondent moved it into evidence.

PROCEDURAL FINDINGS

1. On April 15, 2009, Mr. Boone filed a Disability Retirement Election Application for Industrial Disability Retirement (application). In filing the application, Mr. Boone claimed disability on the basis of "reflex sympathetic dystrophy and grade II antalgic gait" resulting from an orthopedic left knee condition sustained while on duty.

2. At the time Mr. Boone filed his application for industrial disability retirement, he was employed by the California State Prison Lassen County as a Correctional Officer. By virtue of his employment, Mr. Boone is a state safety member of the California Public Employees' Retirement System (CalPERS), subject to Government Code section 21151.

3. CalPERS obtained medical reports concerning Mr. Boone's medical condition from competent medical professionals. On the basis of the medical evidence, CalPERS determined that Mr. Boone was not permanently disabled or incapacitated from performance of his duties as a Correctional Officer at the time his application for disability retirement was filed.

4. On January 27, 2010, CalPERS notified Mr. Boone that his application for disability retirement was denied. Mr. Boone filed a timely appeal of the denial.

5. Mary Lynn Fischer, in her official capacity as Chief, Benefit Services Division, Board of Administration, CalPERS, made the Statement of Issues on December 10, 2010, and filed it thereafter.

6. The issue on appeal is whether Mr. Boone was permanently disabled or incapacitated on the basis of an orthopedic left knee condition from performance of his duties as a Correctional Officer for the California State Prison Lassen County, when he filed his application for disability retirement.

7. At hearing, CalPERS submitted medical records and reports from Baer Rambach, M.D., Steven L. McIntire, M.D., and John Branscum, M.D., three Reports of Investigation-Interview and two sub rosa video surveillance recordings. Mr. Boone submitted four documents related to the physical requirements of the position. Mr. Boone, Dr. Rambach, Dr. McIntire and two CalPERS investigators testified at hearing.

FACTUAL FINDINGS

Medical Treatment

1. Mr. Boone was born in 1982. In April 2005 he was employed by California State Prison Lassen County (High Desert State Prison) as a correctional

officer. On April 5, 2008, he reported to Banner Lassen Medical Center Emergency Room stating he had twisted his left knee while trying to bring an inmate to the ground. He was diagnosed with a sprain/strain of the left knee. X-rays were negative. Examination revealed no pain or instability when stressing the joint, no evidence of redness or warmth, non-tenderness over the patella, normal tracking of the patella and no significant swelling. Mr. Boone was taken off work.

2. A May 7, 2008 MRI showed impression of a small knee effusion, no definite meniscal tear and no tendon or ligament injury.

3. Mr. Boone treated with physical therapy commencing on June 6, 2008. He complained of significant pain in the left knee and exhibited antalgic gait; a limp adopted so as to avoid pain on weight bearing structures.

4. Dr. J. David Schillen, an orthopedist, treated Mr. Boone throughout 2008 and 2009. Mr. Boone reported that physical therapy was increasing his pain. His active range of motion was good. He was given a diagnostic injection of lidocaine and Marcaine, which Mr. Boone reported did not decrease the pain. Mr. Boone reported that the injection resulted in a shooting pain down the anterior part of his left leg, continued stiffness and achy pain down the back of his leg. He was diagnosed with chondromalacia (softening of the cartilage) patella, left knee, and chronic pain of the left knee, not otherwise specified. Mr. Boone was given two injections with hyaluronic acid in August 2008 and reported his pain was worse. He was referred to a pain management specialist, Dr. Pervez Iranpur, who started him on Lyrica and Ultram.

5. In November 2008, Mr. Boone underwent three lumbar sympathetic blocks at L3 on the left. Mr. Boone reported no significant relief from the pain. An MRI taken November 8, 2009 of the left knee revealed moderate degenerative disc disease and chondromalacia around the patella and within the patellofemoral joint space.

Videotape Surveillance

6. Surveillance videotape of September 14, 2010 shows Mr. Boone arriving at a gas station in his truck at 4:30 p.m. and pumping gas into his truck. While waiting for the gas to pump he enters and exits his truck 3 times removing trash. He bends and stands and does not exhibit a limp or difficulty getting into or out of his vehicle. Four minutes later he entered the truck and drove off. At 4:44 p.m. he arrived at a residence in Palo Cedro. He walked into the residence. At 4:53 p.m., Mr. Boone was observed in the backyard of the residence. He, his three-year-old daughter and another young girl were playing with a trampoline. Mr. Boone did not get on the trampoline but sat or pushed against it causing it to bounce, for less than a minute. Then his daughter mounted his back and he crouched over the trampoline with his daughter on his back bouncing her rigorously for about four minutes. She then

dismounted, he stood for a moment and bent at his waist to pick up something. He stood a while longer and then picked his daughter up off the trampoline, placed her on the ground and walked without a limp in the backyard.

7. Surveillance videotape of the next morning, September 15, 2010, showed Mr. Boone exiting his truck at Shasta College in Redding, with a heavy backpack across his back at 8:45 a.m. and walk from class to class and then to the library. His gait and movements were normal.

8. On April 19, 2011, Mr. Boone was scheduled for an independent medical examination in Sacramento with Dr. McIntire. Videotape surveillance was conducted. Mr. Boone arrived as a passenger in a vehicle driven by his father at 10:34 a.m. He exited the vehicle and walked toward the east entrance of the medical building, exhibiting a significant limp in his left leg. Approximately two hours later, Mr. Boone emerged and walked with a significant limp, gingerly moving his left leg over a curb but then putting all his weight on it as he stepped from the curb. He entered the passenger side of the vehicle and his father drove out of the area. Investigators followed and reported that two hours later, Mr. Boone and his father arrived at Burger King in Corning. Mr. Boone switched to the driver's seat and they drove through the Burger King drive-through and out of the area. This was not captured on videotape. At 2:55 p.m. they arrived at a Les Schwab store in Anderson. Mr. Boone exited the car and walked across the parking lot and into the building. He did not exhibit a noticeable limp. At 3:37 p.m., Mr. Boone and his father walked across the parking lot and got into the vehicle and drove about half an hour to Mr. Boone's residence.

9. The next morning, April 20, 2011, video surveillance was taken at 7:43 a.m. of Mr. Boone parking his truck at Shasta College in Redding. He exited his truck, placed a backpack of books over his back and was filmed as he walked to class over wet surfaces. His gait and movements were normal. After the class concluded about 45 minutes later, Mr. Boone was filmed walking to the campus library and sitting at the library until 10:16 a.m., when he was filmed walking to another building, then exiting the building and then walking to another building. His gait was normal and he continued to carry the backpack. Mr. Boone got into his vehicle at 11:52 a.m. and drove out of the area.

Dr. Rambach's Opinion

10. On December 2009, Mr. Boone was evaluated by Baer Rambach, M.D., in connection with his application for industrial disability retirement. Dr. Rambach is an orthopedic surgeon, certified by the American Board of Orthopedic Surgery. Dr. Rambach has extensive treatment, diagnostic and consulting experience in the field of orthopedics and orthopedic surgery. Dr. Rambach reviewed Mr. Boone's medical records, took a history and conducted an examination. His diagnostic impressions were "(1) sprained/strained left knee, resolved, probably secondary to

trauma as of April 5, 2008, and (2) complex regional pain syndrome (reflex sympathetic dystrophy) left knee by history and review of medical records, which appears to be resolving at the time of this examination.”

11. Dr. Rambach wrote in the Discussion/Opinion section of his report:

Mr. Boone probably did sustain a contusion and sprain to his left knee joint that resulted in a sympathetically mediated – type of chronic pain response to his left knee, however, I would classify this as mild to moderate. The diagnosis of complex regional pain syndrome is based on physical examination findings, because no laboratory or radiologic tests can reliably confirm or exclude the diagnosis. In this gentleman’s case, x-rays are reported as being within normal limits in addition to a normal MRI of the left knee joint, and a bone scan which is essentially normal. In this case there is no description other than a subacute stage of the complex regional pain syndrome noted in any of the physicians’ reports including the QME by John L. Branscum, M.D. on February 19, 2009. Dr. Branscum noted that the skin around the knee was bright and shiny and the knee was at least 1 to 2 degrees cooler than the right knee. He also had noted that the extremes of knee motion produced severe pain. At the time of this examination there is no indication of any similar findings.

12. On December 8, 2010, Dr. Rambach performed a re-examination of Mr. Boone and reviewed updated medical records. He noted in the medical records that Dr. Harris had treated Mr. Boone between March 10, 2010 and August 26, 2010, that Mr. Boone had reported severe pain in his left knee at all times, that Norco had been ineffective, and that he was having a significant amount of pain down the left leg. Dr. Harris authorized physical therapy to strengthen the back and adjust Mr. Boones’ gait. Dr. Rambach recorded that Mr. Boone told him he has gotten worse since he was last seen on December 16, 2009. He was taking ibuprofen 200 mg six tablets per day and had been adding two Tylenol when his pain got worse. He did not derive any relief from this medication. Dr. Rambach recorded that “Mr. Boone’s gait was altered favoring his left lower extremities on a continuous basis. He complained of only being able to stand for short periods of time without having increased pain and had to limit his walking. On physical examination he moved from the sitting into a standing position slowly and cautiously. He was able to stand erect but complained of pain in his lower back and left knee when doing so. He walked with a definite left lower extremity antalgic – type gait referral to his left region. When attempting to toe or heel walk he complains of increasing pain in the back of the lower part of his left thigh and knee. He has limited dorsiflexion and plantar flexion of the left foot and ankle because of pain.”

13. In the section of this report entitled Discussion/Opinion, Dr. Rambach wrote:

After having the opportunity to reevaluate Mr. Boone approximately one year following my initial evaluation, my opinion has changed. At the present time it is my opinion that he has ongoing pain primarily in the left knee area, which is sympathetically mediated. Although he does not have the classic objective findings of complex regional pain syndrome (reflex sympathetic neuropathy), I do believe his left knee pain is sympathetically mediated. The hallmark pain of complex regional pain syndrome is generally described as burning, tearing, searing and throbbing. He does have consistent complaints and that is a tearing and burning sensation, particularly in the back of his knee and to some degree anteriorly. The clinical objective findings are some atrophy of the quadriceps and musculature as noted under the physical examination [left less than a quarter of an inch] there is also some coolness, although mild, in the anterior aspect of the left knee and antalgic gait which is described above. I can find no indication of any mechanical nerve root compression signs suggestive of intervertebral disc injury with nerve root irritation emanating from the lumbosacral spine. Most probably his lower back pain is related to the abnormal distribution of weight bearing, which produces a mechanical stress or strain to the lumbosacral musculature however, his major problem is his left knee and lower extremity, which would prevent him from being able to return to work as a correctional officer.

14. Dr. Rambach wrote that Mr. Boone would be unable to perform his job duties, including having to crawl, stoop, crouch or bend his left knee. He could not stand in the same position continuously and he is unable to walk over uneven surfaces. He would definitely be unable to run in an all-out effort while responding to alarms or serious incidences. He would be unable to take down and restrain an inmate if necessary.

15. On March 4, 2011, Dr. Rambach wrote a supplemental report after reviewing the surveillance video of Mr. Boone taken on September 14 and September 15, 2010. He wrote that he had viewed Mr. Boone playing with what appeared to be his two young daughters on a trampoline and walking from his classes at college. He noted that this was three months prior to his examination in December 2010, during which Mr. Boone walked in the examining room with a left lower extremity limp and had subjective responses of pain and discomfort during certain portions of the physical examination of his left knee. Dr. Rambach wrote that he did not observe Mr. Boone "displaying any form of a limp or abnormal gait" while walking in various situations or performing the activities depicted in the surveillance video. He also

noted that the video depicted that Mr. Boone was able to get in and out of his pickup truck without any difficulty. "This is not consistent with his history of continued pain and discomfort in his left knee." Dr. Rambach also wrote that "Mr. Boone's activities and actions recorded in the CD surveillance CD are inconsistent with his subjective complaints of pain, and a lower extremity limp." Dr. Rambach concluded that Mr. Boone is able to perform his usual duties as a correctional officer.

16. At hearing, Dr. Rambach testified that most of the findings he recorded in his examinations of Mr. Boone were negative or were within normal limits and there were no significant abnormalities. His knee was taken to full ranges of motion and there were no other indications of orthopedic or musculoskeletal problems. There was a slight variation between the right and left by measurements which was negligible.

17. Dr. Rambach described complex pain syndrome. It usually occurs from a traumatic neuropathic abnormality. The nerves produce pain and discomfort to an extremity. The syndrome is now called complex regional pain syndrome (CRPS) and is difficult to diagnose. Dr. Rambach testified that he gave Mr. Boone the "benefit of the doubt" when he eventually found him to have CRPS and to be unable to work. Initially he felt he was temporarily unable to work and gave him six months of exercise limiting him from situations where he could be subjected to undue force or stress. This should have been sufficient time to recover.

18. Dr. Rambach explained that after a year had passed between his first and second examination of Mr. Boone, Mr. Boone's examination was almost the same. He continued to demonstrate antalgic gait. He had findings a little more obvious than the previous examination, so he gave the same diagnosis and determined that Mr. Boone had moderate regional sympathetic dystrophy which had worsened because of the pronounced antalgic gait and lack of improvement after various therapies. Therefore, he gave him the benefit of the doubt and concluded that he was permanently disabled.

19. Dr. Rambach described what he observed on the September 14, 2010 surveillance videotape. Mr. Boone was bouncing his three-year-old daughter on his back, bending up and down consistently and had to be using his knees and his hips. Dr. Rambach testified that he has "never seen anyone with CRPS of any grade be able to work like that." He testified that Mr. Boone did not exhibit any aberration. The next morning, September 15, 2010, Mr. Boone is filmed walking around a college campus. Dr. Rambach saw no gait abnormalities and no limp.

20. Dr. Rambach described what he observed on the surveillance videotape taken on April 19 and April 20, 2011. Mr. Boone was observed to arrive at a physician's office on the 19th and get out of the car exhibiting an antalgic gait of at least a grade II, which is more than a mild limp but is a "pretty obvious limp." After he left the physician's office he was observed walking around and there was "a little

gait aberration.” On the morning of the 20th he was observed going to his college campus and walking throughout the day carrying books in a backpack. He had no limp whatsoever.

21. Dr. Rambach testified that he altered his opinion about Mr. Boone’s condition because people who have CRPS do not make a significant difference or improvement day to day or even over a few months. One “does not limp one day and then not limp the next day.” An antalgic gait does not go away overnight and one cannot walk freely without evidence of a limp. Mr. Boone would not have been able to disguise or control his limping consciously, even after some training in physical therapy. Limping is an involuntary response to pain and Mr. Boone was not limping in the videotapes. Nor was he limping in the hearing room. There was no physiological or orthopedic explanation for the discrepancies in the disability he portrayed to physicians versus his performance in the videotapes. Dr. Rambach testified that his impression was that Mr. Boone actually presented himself in two different fashions in a short period of time and was either exaggerating and magnifying his complaints or not being truthful. Both videotapes confirm he was not being legitimate. Dr. Rambach has changed his opinion and finds that if Mr. Boone had a sympathetic nerve problem, he has a mild gradation of CRPS, and is able to perform the duties of a correctional officer.

Dr. McIntire's Opinion

22. On April 19, 2011, Steven L. McIntire M.D. evaluated applicant in connection with his application for disability retirement and issued a report. Dr. McIntire is a neurologist, and a Diplomate of the American Board of Psychiatry and Neurology. He has extensive treatment, diagnostic and consulting experience in neurology. Dr. McIntire reviewed Mr. Boone’s medical records, took a history and conducted an examination. Dr. McIntire noted that he did not have the job description for review but he found that Mr. Boone would only be restricted from extremely physical activity such as crawling on all fours or on his knees and that he would not be able to engage in takedowns or physical restraining of inmates or run at full speed. His diagnostic impression was that Mr. Boone had clear hyperesthesia (unusual or pathological sensitivity of the skin or of a particular sense to stimulation) and allodynia (pain from stimuli which are not normally painful) and appeared to have sympathetic mediated pain with limited deficits. He found that Mr. Boone’s incapacity would be permanent given the time that had passed since the injury.

23. Dr. McIntire also reviewed the surveillance videotape of September 14 and September 15, 2010, and noted that Mr. Boone was observed playing with a couple of children on a trampoline. At one point he appeared to be holding one of the children up on his back while in a crouched or kneeled position and appeared to bounce with her. The position of his knee was not clear from the video. Other times he was observed to be ambulating without a distinct limp. The videotape did not change his underlying opinion, even though it was very clear Mr. Boone was either

flexing or extending crouched at the knees or bouncing at the knees and his upper and lower trunk were moving up and down.

24. On May 31, 2011, Dr. McIntire issued a supplemental report noting that he had reviewed the surveillance videotapes of April 19 and April 20, 2011, "wherein Mr. Boone was observed walking in various areas." Dr. McIntire noted that "his gait is generally normal or minimally antalgic." At this time Dr. McIntire had the opportunity to review the physical requirements of the position of correctional officer. He noted that Mr. Boone was required to crawl up to 50 yards and expected to carry over 100 pounds for 200 yards on an occasional basis. He found that "although there are limited findings on examination of the claimant, the findings do substantiate a neuropathic pain condition or sympathetically mediated pain. Given the extreme physical requirements of the position, such as needing to be able to crawl for 50 yards, Mr. Boone would not be able to complete the activities of a correctional officer. He is, therefore, substantially incapacitated in the performance of his duties."

25. On March 5, 2012, Dr. McIntire issued a supplemental report noting that he had read a report of investigation dated November 10, 2011, containing a statement of Lieutenant Erik Beck, Mr. Boone's supervisor. The statement of Lieutenant Beck "clarifies that the claimant did not have to carry significant weight for over 100 yards. It also indicates that the claimant did not have to crawl for 50 yards. The physical nature of the claimant's job duties is clarified beyond what had been provided previously." Dr. McIntire opined: "Based on this report, therefore, I have to change my opinion regarding the claimant's capacity to perform his duties. Based upon this report, Mr. Boone would not be substantially incapacitated for the performance of his job duties. The claimant should be able to return to his previous form of work as a correctional officer."

26. At hearing, Dr. McIntire explained that he initially precluded Mr. Boone from extreme physical activity such as crawling on all fours or on his knees and running at full speed or conducting takedowns. This was based on his neuropathic pain diagnosis. Based on Dr. McIntire's limited understanding of what the job requirements were at the time, he assumed Mr. Boone would be significantly engaged in rigorous activities. He testified that Mr. Boone did not present with the more severe diagnosis of CRPS, but with sympathetic mediated pain, which is a less severe diagnosis. He noted that he had pointed out in his report that Mr. Boone had a mild condition with apparently very limited impact or deficit. The only aspects of CRPS that he was reporting was that he perceived non-noxious stimulus as painful, such as a light touch producing pain. Because of this degree of hypersensitivity, Dr. McIntire felt that if Mr. Boone had to crawl a significant amount of time on his knees it would be very painful. He later learned from Lieutenant Beck's report that Mr. Boone only had to get on his knees to look under a bunk when doing a cell search a few times a day. Dr. McIntire had also "envisioned hand-to-hand" type of fighting and crawling over the dirt in a military type combat, which was not what Lieutenant Beck described.

27. Dr. McIntire testified that after he reviewed the videotapes of April 19 and April 20, 2011, it was clear to him that "things were not adding up," but given the extreme nature of what was reported as the duties of a correctional officer, Dr. McIntire felt Mr. Boone could have limitations. He believed at the time that some very mild subtle abnormalities on examination could become significant under most extreme circumstances. After reviewing Lieutenant Beck's description of job duties, and hearing Lieutenant Beck testify at hearing, he no longer believes Mr. Boone is incapacitated. He testified that "it is medically probable that Mr. Boone exaggerated his condition" and that he is not substantially incapacitated from performing his usual duties.

Dr. Branscum's Opinion

28. John Branscum M.D. is a board certified orthopedic surgeon. He performed a qualified medical evaluation of Mr. Boone on February 19, 2009 and a re-evaluation on December 6, 2010. He performed record reviews and examined Mr. Boone. During the February 19, 2009 interview, Mr. Boone reported he had a constant stabbing pain in his left knee and it felt to him like there was a pulled muscle in the back of his leg. He had sensations of burning in and below the knee. On a good day he rated the pain at a level of 4 out of 10, but on bad days the pain increased to 9 out of 10. Even on good days, if he walked for any length of time the pain increased to 9 out of 10. Prolonged sitting and hard impact activities such as running or jumping increased the pain. In order to relieve the pain he had to reposition his knee every so often. He reported very severe 10 out of 10 pain with activities such as heavy lifting, heavy carrying, pushing, pulling, running, jumping, prolonged sitting, prolonged driving, standing, kneeling, squatting and walking on flat or uneven surfaces. Dr. McIntire diagnosed him with well-documented reflex sympathetic dystrophy involving the left knee. Dr. Branscum had opined in February 2009 that over time reflex sympathetic dystrophy would usually burn itself out provided the patient forced himself to walk on the leg even though he experiences severe pain. The worst thing he could do was to give in to the pain and the doctor recommended that he obtain a cane and walk for an hour every day, even though walking would be extremely painful. He had exhausted all forms of conservative therapy and Dr. Branscum determined he could not return to his usual and customary occupation.

29. During the re-examination of December 6, 2010, Mr. Boone was walking with a limp and reported that he had developed back pain due to his antalgic gait. He complained his left knee symptoms remained unchanged and were severe and caused him to limp on his left leg. He reported a fairly constant slight pain with intermittent episodes of severe pain. He reported that once the back pain begins he has severe pain for 3 to 4 hours before it begins to subside. He reported he can sit for an hour but he is only able to stand for 10 minutes and to walk for 20 minutes. He required a cane to assist in ambulation.

30. Dr. Branscum found Mr. Boone to have clinical evidence of reflex sympathetic dystrophy of the left knee with tightness, shininess and coolness of the knee, an exquisite tenderness to light palpation and dysthetic burning pain and antalgic gait on the left. These symptoms precluded him from heavy lifting, heavy carrying, pushing, pulling, prolonged weight-bearing, running, jumping, kneeling, squatting, crawling, and climbing and walking on uneven terrain or sloping surfaces.

31. Dr. Branscum was not provided with the videotapes of Mr. Boone bouncing his child on his back, and walking about campus without a limp on September 14 and September 15, 2010, just three months before he reported to Dr. Branscum with severe knee pain, back pain, limping and inability to walk without a cane. Nor was he provided with the April 19 and April 20, 2011 videotapes of Mr. Boone walking without a cane or a limp after his appointment with Dr. McIntire and on his college campus.

Testimony of Mr. Boone

32. The pertinent portions of Mr. Boone's testimony are as follows. He was assigned to the High Desert facility which has a higher level of inmates in the sense that they pose more risk. This population of inmates has been sentenced for murder and robbery and the environment is more volatile. There are occasional riots in this facility. On the date of the injury, April 5, 2008, an inmate head butted his partner and Mr. Boone had to wrestle the inmate to the ground and hold him down with his knee while wrestling his arms behind his back in order to restrain him.

33. Mr. Boon testified that correctional officers need to qualify with a weapon and have to be available for mandatory overtime over their standard eight hour shift. The job involves bending at the waist and knees and squatting several times a day when doing searches or when putting inmates against the wall. Correctional Officers are required to walk occasionally to continuously and must run occasionally with an all-out effort when responding to incidents, the furthest distance would be 200 yards and would include stairs and slippery surfaces including snowy surfaces. He has to carry trays weighing 10 to 15 pounds and crawl and crouch in cell searches six times per shift. He has to physically restrain and drag inmates and brace during altercations.

34. Mr. Boone explained that he has complex regional pain syndrome on his left knee due to the April 5, 2008 incident. He has permanent symptoms of constant pain in his left knee with his left leg going stiff and shooting pain into the left leg from the knee, making it hard to walk. He has stiffness in the left knee joint and numbness from the top of the knee to the ankle. He experiences the symptoms every day. If he works for hours and hours in the day it starts to stiffen and he has increased pain and if he falls in a hole or a pothole it really hurts. Bending or sitting in a car starts to make the knee sore. Walking is limited. He has fallen a few times carrying his daughter from his truck to the house when she is asleep. If he has to pick

up his daughter he ends up icing his knee and staying in bed. He does not run anymore and it is very hard to stand for long periods of time.

35. Mr. Boone testified that his pain does not prevent walking or standing and he walks on a daily basis at least a couple of miles. Dr. Branscum asked him to do this so that he would not lose muscle in his knee. He walks around the school campus and at his job in a jewelry store. He begins to limp when his knee is hurting a lot and he tries to walk without a limp. Limping was starting to hurt his back but he limps depending on the severity of the pain. He can squat and stand with pain and probably run for a small distance. He does not know if he could complete firearms qualifications as he has not tried. He does not believe he could restrain an inmate or defend himself or conduct inmate searches "after a while." He could not walk an eight hour shift or a sixteen hour shift. He does not believe he could carry out the functions of a correctional officer.

36. Mr. Boone testified that he used to run up to 9 miles a day training for a marathon and he used to snowboard. In the last months he has used an elliptical trainer to try to keep fit, about 15 minutes every other day to give his knees a break. He avoids squatting because it hurts and the pain stays with him for the rest of the day. His knee becomes very stiff and sore and is hard to walk on after driving, for instance driving from Redding to the hearing took 2.5 hours and was very difficult. He noted that "after a while it becomes a little painful walking, over an hour I imagine I never tested it and I do not know for sure whether I could carry over 30 pounds as I have not tested it." He also has not tested crawling but would imagine it would be very hard. He acknowledges that he never had to crawl over 50 yards in the correctional setting. He understands that his restrictions from Dr. Branscum were not that he could not do these activities but that he should not. He testified that occasionally he uses a cane a couple of times every couple of months for a day when the knee gets very bad and it is very hard to walk on it. His lower back pain is gone because he stopped limping as much. He started trying to limp less and worked on not limping after he started physical therapy. He is not in physical therapy anymore. He has a prescription for Norco but he does not take it because he has to go to work and school and take care of his daughter.

37. Mr. Boone testified that he can sit more than 10 minutes now and walk more than 20 minutes. Over an hour of walking starts to cause a lot of pain. Mr. Boone acknowledged that he walked into and out of Dr. McIntire's IME appointment on April 19, 2011 with a significant limp, because he was feeling severe pain. The drive from Redding to Sacramento for the appointment had increased his symptoms. Mr. Boone did not explain why he stopped limping when the vehicle stopped in Anderson on the way home and why he switched places with the driver. He explained that the next day, on campus, he was walking without a limp because he was not experiencing severe pain. He also explained that his knee feels better in the morning because he has not been doing a lot on it. And at the college campus there are only a few hundred yards from class to class.

38. Mr. Boone did not explain anything related to the videotape of September 14, 2010 where he was bouncing his daughter on his back.

Duties of Correctional Officer

39. Lieutenant Beck has worked at High Desert State Prison in Susanville for over 17 years. He was a sergeant when Mr. Boone was employed and was Mr. Boone's supervisor. He testified that Mr. Boone worked as a Housing Unit Officer assigned to the Reception Center where they receive county level prisoners into state prison. Four to six officers are assigned to this unit. Lieutenant Beck described the duties of the Correctional Officer position, which are summarized as follows. Duties include transporting inmates to appointments on the premises and supervising them while they are at these appointments. The officer is responsible for walking paper work to and from various departments within the facility, escorting inmates to their housing unit and supervising inmates in the housing unit. When escorting inmates to their unit or to an appointment the officer is required to transport the inmate's belongings. He also has to conduct six cell searches per shift and carry food trays to inmate's cells on occasions when inmates were not allowed to go to the dining room. Carrying trays require the officer to walk up four flights of stairs approximately 20 times per shift. Most everything lifted is under 100 pounds and the inmates' belongings usually weigh approximately 50 pounds. The distance from the reception area to the inmates housing unit could be up to 200 yards however they had a hand truck for officers to use. Lieutenant Beck has never had to carry 100 pounds for 200 yards and no other correctional officer "in recent history" has been required to so. He has never had to crawl 50 yards during the course of his employment and has never seen anyone else crawl that distance during their employment.

40. Lieutenant Beck explained that cell searches require officers to get on their hands and knees to look under beds and Mr. Boone would have been required to conduct six cell searches per shift. During weapons qualifications, annually, officers will fire some rounds from a kneeling position. There may have been times a long time ago when an officer would have to run 400 yards in response to an alarm. But now there are response teams and only those assigned are required to respond. The majority of the officer's time is spent standing, but at times they are able to sit down and take weight off or eat lunch. And when they are assigned to a tower they can sit and supervise from a seated position at times. If an officer is assigned to overtime, a 16 hour shift, they would be required to stand a great deal of that time. There is a significant amount of running to responses multiple times a day and officers are required to get to the location in an expedient manner without tiring themselves out too much to be able to function when they get there. When they respond to a rallying point they have non lethal as well as lethal forms of defense and do not necessarily have to engage in a wrestling match and could simply be responding to medical alarms.

41. Lieutenant Beck acknowledged that High Desert State Prison is a very active institution and there is a significant amount of running in response to incidences. However, officers respond as a group to a specific point location where they form a response line to respond. In 17 years, Lieutenant Beck has been involved in five takedowns. The takedowns require several officers taking an inmate to the ground and restraining him.

42. The Duty Statement of Correctional Officer, the Essential Functions and the Job Analysis of the position were submitted in evidence. These documents reiterate that a correctional officer must be able to walk and stand for long periods of time, run with all-out effort on occasion, sit occasionally to continuously and continuously to frequently carry 20 pounds to 50 pounds throughout the day. The documents describe occasional very heavy lifting, carrying an inmate and physically restraining an inmate, dragging an inmate from a cell and performing lifting and carrying activities. Lieutenant Beck confirmed that these latter duties are performed by teams and not by single individuals.

Discussion of Evidence

43. It was clear from the summaries of medical records that Dr. Rambach, Dr. McIntire and Dr. Branscum made, and from their own observations, that there was no evidence of internal derangement of Mr. Boone's left knee, although there were mild degenerative changes in the left knee and some softening of the cartilage. The physicians found very little objective evidence of a neuropathic pain condition or sympathetically mediated pain, although there was some objective evidence on examination that supported Mr. Boone's complaints. For instance his left knee was swollen when he was examined by Dr. Branscum on December 6, 2010. However, the physicians were initially persuaded that Mr. Boone could not perform his job duties because of his reports of continuous severe pain, his failure to improve over time with multiple conservative therapies, his reports that these conservative therapies increased his pain and his pronounced antalgic gait and use of a cane.

44. Dr. Rambach initially felt that Mr. Boone's symptoms would resolve, but gave Mr. Boone the benefit of the doubt a year later after he reported that the pain had worsened and he demonstrated a grade II antalgic gait. Dr. McIntire believed that Mr. Boone was subject to much more rigorous work duties and that even if his pain was not as severe; he could not perform these duties. Both physicians gave Mr. Boone the benefit of their doubts and accepted that his pain syndrome was significant enough to preclude him from work. Both physicians changed their views with additional evidence.

45. Dr. Branscum's opinion remains the only medical opinion supporting Mr. Boone's claim that he is substantially incapacitated from performing his usual job duties due to pain and an antalgic gait. Dr. Branscum's last opinion was issued on December 6, 2010 and he has not reevaluated Mr. Boone. In forming his opinion, Dr.

Branscum emphasized that Mr. Boone had grade II antalgic gait, required a cane and as of August 2010 had developed left lumbar back pain due to the limp. He noted that when he first examined Mr. Boone in February 2009, he complained of severe constant pain with walking and prolonged sitting. He noted that Mr. Boone had not improved. Dr. Branscum did not view the videotape taken less than three months before the December 6, 2010 appointment, which showed Mr. Boone vigorously bouncing his 30 pound daughter on his back for several minutes and Mr. Boone walking with a normal gait. Dr. Branscum did not observe the normal gait Mr. Boone displayed in the April 19 and April 20, 2011 videotapes. Dr. Branscum also was persuaded by Mr. Boone's reporting that he had developed lower back pain in August 2010, which was less than a month before he was observed playing with his daughter on the trampoline. For the above reasons, Dr. Branscum's opinion was given less weight than the opinions of Dr. McIntire and Dr. Raumbach.

46. In sum, Mr. Boone failed to meet his burden of establishing that he is substantially incapacitated from the performance of his usual duties as a Correctional Officer.

LEGAL CONCLUSIONS

1. Mr. Boone seeks disability retirement pursuant to Government Code section 21151, subdivision (a), which provides in pertinent part:

Any patrol, state safety, state industrial, state of 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. Government Code section 20026 provides that:

"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.

3. "Incapacity for the performance of duty" under Government Code section 21022 [now section 21151] "means the substantial inability of the applicant to perform his usual duties." (*Mansperger v. Public Employees' Retirement System* (1970) 6 Cal.App.3d 873, 876.) Substantial inability to perform usual duties must be measured by considering applicant's abilities. Discomfort, which makes it difficult to perform ones duties, is insufficient to establish permanent incapacity from

performance of one's position. (*Smith v. City of Napa* (2004) 120 Cal.App.4th 194, 207, citing *Hosford v. Board of Administration* (1978) 77 Cal.App.3d 854, 862.) A condition or injury that may increase the likelihood of further injury, as well as a fear of future injury, do not establish a present "substantial inability" for the purpose of receiving disability retirement. (*Hosford v. Board of Administration of the Public Employees' Retirement System* (1978) 77 Cal. App. 3d 854, 863-864.) As the court explained in *Hosford*, prophylactic restrictions 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.

4. An applicant for disability retirement must submit competent, objective medical evidence to establish that, at the time of application, he or she was permanently disabled or incapacitated from performing the usual duties of his or her position. (*Harmon v. Board of Retirement* (1976) 62 Cal.App.3d 689, 697 [finding that a deputy sheriff was not permanently incapacitated from the performance of his duties, because "aside from a demonstrable mild degenerative change of the lower lumbar spine at the L-5 level, the diagnosis and prognosis for the [the sheriff's] condition are dependent on his subjective symptoms."].)

5. Findings issued for the purposes of workers' compensation (e.g., that respondent was permanent and stationary and was a "qualified injured worker") are not evidence that respondent's injuries are substantially incapacitating for the purposes of disability retirement. (*Smith v. City of Napa* (2004) 120 Cal.App.4th 194, 207; *English v. Board of Administration of the Los Angeles City Employees' Retirement System* (1983) 148 Cal.App.3d 838, 844.)

6. The burden of proof is on Mr. Boone to show that he is permanently and substantially unable to perform his usual duties such that he is permanently disabled. (*Harmon v. Board of Retirement of San Mateo County* (1976) 62 Cal. App. 3d 689; *Glover v. Board of Retirement* (1980) 214 Cal. App. 3d 1327, 1332.) Mr. Boone has not met that burden, by virtue of the Factual Findings and Legal Conclusions.

7. Mr. Boone is not permanently and substantially disabled or incapacitated from the performance of his job duties and, therefore, is not entitled to industrial disability retirement pursuant to Government Code section 21151, based on the Factual Findings and Legal Conclusions.

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ORDER

1. Mr. Boone's appeal of the CalPERS determination that he is not eligible for industrial disability retirement is DENIED.
2. Mr. Boone's application for industrial disability retirement is DENIED.

DATED: December 17, 2012



ANN ELIZABETH SARLI
Administrative Law Judge
Office of Administrative Hearings