

ATTACHMENT A
THE PROPOSED DECISION

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

In the Matter of the Employer's Application
for Disability Retirement of:

STEVEN J. BLANCARTE, JR.

Respondent,

and

CITY OF IRWINDALE,

Respondent.

CASE NO. 7839

OAH NO. 2010070989

PROPOSED DECISION

Michael A. Scarlett, Administrative Law Judge (ALJ), Office of Administrative Hearings, heard this matter in Glendale, California on January 11-12, 2012.

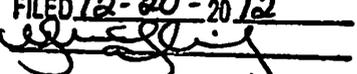
Patricia Miles, Senior Staff Counsel, represented the California Public Employees' Retirement System (CalPERS).

Douglas D. Barnes, Attorney at Law, represented Respondent Steven J. Blancarte Jr. (Respondent), who was present at hearing. There was no appearance by Respondent City of Irwindale.

Oral and documentary evidence was received and the matter was submitted on and the record was left open to allow the parties to submit written closing arguments. On February 22 and 23, 2012, Respondent and CalPERS submitted timely written closing arguments, identified as Exhibits M and 14 respectively, and the matter was submitted on February 23, 2012.

FACTUAL FINDINGS

1. Mary Lynn Fisher filed the Statement of Issues in her official capacity as the Chief of the Benefit Services Division of CalPERS.

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2. Respondent, Steven J. Blancarte Jr., was employed by Respondent City of Irwindale (Irwindale) in Irwindale, California. At the time Respondent filed his application for retirement, he was employed as the City Manager for Irwindale.

3. By virtue of his employment, Respondent was a local miscellaneous member of CalPERS subject to Government Code section 21150. He meets the minimum necessary eligibility requirements for retirement benefits from CalPERS.

4. On September 21, 2005, Respondent submitted an application for service retirement pending disability retirement. The service retirement request was based on a disability as a result of cardiological and psychological conditions. Respondent retired from service effective January 26, 2006, and has been receiving his retirement allowance since that date.

5. On December 4, 2006, CalPERS notified Respondent of its determination that he was "not substantially incapacitated" for the performance of his job duties as a City Manager for Irwindale, and that therefore, Respondent's application for disability retirement was denied. Although Respondent's disability retirement application was denied, he continued to receive his service retirement benefits.

6. On December 18, 2006, Respondent filed a timely appeal requesting a hearing. Thereafter, this hearing ensued.

Respondent's Job Duties as City Manager of Irwindale

7. Pursuant to the job description for the City Manager position as of June 23, 2000, when Respondent was hired as the City Manager of Irwindale, the position description and duties were as follows:

The City Manager reports directly to and serves at the pleasure of the City Council. As the city's Chief Executive Officer, he/she provides policy-based program and financial decision-making advice and support to the Council, implements Council direction, and initiatives, appoints the City Planner, Police Chief, Director of Finance, Director of Public Works, and support staff, develops and administers the City's budget, and provides leadership to City employees to meet the Council's ambitious goals and objectives. In addition, the City Manager serves as the Executive Director of the City Redevelopment Agency and Personnel Director.

The City Manager's responsibilities include the following:

The City Manager has primary responsibility for over seeing the day to

day operations of the City. He/she works closely with the City's senior executive team in formulating strategic, community, public safety, and economic plans and programs, developing management and personnel policies and procedures, assessing staffing needs, selecting and developing staff, establishing performance standards and measures, evaluating employee effectiveness, conducting organization analysis, negotiating labor contracts, monitoring revenues and expenditures, and ensuring that the City has sound management, fiscal, personnel, and information systems. The City Manager is an important link between the City Council, city staff, citizens, businesses, community groups, the mining industry, special interest groups, and other public agencies and regulatory bodies. He/she promotes community participation in city government and supports City staff involvement in community activities.

8. In 2006, Irwindale had a population of about 1,500 residents and an annual operating budget, including the Redevelopment Agency and the mining fund, of approximately 55 million dollars per year. The City Manager served at the pleasure of a five member City Council which meant that he or she could be fired at any time on a majority vote by the City Council. Respondent described the City Manager position as being highly political and subject to extreme political pressures from residents, the business community and the Redevelopment Agency. The small size of the City and the relatively large budget and financial interests, created a very difficult political environment in which the City Manager had to operate. Given the frequent turnover in City Council members because of the small electorate and politically charged environment, Respondent's job security frequently depended on the composition of the City Council and whether the council was comprised of a majority of members that shared or was not opposed to the policies and objectives he was trying to implement. As the City Manager in a small city, Respondent was responsible for a wide range of duties including budget, finance, personnel, redevelopment, and advising the City Council. Respondent testified that the politically charged and fluid environment of this small city with divergent constituency interests contributed greatly to the stress he experienced as the City Manager of Irwindale from 2000 to 2006.

Respondent's Medical Condition

9. In 2000, Respondent was diagnosed with hypertension (high blood pressure) and high cholesterol. Prior to this time, he was considered to be reasonably healthy and he was an avid golfer, frequently playing golf competitively. On June 10, 2001, Respondent began experiencing severe pain in his chest and abdomen while playing golf. He was rushed to the hospital emergency room and was diagnosed with a Type B aortic dissection, a tearing in the wall of the aorta. The aortic dissection was accompanied by an aortic aneurysm, the ballooning or swelling of the aorta. His physicians determined that surgery was not feasible and that his condition could be treated by medication. He was placed on medication to lower his blood pressure and cholesterol. Respondent's medications included Clonidine, 0.1 mg.

daily; Hydrochlorothiazide, 25 mg. daily; Zestril (Lisinipril) 5 mg. twice a day; and Labetalol 200 mg. three time per day to lower his blood pressure, and Mevacor, 20 mg. every day for high cholesterol. Respondent was also restricted from doing any heavy lifting, physically demanding exercise, including playing competitive golf, and told to stop smoking cigars. Respondent remained in the hospital for approximately seven days until his pain subsided. He returned to work in July 2001, and continued to work as the Irwindale City Manager for the next four and a half years.

10. Over the next four years, 2001-2005, Respondent closely monitored his blood pressure per instructions from his physicians. His medications were intended to keep his blood pressure as low as possible to lessen the risk of rupturing his aortic aneurysm. The physicians advised him that an elevated blood pressure would increase the pressure on the aortic walls and could result in the rupture of the aorta which would almost certainly result in death. Respondent's physicians had hoped that aggressive treatment with medications would keep Respondent's blood pressure level in the area of a systolic in the 80 and a diastolic in the 60's. While at work, Respondent routinely checked his blood pressure with a portable blood pressure monitor. Respondent felt considerable stress while he was working as a result of the demanding nature of his position as the City Manager. Whenever he would feel stressed at work, Respondent would become flush and develop pink and rosy cheeks. He could feel his face warming up and his arms would get heavy. Respondent associated the flushed feeling and heavy arms with the elevation of his blood pressure. He would periodically take his blood pressure at work, which revealed that during periods he was calm, his blood pressure would average 105/65 and during stressful periods, his blood pressure would elevate to 145/105. Respondent believed that the elevated blood pressure levels would occur approximately one to four times per day while at work.

11. Since 2001, Respondent has also been evaluated with frequent CT Scans to monitor his aortic aneurysm and dissection. The CT Scans showed that Respondent's aortic aneurysm has increased in size since the June 10, 2001 aortic dissection and aneurysm. In August 2005, Respondent's treating physician, Dr. Dodofredo Gutierrez, M.D., reviewed Respondent's 2004 and 2005 CT Scans. Dr. Gutierrez requested Dr. Kwok L. Yun, M.D., Assistant Chief of the Regional Department of Cardiac Surgery at Kaiser Permanente in Los Angeles, California, to review Respondent's CT Scans. On August 29, 2005, Dr. Yun, after reviewing the 2004 and 2005 CT Scans, informed Dr. Gutierrez the following: "It appears that the proximal descending aorta has increased in size from over 5cm to a little over 6cm. The aorta at the level of the PA (pulmonary artery) is about 0.5 cm larger. So it appears that the aorta is enlarging at a rate that is faster than normal (1.2mm per year)." Dr. Yun went on to state that Respondent's aorta was at a size that an operation should be considered, and further suggested that Respondent's CT Scans be reviewed by Dr. Thomas A. Pfeffer, M.D., Chief of Service at Kaiser Permanente's Regional Department of Cardiac Surgery. Respondent scheduled a consultation with Dr. Pfeffer, who usually performed the surgeries associated with a descending aortic aneurysm.

12. On September 7, 2005, after a consultation with Respondent and reviewing his

CT Scans, Dr. Pfeffer concluded that “there has been a gradual progression particularly of the proximal descending thoracic aorta with maximal diameter of approximately 6.2 cm.,” although Respondent’s radiology CT Scan reports had indicated no “significant change in caliber.” Dr. Pfeffer discussed the rationale for surgical intervention, and noted that if Respondent were to have surgery, “he will require cardiac catheterization, carotid duplex study, pulmonary function tests and aortogram to delineate the aortic arch anatomy.” At the time of the consultation, Dr. Pfeffer gave Respondent the option to have the surgery immediately or to await the results of another CT Scan in January 2006.

13. According to Respondent, Dr. Pfeffer recommended the surgery and explained the details of the surgery during their consultation. In 2005, the surgical option available to Respondent involved an extensive and evasive reconstruction of the aorta. Respondent stated that Dr. Pfeffer advised him that the “mortality rate” for patients undergoing this type of surgery was 95 percent, meaning there was a five percent chance he would not survive the surgery. There was a 90 percent survival rate without paralysis, meaning there was a ten percent chance he could be paralyzed after the surgery, due to the risk of the interruption of blood flow to the spinal cord during the surgical procedure. Respondent testified that Dr. Pfeffer advised him that he needed to “reduce all the stress” in his life and to have the surgery. Respondent, being surprised and alarmed by the extent of the surgical procedure, told Dr. Pfeffer “I really need to retire.” Respondent testified that Dr. Pfeffer then told him “that would be a good idea.” Thus, although Dr. Pfeffer did not specifically recommend at that time that Respondent retire, Dr. Pfeffer agreed that that retirement would be a good idea given Respondent’s medical condition.

14. In September 2005, Respondent was not willing to risk the surgical option and decided to retire from his position as City Manager of Irwindale in an attempt to reduce the stress in his life.¹ On September 8, 2005, Respondent advised Dr. Gutierrez that he had decided to wait on the results from a CT Scan in January 2006 and that he would retire in January 2006. Respondent chose January 2006 as a retirement date so that he could afford Irwindale four months for an orderly transition for his replacement. Respondent’s last day of work was January 4, 2006, and his retirement became effective January 26, 2006.

15. On October 6, 2005, Dr. Gutierrez completed a CalPERS Physician’s Report on Disability form which was submitted to CalPERS. Dr. Gutierrez concluded that Respondent was substantially incapacitated from performing the usual duties of his

¹ Respondent testified at hearing that he did not consider the surgical option in 2005 because of the risk associated with the surgery at that time. However, since that time the surgical prospects for repairing the aortic dissection and aneurysm had improved. At the time of hearing, Respondent had already completed the first phase of the surgical procedure to repair his dissection and aneurysm, but the major portion of the surgery had not been scheduled. The result of the future surgery is not relevant to the inquiry currently before CalPERS. This hearing concerns Respondent’s medical condition at the time of his application for disability retirement on September 21, 2005.

employment due to the significant mental stress associated with Respondent's employment that made it difficult for Respondent to control his hypertension. He noted that Respondent's aortic aneurysm was worsening despite optimal medical therapy. Finally, Dr. Gutierrez stated that the aortic dissection and aneurysm would require surgical repair to prevent an aortic rupture and that until he could have the surgery, hypertension control was important.

16. In 2005, Respondent was continuing with aggressive medication treatment to lower his blood pressure and to control his high cholesterol. At that time, his medications included Clonidine, 0.1 mg. three times per day; Labetalol three times per day, Lisinopril, 20 mg. twice per day to lower his blood pressure, and Lovastatin, 10 mg. twice per day and Zetia, 10 mg. per day for high cholesterol. Currently, Respondent remains on the aggressive treatment of medications to lower his blood pressure and cholesterol.

CalPERS' Independent Medical Evaluation

17. On May 3, 2006, Dr. Howard M. Staniloff, M.D., a cardiologist certified by the American Board of Cardiovascular Diseases, and CalPERS' Independent Medical Evaluator (IME), reviewed Respondent's medical records and examined Respondent for purposes of determining his eligibility for CalPERS disability retirement benefits. He prepared an IME report dated May 8, 2006, and testified at hearing as CalPERS' expert witness. Dr. Staniloff reviewed medical records provided to him as of May 2006. His report indicated that:

The most recent scan which is included from 8/12/2005 documents a type B dissection starting beyond the origin of the left subclavian artery and ending at the common iliac artery. There was description of a dilatation in the junction of the aortic arch to the descending thoracic aorta which at its maximum cross-sectional diameter is 6.2 x 4 cm.

18. Dr. Staniloff testified that based upon the reports reviewed, Respondent's aortic dissection "was a tear in the aorta just downstream from where the major blood vessel goes to the left arm called the 'subclavian artery.'" The tear extended from the "false lumen" all the way down the full length of the aorta and exited at Respondent's right leg. Dr. Staniloff testified that Respondent's dissection was "about as large as they can get and be a Type B" dissection. Regarding the aortic aneurysm, he testified that the 6.2 x 4 cm enlargement of the aorta was "quite large" given the normal diameter for the aorta would be in the range of three centimeters. Dr. Staniloff also testified that treating high blood pressure was a factor in relationship to treatment of an aortic aneurysm, and that lowering Respondent's blood pressure as low as possible was the intent of the medications he was taking. When Dr. Staniloff examined Respondent in May 2006, his blood pressure was 90 over 65, which was considered low blood pressure. Respondent told Dr. Staniloff that his blood pressure had decreased since he stopped working in January 2006.

19. Following his physical examination of Respondent on May 3, 2006, Dr.

Staniloff diagnosed Respondent with the following: (1) Aortic dissection Type B; (2) Perceived increase in stress; (3) Hypercholesterolemia; (4) Hypertension; (5) Asthma; (6) Nocturia; (7) Hay fever; and (8) Anemia. His IME report noted the following:

This man has a well-documented dissection of his aorta which is type B. This is normally treated with medications as his was. He now has documentation that there is dilatation of the junction of the aortic arch with the aneurysm. This is 6 4 cm [sic] in diameter. Certainly as the dimensions increase, there is increased chance of dissection or rupture at that point. He is being closely evaluated by his physicians and to optimize the time of surgery. The expectation is that this could happen within the next six months or year, but this is uncertain.

The aneurysm does not appear to be causing any symptoms on its own. The hypertension and hypercholesterolemia appear to be well controlled. They are not causing any symptoms and they appear to be well controlled. He comments that his blood pressure was higher at work. He also comments significantly about the stress at work and this appears to be his major restriction.

From a cardiovascular standpoint, I think he is stabilized with medication. The present problems are not causing symptoms at work. He is concerned about a possible operation. Certainly that would have associated risks and recuperation, but it would not be considered part of retirement, since it would not necessarily be permanent or of prolonged period. In addition, there was the concern about rupture. The retirement guidelines for CalPERS clearly define that prophylactic measures are not considered a component of retirement.

20. In providing his opinion, Dr. Staniloff specified that he was dealing only with the "present cardiovascular components" and not Respondent's "stress components" which would need to be addressed separately, noting that a proper stress evaluation should be performed to address this condition.

21. Ultimately, Dr. Staniloff concluded in pertinent part that: (1) there were not specific job duties that Respondent was unable to perform because of his medical condition; (2) Respondent was not presently substantially incapacitated from performing the usual duties of his position as a City Manager; (3) that Respondent was not presently substantially incapacitated from performing his duties but that things could change in the future, particularly if he has the surgery to repair the dissection and aneurysm; (4) that Respondent was not substantially incapacitated from performing the "usual duties of the position for other California public agencies in CalPERS, based upon his medical condition; and (5) that Respondent did not exaggerate his complainants to any degree, and that he cooperated with the physical examination. He concluded that the major factor impacting Respondent's blood

pressure was his medications, and not stress related to his employment as a City Manager. However, at hearing Dr. Staniloff conceded that if Respondent's aortic aneurysm was to rupture, there was a 60 to 70 percent chance such rupture would result in his death.

Respondent's Medical Expert's Opinion

22. Dr. Jay N. Schapira, M.D., a cardiologist certified by the American Board of Cardiovascular Diseases and American Board of Internal Medicine, testified as an expert witness on Respondent's behalf. Dr. Schapira conducted a physical examination of Respondent in August 2011 and reviewed his medical records, including Respondent's CT Scan reports and the actual CT Scans and X-rays, from March 2002 through August 2011. Respondent told Dr. Schapira that he was under considerable stress at work and that he worked long hours as the City Manager of Irwindale. He described side effects from the blood pressure medications to include fatigue, impotence, tiredness and difficulty concentrating. Respondent told Dr. Schapira that he has pains in his chest a few times per week which last for five to ten seconds and were approximately a two on a scale of one-to-ten in severity. He also mentioned a "weighty" and "tingly" feeling or sensation in his arms, but stated that these feelings had dissipated since his retirement from work in 2006. Respondent complained about a definite increase in symptoms when he was at work, as opposed to since he has been retired from his job.

23. Dr. Schapira diagnosed Respondent with the following: (1) Type B aortic dissection extending from the proximal portion of the descending aorta into the iliac arteries bilaterally, with a double-barreled aorta and false lumen patency; (2) Hypertension; (3) Hyperlipidemia; (4) Occupation stressors; (5) History of anemia; and (6) History asthma. Based upon his review of Respondent's CT Scans, Dr. Schapira noted a definite increase in the size of Respondent's aortic aneurysm since 2001. He stated that the "dimension of the aorta in the axial point of the body" was measured "at 8.1 x 6.5 cm in 2008 with no change since that time." Dr. Schapira testified that his review of Respondent's CT Scans revealed a slightly higher degree of enlargement of the aneurysm than was indicated by the Kaiser Permanente CT Scan Reports. He noted that Dr. Yun's review of the 2004-2005 CT Scans indicated that the aorta was enlarging at a rate that was faster than normal, a little over five centimeters to six centimeters from 2004 to 2005, compared to a normal rate of about 1.2 mm per year. Dr. Schapira explained that apparent discrepancies in the CT Scan Reports may be a result of the different points at which the radiologists were measuring the aorta from CT Scan to CT Scan. But, he concluded even the 7.1 to 7.3 cm measurements documented by the CT Scan Reports in August 2011 established that Respondent's aneurysm was enlarging at an alarming rate.

24. Dr. Schapira concluded that Respondent's aneurysm was increasing in size at a rate more than the normal rate of enlargement for a patient with Respondent's type of aortic dissection and aneurysm. He noted that Respondent's aortic aneurysm had a maximum diameter of the greater than eight centimeters at that time he examined Respondent in August 2011. Dr. Schapira opined that "the etiology of this dissection and aortic aneurysm is

substantially due to increasing aortic wall stress causing the wall to stretch and balloon (aneurysm) and to split apart (dissect).” He further opined that:

The blood pressure ‘symptoms’ along with the blood pressure measurements correlate with the chest symptomatology to identify increased stress on the aortic wall. As increased stress proceeds on the aortic wall, there is further dilatation of the aortic wall, pushing Mr. Blancarte closer and closer to the point of rupture as the aneurysm continues to expand....

Considering Mr. Blancarte’s overall health, there is a reasonable medical certainty that his death will be due to the dissecting aortic aneurysm....

The role of Mr. Blancarte’s work in his overall health is that it was stressful for him as described in this report and was found to elevate his blood pressure as well as cause vascular symptoms. The elevated blood pressure causes stress on the aortic wall and the emotional stress causes the blood pressure to go up and thereby cause stress on the aortic wall. The stress on the aortic wall would tend to make the dissection more extensive. Stress leads to more pressure which leads to the expansion of the aneurysm closer to the point of rupture....

This is not a prospective problem but rather a medical certainty that as stress is induced on the aorta that it puts Steve Blancarte in a place closer to rupture. To a reasonable medical certainty Mr. Blancarte will die of aortic rupture caused by stress on the aortic wall caused by hypertension and stressor which would be significantly sustained by returning to work as City Manager in Irwindale. Returning him to work would, to a reasonable medical certainty, hasten his death, by putting him under the stress of his job that then translates into stress on his aorta....

25. A review of the medical evidence and opinions in this case established that on June 10, 2001, Respondent suffered a Type B aortic dissection and aneurysm. The aortic aneurysm has been increasing in size since 2001, and renders Respondent susceptible to the serious risk of rupture. Since 2001, Respondent’s aneurysm has increased in size at a rate that was faster than normal, and as of 2005, had increased in size to about 6.2 cm at the largest point of the aneurysm. Dr. Gutierrez, Dr. Yun, Dr. Pfeffer, Dr. Staniloff, and Dr. Schapira all agreed that Respondent’s aneurysm was enlarging at an alarming rate. The normal size for the aorta is considered to be three centimeters and the evidence showed that Respondent’s aortic aneurysm had doubled in size by August 2005, and was at 7.3 centimeters by August 2011. Dr. Schapira’s review of Respondent’s CT Scans revealed that Respondent’s aneurysm had increased in size from four centimeters in March 2002 to 6.2

centimeters in August 2005, an increase of 2.2 centimeters over a three and a half year period. He attributed this faster than normal increase in size to the stress associated with Respondent's employment as a City Manager, which caused Respondent's blood pressure to rise and placed stress on the walls of his aorta. CT Scans from 2006 to 2011, after Respondent's retirement, showed that his aortic aneurysm increased from 6.2 centimeters to 7.3 centimeters, just 1.1 centimeters, an indication that the rate of enlargement had slowed since his retirement from employment, over almost a five year period of time. Dr. Schapira opined that the slower rate of growth directly reflected the removal of stressors associated with Respondent's employment as City Manager of Irwindale.

26. Dr. Staniloff, although conceding that Respondent's aneurysm had enlarged since returning to work in 2001, declined to offer an opinion regarding the impact of work-related stress on the enlargement of the aortic aneurysm. However, Dr. Schapira, Dr. Pfeffer, and Dr. Gutierrez believed that Respondent's employment was contributing to his stress and that increased stress negatively impacted the aortic aneurysm, causing enlargement. Respondent's aggressive treatment of his hypertension with medications was intended to keep his blood pressure low in an attempt to relieve stress on the walls of the aorta and lessen the risk of aortic rupture. Dr. Schapira believed that work-related stressors were contributing to the faster than normal enlargement of Respondent's aortic aneurysm. His opinion was corroborated by Dr. Pfeffer and Dr. Gutierrez, who both believed that Respondent should have discontinued working in 2005 because of the stress and resulting blood pressure elevation. Consequently, Dr. Schapira's opinion that work-related stress was causing enlargement of the aorta is credited over Dr. Staniloff's opinion that Respondent's aortic aneurysm was stable and controlled by medications in 2006. Additionally, Dr. Schapira's examination of the actual CT Scans, as opposed to Dr. Staniloff's mere review of the CT Scan Reports, renders Dr. Schapira's diagnosis more compelling based on his access to the actual x-rays of the aortic aneurysm.

27. The medical evidence showed that Respondent is at significant risk of a rupture of his aorta due to the June 2001 aortic dissection and aneurysm. It is undisputed that such a rupture of the aorta would to a reasonable medical certainty cause Respondent's death. Respondent's medical condition is not prospective or prophylactic in nature, but is an actual, existing medical condition that necessarily required his retirement from employment to prevent the rupture of his aortic aneurysm. There is sufficient evidence to conclude that work-related stressors were in fact increasing Respondent's blood pressure level which consequently placed pressure on the aortic wall. Respondent's aortic aneurysm had increased in size at a faster rate than normal as of August 2005, and thus, increased work-related stress significantly increased the probability that Respondent's aortic aneurysm would rupture. These factors, as of September 2005, rendered Respondent incapacitated from performing the usual duties of his employment without the significant risk of rupturing his aorta, which could ultimately cause his death. CalPERS' contention that such a risk constituted a prospective injury or prophylactic restrictions were not supported by the record.

28. Based on the evidence and medical opinions offered at hearing, as of

September 2005, Respondent's medical condition was shown to be a current, substantially incapacitating condition that prevented him from performing the usual duties of his employment. Accordingly, the evidence established that Respondent was disabled for purposes of qualifying for CalPERS disability retirement benefits when he submitted his application on September 21, 2005.

LEGAL CONCLUSIONS

1. An applicant for retirement benefits has the burden of proof to establish a right to the entitlement. (*Harmon v. Board of Retirement* (1976) 62 Cal.App.3d 689, 691.) Government Code section 20026 provides in pertinent part 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." The incapacity must be a substantial inability to perform usual duties.

(*Mansperger v. Public Employees' Retirement System* (1970) 6 Cal.App.3d 873, 876-877.) It is not enough that a physical condition would make it more difficult to do certain duties. The fact that a small percentage of duties could not be performed does not result in a substantial inability to perform. *Mansperger* reasoned that although a fish and game warden was limited in lifting heavy objects due to an injury to his arm that limited the power in his elbow by 20 percent, and his forearm by 40 percent, the warden could still carry out the normal duties of a fish and game warden. (*Ibid.*)

2. Government Code section 21150 provides in pertinent part that: "Any member incapacitated for the performance of duty shall be retired for disability pursuant to this chapter if he or she is credited with five years of state service, regardless of age" Section 21156 provides in pertinent part: "If the medical examination and other available information show to the satisfaction of the board . . . that the member is incapacitated physically or mentally for the performance of his or her duties in the state service and is eligible to retire for disability, the board shall immediately retire him or her for disability"

3. Respondent established by a preponderance of the evidence that he is substantially incapacitated from performing his usual job duties as a City Manager for the City of Irwindale, by reason of Factual Findings 1 through 28.

4. CalPERS contends that Respondent's injury or medical condition, i.e., the aortic dissection and aneurysm, constitutes a substantial risk of incapacitation, not present substantial incapacitation, and thus, his injury or further injury is prospective in nature. They point to Respondent's ability to work for four and one half years after the June 10, 2001 occurrence of the Type B dissection and aneurysm as proof that Respondent is capable of performing the normal duties of his job. CalPERS cites *Mansperger* and *Hosford v. Board of Administration* (1978) 77 Cal.App.3d 854 in arguing that Respondent's medical condition does not presently render him substantially incapacitated from performing the normal duties

of his job as a City Manager.

However, both *Mansperger* and *Hosford* are distinguishable from the case at hand. *Mansperger* as discussed above had an arm injury that limited his ability to lift heavy objects, which restricted him from performing a very small percentage of his normal duties as a game warden. *Hosford* involved a California highway patrolman who injured his back lifting an accident victim. In *Hosford*, the highway patrolman argued that sitting for long periods of time would “probably bother his back” and the physical activity required of a patrolman subjected him to the “risks” of further injury to his back. However, the evidence showed that *Hosford* was able to sit for long periods as well as perform the physical activities he feared would further injure his back. *Hosford* held that the evidence showed the patrolman’s back injury and purported restrictions did “little more than demonstrate that his claimed disability is only prospective (and speculative), not presently in existence.” (*Hosford, supra*, 77 Cal.App.3d at p. 863.) *Hosford* concluded the California highway patrolman could perform the normal duties of his job and was thus not substantially incapacitated for purposes of receiving disability benefits.

Respondent’s case is more closely analogous to the case of *Wolfman v. Board of Trustees* (1983) 148 Cal.App.3d 787. *Wolfman* involved a teacher who suffered from severe asthma and chronic bronchitis. She was required to take steroids, potent and dangerous drugs with adverse side effects, and in her last year of teaching, her dosage was increased which caused her to become increasingly ill. (*Id.* at p. 789.) Her doctors advised her to retire from teaching because of the risk of her condition worsening due to her exposure to rampant infectious agents carried by small children. The court concluded she was disabled and stated:

Although physically capable at the time of hearing to perform her duties, it would be medically unwise. Her improved state was due to the discontinuance of her classroom contacts and a resultant decrease in the steroids she required. Reinstatement would initiate the vicious circle of infection leading to severe pulmonary attack and increased necessity for dangerous steroid therapy.

(*Wolfman, supra*, at p. 791)

The court further concluded that the teacher’s disability in *Wolfman* was not speculative, but that “[d]uring her final years of employment she consistently reached a medically determinable stage of severity. It was not merely a prospective probability, but a medical certainty.” (*Wolfman v. Board of Trustees, supra*, 148 Cal.App.3d at p. 791.) The court concluded that “*Wolfman* suffers from a chronic disease, preventing her from effectively performing her duties. ‘The provisions for disability retirement are also designed to prevent the hardship which might result when an employee who, for reasons of survival, is

forced to attempt performance of his duties when physically unable to do so.” (*Ibid.*, quoting *Quintana v. Board of Administration* (1976) 54 Cal.App.3d 1018, 1021.)²

Here, the evidence established that Respondent’s aortic dissection and aneurysm was not prospective or speculative in nature. Respondent’s Type B aortic dissection was described by both experts, Dr. Staniloff and Dr. Schapira, as the most severe case of a dissection they had ever seen, and that Respondent’s survival after this event was miraculous. The evidence showed that Respondent’s aortic aneurysm was increasing in size at a rate that was faster than normal from 2001 to 2005, and that his aneurysm had increased to 6.2 centimeters in diameter by August 2005. The average diameter for an aorta is considered three centimeters. Respondent’s physicians and Dr. Schapira believed that there was a substantial risk of the rupture of Respondent’s aorta if the aneurysm continued to increase in size at the rate it was increasing in 2005. His treating physicians, Dr. Guiterrez, Dr. Pfeffer, and Dr. Yun, recommended surgery to repair the Respondent’s aorta, but the surgical option at that time called for an evasive and extensive reconstruction of the aorta and bore unacceptable risks of paralysis and death, which Respondent was unwilling to risk.

Respondent was on an aggressive medication treatment for his high blood pressure in August 2005, but the stress of his work was inhibiting his ability to control his blood pressure at the very low levels his physicians recommended. The amount of medications he was taking was causing some side effects and the possibility of increasing the dosages of medication was not practical. The evidence showed that work-related stress was significantly contributing to the elevation of Respondent’s blood pressure while at work. An elevated blood pressure increased the pressure on the aortic walls and made the likelihood of a rupture almost a certainty. The enlargement of Respondent’s aortic aneurysm slowed after he retired from the City of Irwindale in January 2006. Dr. Pfeffer recommended that Respondent retire from employment to reduce the amount of stress in Respondent’s life. Dr. Schapira testified that there existed reasonable medical certainty that Respondent’s aorta aneurysm would rupture if he continued working in the stressful position of a City Manager at Irwindale. Both Dr. Schapira and Dr. Staniloff testified that a rupture of the aortic aneurysm would likely be fatal for Respondent.

Like the teacher in *Wolfman*, Respondent’s aortic aneurysm had reached a “medically determinable state of severity” in September 2005 which made it “medically unwise” for him to continue working as a City Manager. The work-related stress was causing his blood pressure to elevate, which subsequently placed increased pressure on the walls of his aorta. This increased pressure created a significant risk of rupture, which

² Although *Wolfman* considered a disability under the Education Code section 22122, which it noted required a finding of “impairment,” a lesser standard than the “incapacity” required under Government Code section 21022 [recodified as section 21151], the court considered the standards in both *Mansperger* and *Hosford*, and concluded that *Wolfman* would have been disabled under the standards set forth in *Mansperger* and *Hosford*. (*Wolfman, supra*, at p.792.)

ultimately could have led to Respondent's death. There is nothing prospective or speculative about Respondent's disability. The evidence showed that there was more than a 90 percent chance that eventually the Type B aortic dissection and aneurysm would probably be the cause of Respondent's death, even after his retirement in January 2006. However, continuing to work under the stressful conditions as a City Manager would have hastened this eventuality. Respondent's elevation in blood pressure levels when working, an occurrence that happened one to four times per day while at work, would place stress on an aortic aneurysm that was already increasing in size at an alarming rate. A decision to continue to work would have been medically unwise given the severity of his medical condition and resulting disability.

5. Accordingly, Respondent established that he was substantially incapacitated from performing his usual duties as a City Manager for the City of Irwindale. Thus, CalPERS inappropriately denied Respondent's application for disability retirement benefits.

ORDER

WHEREFORE, THE FOLLOWING ORDER is hereby made:

Respondent Steve Blancarte Jr.'s application for disability retirement benefits is granted.

Dated: December 19, 2012.


MICHAEL A. SCARLETT
Administrative Law Judge
Office of Administrative Hearings