ATTACHMENT A

THE PROPOSED DECISION

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

In the Matter of the Application for Industrial Disability Retirement of: RORY M. MAYBERRY, Respondent, and DEPARTMENT OF MENTAL HEALTH, VACAVILLE PSYCHIATRIC PROGRAM, Respondent.	Case No. 2012-0522 OAH No. 2012080852

PROPOSED DECISION

This matter was heard before Administrative Law Judge Jonathan Lew, State of California, Office of Administrative Hearings, on April 10, 2013, in Sacramento, California.

The California Public Employees' Retirement System (CalPERS) was represented by Elizabeth Yelland, Senior Staff Counsel.

Samuel C. Mullin III, Attorney at Law, represented Rory M. Mayberry, who was also present. There was no appearance on behalf of the Department of Mental Health, Vacaville Psychiatric Program.

Submission of the case was deferred pending filing of hearing briefs. Respondent's Hearing Brief was filed on April 22, 2013, and marked as Exhibit E for identification. CalPERS' Reply Brief was filed on April 29, 2013, and marked as Exhibit 13 for identification. The matter was submitted for decision on April 29, 2013.

FACTUAL FINDINGS

1. Rory M. Mayberry (respondent) was employed as a Senior Medical Assistant by the Department of Mental Health, Vacaville Psychiatric Program (Department). By virtue of his employment, respondent is a state safety member of CalPERS subject to Government

CALIFORNIA PUBLIC EMPLOYEES'
RETIREMENT SYSTEM
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Code section 21151.[1] On October 7, 2010, respondent filed an application for industrial disability retirement with the Benefits Services Division of CalPERS. He described his specific disability as follows: "Disk herniated at C-5 C-6 with on-going neck pain and limited range of motion. Progressively worsens with increased level of activity. Weakened left side from previous injuries to left wrist, left shoulder, left biceps (bicep tendon rupture). Left and right carpal tunnel. Increased anxiety/agitation, intense headaches."

On October 7, 2010, respondent also signed an application for service retirement. He retired for service effective May 1, 2011, and has been receiving his retirement allowance from that date.

2. CalPERS obtained or received medical reports concerning respondent's orthopedic (left shoulder, neck, and bilateral wrist) conditions from competent medical professionals. After reviewing the reports, CalPERS determined that respondent was not permanently disabled or incapacitated from performance of his duties as a Senior Medical Assistant at the time his application for industrial disability retirement was filed. CalPERS' determination was based upon its review of medical records pertaining to respondent's orthopedic condition, including a report prepared by orthopedic surgeon Joseph W. McCoy, M.D.

By letter dated May 23, 2011, CalPERS notified respondent of its determination and advised him of his appeal rights. Respondent filed an appeal and request for hearing by letter dated June 12, 2011. CalPERS filed a Statement of Issues on August 31, 2012. Per the Statement of Issues, respondent's appeal is limited to the issue of "whether, on the basis of orthopedic (left shoulder, neck, and bilateral wrist) conditions, respondent Mayberry is permanently disabled or incapacitated from performance of his duties as a Senior Medical Assistant for respondent Department of Mental Health, Vacaville Psychiatric Program. If disability is found to exist, any dispute as to whether the disability is industrial or nonindustrial will be resolved pursuant to Government Code section 21166."

3. Respondent began working as a Senior Medical Assistant for the Department in February 2002. He continued working there through May 2010. A Senior Medical Assistant supervises, directs and works with staff performing health care and custodial activities in an assigned area of the Vacaville Psychiatric Program (VPP). The VPP is situated within the California Medical Facility in Vacaville, California. The facility houses state prison inmates diagnosed with psychiatric conditions (e.g. suicidal, schizophrenic, bipolar disorder) that make them prone to highly assaultive and violent behaviors. Respondent's position required that he have both peace officer status, as well as responsibility as a medical assistant. He wore a uniform with sergeant chevrons that outwardly identified him as a correctional officer. Respondent believes he was so perceived

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[1] Government Code section 21151, subdivision (a), provides: "Any 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."

by inmates. His job responsibilities included escorting inmates, enforcing VPP rules, insuring the good order of group therapy sessions, and maintaining inmate control in combative and emergency situations.

4. Responsibilities for maintaining inmate control included stopping assaults on staff or other inmates, preventing inmates from injuring themselves, and restraining inmates. Respondent estimated that he had to control inmates in this fashion three to four times per month. Respondent was required to wear a stab-proof vest under his uniform, and a utility belt that included restraint devices.

Respondent worked around maximum security (Level IV) inmates and he was responsible for maintaining discipline and order within the VPP. He had contact with inmates over 90 percent of the work day.

While the job title "Senior Medical Assistant" does not bring to mind the above described job duties, respondent averred that inmate control and restraint were central to the Senior Medical Assistant's position within the VPP. He believes the inability to perform such duties would substantially impair a Senior Medical Assistant's capacity to perform the usual duties of that position. And that the ability to react immediately, without hesitation, is critical to maintaining control of violent inmates and insuring the safety of fellow staff members.

Physical Injuries

5. Respondent was first injured on November 20, 2003. He suffered a pulling and twisting injury to his left wrist, and ultimately underwent surgery for a rupture of the extensor carpi ulnaris tendon, approximately a year following this injury.

Respondent returned to work at the VPP. On May 21, 2004, he was "blindsided by an inmate who punched me twice in the face." During the course of taking the inmate down and cuffing him, respondent suffered injuries and was taken to the VacaValley Emergency Room, where he was evaluated, treated and released. Respondent was diagnosed with injuries to the cervical spine and left shoulder, and aggravated injury to his left wrist.

6. Respondent came under the care of Blaine Johnson, M.D. Dr. Johnson diagnosed cervical spondylosis, and also noted a probable rotator cuff tear of the left shoulder. Over the next several years, respondent was evaluated by a number of physicians. Marvin Zwerin, D.O., evaluated him around March 1, 2005, and noted a history of left wrist strain, with ligament tear due to the November 20, 2003 injury, and surgery as a result of the May 21, 2004 incident. Diagnostic studies at the time of surgery revealed a partial-thickness rotator cuff tear, with a complete disruption of the biceps tendon and subacromial impingement. Respondent underwent an arthroscopic subacromial decompression procedure with repair and debridement of the partial-thickness rotator cuff tear. The biceps tendon tear was irreparable, and repair was not even attempted.

7. Respondent continued to see Dr. Johnson, who diagnosed him with progressive cervical spine degenerative disc disease. Dr. Johnson referred him to David Schiff, M.D., who provided a consultation on July 16, 2008. At that time Dr. Schiff noted cervical spondylosis with radiculitis.

Respondent subsequently came under the care and treatment of David Woodhouse, M.D. Dr. Woodhouse diagnosed him with carpal tunnel syndrome, cervical spondylosis, and possible cervical radiculopathy. Respondent was allowed to continue working. As respondent's symptoms progressed, an MRI of the cervical spine was performed on January 8, 2010. This revealed underlying degenerative disc disease with mild cerebral atrophy. A second MRI of the cervical spine with contrast was performed a month later. This confirmed a C4-5 nucleoplasty with disc space narrowing and some instability. There was also a broad-based disc bulge at C5-6, and diffuse facet degenerative changes.

8. Respondent was referred to orthopedic hand surgeon Elise Smith-Hoefer, M.D. She performed a right carpal tunnel release on May 14, 2010, and on June 25, 2010, she performed left carpal tunnel release with injection of cortisone into the thumb carpometacarpal joint. Respondent went on disability leave prior to the May 14, 2010 surgery. He did not return to work after his carpal tunnel release surgeries, electing to service retire pending decision on his application for industrial disability retirement.

Respondent's Testimony

9. Respondent indicated that when he bends his left arm, it goes into spasm which he described as a "charley horse." He cannot even apply deodorant without his arm knotting up. He indicated that were he to lift his left arm to grab an inmate, he would not be able to do so. Respondent averred that he cannot even reach out with his left arm to cuff an inmate, and that he was essentially limited to one arm were he to attempt to restrain, control or take down an inmate. Respondent acknowledged working up to May 2010. For the 10 months leading up to May 2010, he averred that his symptoms had worsened. He noted that a new rule requiring him to wear the stab-proof vest contributed to increasing neck pain and headaches. He took more pain medications as a result over that period, and this caused him to feel less aware than he believed he needed to be. He was taking Norco and muscle relaxants, and went through four to five different medications over this period. At the time he stopped working at VPP, respondent did not believe he could protect himself or others from assaultive inmate behaviors. He did not feel he could take an inmate down to the ground, or otherwise protect other VPP staff.

Evaluation by Joseph McCoy, M.D.

10. Respondent was seen for an independent medical examination by orthopedic surgeon Joseph McCoy, M.D., on March 16, 2011, in Napa, California. Dr. McCoy is board certified in orthopedic surgery and has practiced, including residency training, nearly 30 years in the field. Dr. McCoy testified at hearing.

Respondent reported to Dr. McCoy that he had increasing pain predominately on the left side extending into his left upper extremity. He reported that extension of his neck or left lateral rotation caused tightness and the sensation of impending snapping of his neck. Respondent indicated that his activities caused no significant issues during normal activity, but with more strenuous activity he had significant increased pain.

11. Upon orthopedic examination, Dr. McCoy noted "a noticeable deformity involving his left upper arm with an apparent proximal rupture of the long head of the biceps with bunching up of his biceps and slightly greater circumference on that side measuring 32 5 cm compared to 31 0 cm on the right. His right forearm is 27 0 compared to 26 5 cm on the left compatible with him being right hand dominant." Dr. McCoy examined respondent's cervical spine, and found no palpable spasm or deformity. He noted some mild diminished range of movement, particularly with left lateral rotation and extension. Respondent demonstrated giveaway weakness in all the muscle groups of the left arm including grip strength. This suggested to Dr. McCoy "some lack of complete effort." No specific neurological deficit was identified.

Dr. McCoy measured grip strength with a Jamar dynamometer with three sequential alternating attempts. All three attempts on the right side were done at 85 pounds. The left side test showed substantial decrease and variability 60, 40, and 40. Respondent had excellent range of motion of his left shoulder and left wrist. There was evidence of incisional scarring on the left shoulder and left wrist.

12. Dr. McCoy reviewed the substantial medical records and reports dating from a May 28, 2004 MRI of respondent's left shoulder, up to an October 29, 2010 disability report prepared by David Woodhouse, M.D., respondent's primary care physician. Dr. McCoy considered other medical records and reports by James McMahan, M.D., Eric Grigsby, M.D., David Woodhouse, M.D., Blaine Johnson, M.D., Norman Panf, M.D., David Schiff, M.D., Jeffrey Metheny, M.D., Elise Smith-Hoefer, M.D., and Bryan Andrews, M.D.

Based upon his orthopedic examination and medical record review, Dr. McCoy made the following diagnoses: 1) Left wrist sprain requiring surgical repair in 2003; 2) Left shoulder injury requiring rotator cuff debridement with a proximal biceps rupture in 2004; 3) Bilateral carpal tunnel surgery in 2010; and 4) Chronic history of cervical disc disease; and 5) History of hypercholesterolemia and ill-defined cardiac disease.

13. Dr. McCoy reviewed respondent's job description as a Senior Medical Assistant for VPP, including the physical requirements for the position. Dr. McCoy noted that it was significant that respondent worked up until the time of his carpal tunnel release and that "prior to this application and the carpal tunnel surgery, his various treating doctors felt that he was capable of performing his usual and customary work."

Based upon his review of respondent's job description and the Physical Requirements of Position form, Dr. McCoy opined that respondent was not substantially incapacitated for the performance of his duties. He explained his medical opinion as follows:

> I have reviewed the job description and I am concerned about Mr. Mayberry's ability to physically handle management of assaultive behavior because of his ongoing cervical spine difficulties. He has been performing this duty all along, although it certainly remains an ongoing concern. It is important to note, however, that he was managing these difficulties prior to the above carpal tunnel intervention.
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> I have thoroughly reviewed the medical record and I am struck by the very mild findings on his diagnostic studies regarding his cervical spine. I have no doubt in my mind that Mr. Mayberry is experiencing some ongoing symptoms, however, I do not, at this time, find him substantially incapacitated for the performance of his usual duties. He undoubtedly will experience some discomfort with his most strenuous tasks, although this problem in and of itself does not appear to create a substantial incapacity.

14. Dr. McCoy further opined that if respondent proceeded with surgical intervention on his neck, he would be incapacitated for approximately six months. If such surgery were successful, he anticipated that respondent would be able to return to his usual and customary work "without an ongoing substantial incapacity." In a supplemental report dated May 9, 2011, Dr. McCoy clarified that he was unable to identify any specific tasks that respondent was physically unable to perform at that time.

In a second supplemental report dated May 14, 2012, Dr. McCoy indicated that he had an opportunity to review additional medical records submitted to him by CalPERS. These included a July 28, 2011 Agreed Medical Examination Report by John D. Warbritton, III, M.D. Dr. McCoy's medical opinion regarding respondent's ability to perform his work duties remained unchanged.

15. At hearing, Dr. McCoy explained that the cramping in respondent's left upper extremity (biceps) is a common finding early on, but is not a permanent problem. He acknowledged that respondent has decreased strength in his left arm, and that his left arm may fatigue more quickly if it is subject to repetitive maximum use such as lifting. While taking down an inmate would require maximum contraction of this particular muscle group, Dr. McCoy noted that this condition has existed since 2004, and that if respondent's injury were disabling he would not have been able to engage in this activity from that time.

Other Medical Evaluations

16. Respondent submitted medical evaluations from John D. Warbritton, M.D., dated July 28, 2011, and October 27, 2011. Dr. Warbritton examined respondent as an agreed medical examiner in connection with his workers' compensation case. Dr. Warbritton

did not appear as a witness. Respondent also submitted two Workers' Compensation Appeals Board Stipulations.

These medical reports and Workers' Compensation records were considered to the extent permitted under Government Code section 11513, subdivision (d), for the purpose of supplementing or explaining other medical evidence.

17. Respondent has not demonstrated through competent medical evidence that he is permanently disabled or incapacitated from performance of his duties as a Senior Medical Assistant with the Department of Mental Health, VPP. Competent medical evidence in the form of Dr. McCoy's medical reports and testimony following medical orthopedic evaluation support a finding that respondent's neck, left shoulder, left arm and bilateral wrist conditions do not substantially incapacitate him from performing his duties as a Senior Medical Assistant. There was no competent medical evidence to the contrary in the record that could be considered as direct evidence in this case.

Dr. McCoy's diagnoses do include evidence of 25 percent decrease in respondent's left arm grip strength, and weakening of the left arm with maximum effort. Respondent also had some diminished range of movement, particularly with left lateral rotation. However, Dr. McCoy opined that these conditions would not prevent respondent from performing his specific job duties. Dr. McCoy was cognizant of respondent's critical duties of restraining combative or violent inmates. He acknowledged that it was a concern that respondent would undoubtedly experience discomfort with his most strenuous tasks. However, Dr. McCoy explained that such discomfort did not rise to the level of a substantial incapacity, the applicable standard in these cases. After consideration of the medical evidence relating to respondent's combined orthopedic conditions the application for industrial disability retirement should be denied.

LEGAL CONCLUSIONS

1. Government Code section 21151, subdivision (a), provides: "Any 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."

Government Code section 20026 provides that " 'Disability' and 'incapacity for performance of duty' as a basis of retirement, means disability of permanent or extended and uncertain duration, as determined by the board ... on the basis of competent medical opinion."

2. Being "incapacitated for the performance of duty" means the "*substantial* inability of the applicant to perform his usual duties." (*Mansperger v. Public Employees Retirement System* (1970) 6 Cal.App.3d 873, 875, italics original; *Curtis v. Board of Retirement of Los Angeles County Employees Retirement Association* (1986) 177 Cal.App.3d

293, 297-298 [applying the *Mansperger* standard for "incapacitated for the performance of duty" to the County Employees Retirement Law of 1937].) The inability to perform some of the duties of a position does not render one disabled. (*Mansperger v. Public Employees Retirement System*, *supra*, at pp. 876-877 [fish and game warden's inability to carry heavy items did not render him substantially incapacitated because the need to perform such task without help from others was a remote occurrence].)

In *Mansperger*, the court explained that the term "incapacitated for the performance of duties" meant a substantial inability to perform the employee's usual duties. (*Id.* at p. 876.) The applicant in *Mansperger* was a warden with the Department of Fish and Game whose physician opined that he could no longer perform heavy lifting and carrying. The evidence established that such tasks were an infrequent occurrence, and the applicant's customary activities were the supervision of hunting and fishing. The *Mansperger* court found that the applicant was not entitled to disability retirement because, although he suffered some physical impairment, he could perform most of his usual job duties.

3. Subsequently, in *Hosford v. Board of Administration of the Public Employees' Retirement System* (1978) 77 Cal.App.3d 854, the Court of Appeal applied the *Mansperger* test to the disability retirement claim of a California Highway Patrol sergeant who sustained injuries to his back and leg, which restricted his ability to carry out some of the functions of a patrol officer, including driving a patrol car for lengthy periods. Regarding whether there must be actual present disability or whether fear or possibility of future injury is sufficient to find disability, the court noted that "Hosford relied and relies heavily on the fact that his condition increases his chances for further injury . . . this assertion does little more than demonstrate that his claimed disability is only prospective (and speculative), not presently in existence." The *Hosford* court held that the disability or incapacity must presently exist and that a mere fear of possible future injury which might then cause disability or incapacity was insufficient. (*Id.* at p. 862.)

4. Respondent has the burden of proving entitlement to disability retirement. (*Harmon v. Board of Retirement of San Mateo County* (1976) 62 Cal.App.3d 689, 691; *Rau v. Sacramento County Retirement Board* (1966) 247 Cal.App.3d 234, 238.) It is well accepted that CalPERS may rely on decisions affecting other pension plans when the laws are similar, and since Government Code section 31724 (County Employees' Retirement Law) is similar to Government Code section 21151 (California Public Employees' Retirement Law), the rule concerning burden of proof shall be applied to cases under CalPERS law. (*Bowman v. Board of Pension Commissioners for the City of Los Angeles* (1984) 155 Cal.App.3d 937, 947.)

Evidence of the employee's permanent incapacity must be based on competent medical evidence. (Gov. Code, § 31720.3.)

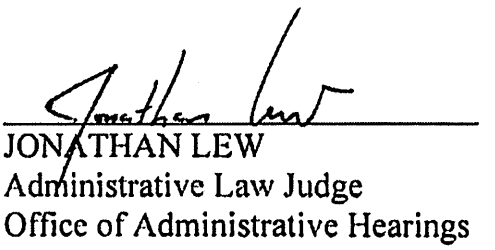
5. The matters set forth in Findings 5 through 17 have been considered. It was not established through competent medical evidence that respondent's orthopedic conditions substantially incapacitate him from the performance of his usual and regular duties as a

Senior Medical Assistant. Dr. McCoy's reports and testimony comprised the only competent and direct medical evidence in this case. Dr. McCoy recognized that respondent experienced discomfort and difficulty performing certain activities, but he nevertheless opined that there are no job duties that respondent could not perform because of his physical condition. Dr. McCoy further opined that respondent is not substantially incapacitated for the performance of his duties. Respondent presented no competent medical evidence to the contrary.

ORDER

The application of Rory M. Mayberry for industrial disability retirement is denied.

DATED: May 28, 2013



JONATHAN LEW
Administrative Law Judge
Office of Administrative Hearings