

ATTACHMENT A
THE PROPOSED DECISION

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

In the Matter of the Application for Disability
Retirement of:

MILAGROS OLIVER,

and

DEPARTMENT OF CORRECTIONS AND
REHABILITATION, DIVISION OF
JUVENILE JUSTICE (HERMAN G. STARK
YOUTH TRAINING SCHOOL),

Respondents.

Case No. 9002

OAH No. 2012021210

PROPOSED DECISION

This matter was heard by Julie Cabos-Owen, Administrative Law Judge with the Office of Administrative Hearings, on September 18, 2012, and May 9, 2013, in Glendale, California. The California Public Employees' Retirement System (CalPERS) was represented by Senior Staff Counsel Rory J. Coffey. Milagros Oliver was present and was represented by Michael Keating, Attorney at Law. No appearance was made on behalf of Respondent Department of Corrections and Rehabilitation.

Oral and documentary evidence was received, and argument was heard. The record was left open to allow for the submission of closing briefs. Respondent timely filed her closing brief, which was marked for identification as Exhibit DD, and was lodged. The record was closed, and the matter was submitted for decision on June 7, 2013.

FACTUAL FINDINGS

1. Mary Lynn Fisher, Chief of the Benefits Services Division of CalPERS, filed the Statement of Issues while acting in her official capacity.
2. At the time she filed her application for retirement, Respondent was employed as a Registered Nurse with the Department of Corrections and Rehabilitation, Division of Juvenile Justice, at the Herman G. Stark Youth Training School (DOC). By virtue of her employment, Respondent is a "state safety member" of CalPERS.

CALIFORNIA PUBLIC EMPLOYEES'
RETIREMENT SYSTEM
FILED 6/24/2013
C. Badillo

3(a). On January 2, 2008, Respondent signed, and subsequently filed, an application for service retirement pending industrial disability retirement (application), claiming disability on the basis of a skin infection to her right middle finger, extending to her right arm. In the application, Respondent claimed that her disability arose while performing dressing changes to infected wounds at work, and that her injury resulted in "diminished and/or permanent loss of strength & flexion [and] recurrent pain & inflammation, [and that her] left arm [was] also affected due to central catheter complications." (Exhibit 1.) Respondent indicated in the application that her injury affected her ability to perform her job in that she is "unable to lift heavy stuff, [and that it is] difficult & painful to write, [and that her] injury resulted in tendonitis." (Exhibit 1.)

3(b). At the administrative hearing, Respondent testified about receiving treatment for asthma, diabetes, psychological problems and other problems. However, none of these ailments was set forth in the application. Consequently, none of these added complaints will be considered in this decision as a stated basis for her application for disability retirement.

4. The Statement of Issues, paragraph III, page 2, lines 8-9, alleged that "Respondent retired for service effective February 7, 2008, and has been receiving her retirement allowance since that date." However, there was no evidence submitted to establish this allegation.

5. After review of medical reports submitted by Respondent in support of her application, CalPERS determined that Respondent was not substantially incapacitated for performance of her duties as a Registered Nurse with the DOC at the time the application was filed.

6. In a letter dated August 8, 2008, CalPERS notified Respondent of its determination that she was not substantially incapacitated for the performance of her duties as a Registered Nurse and that her application was denied.

7. In a letter dated August 19, 2008, Respondent timely appealed the denial and requested a hearing.

8. The issue on appeal is whether, on the basis of an internal condition (right middle finger and arm), Respondent is substantially incapacitated for performance of her duties as a Registered Nurse (RN) for the DOC.

9. Respondent worked as an RN at the DOC facility for approximately seven years. Her duties included performing rounds to see patients, resuscitating wards who attempted suicide by hanging, administering medications, and acting as a first responder to help terminate fights (by employing Mace), and treating wounds if the wards were injured in fights. Respondent was required to walk across the facility grounds, push medication carts to the ward area and keep handwritten patient charts. She testified that, to work in a prison, one must have two healthy hands, since they have no accompanying security personnel to open doors for them.

10. According to Respondent's written job description, the general responsibilities of an RN at a Correctional Facility within DOC include the following:

All health record documentation shall be legible. Signatures shall include the first initial, last name and classification. The use of the assigned rubber name stamp shall be utilized.

[¶] . . . [¶]

Ensure that the emergency equipment (oxygen, suction, emergency drug availability, gas mask, and hand-held radios) are properly functioning.

When assigned to work on the living unit, pick-up the needed controlled medications and syringes from the Clinic at the beginning of each assigned shift. Sign out controlled medications on the appropriate count sheet(s). Sign out syringes taken from the Clinic on the appropriate count sheet (s).

[¶] . . . [¶]

Administer and document medication as prescribed on the Medication Administration Record (MAR).

Obtain and document vital signs in the Unified Health Record (UHR) as prescribed according to policy.

[¶] . . . [¶]

Document ward-patient complaints, assessments, medication tolerance or intolerance, and nursing action in the UHR. Report all significant findings to the physician.

Review UHR for current physician/clinician orders . . . and carry out as appropriate.

[¶] . . . [¶]

Perform hand-held radio check prior to leaving the Clinic and living unit.

Leave the patient care area clean. Properly dispose of all trash, including the red contaminated waste following institutional policy. (Exhibit 10.)

11. Respondent is 64 years old. She last worked on June 17, 2005. On that date, she noticed that her right middle finger was swollen, and after completing her shift, she sought treatment which included intravenous antibiotics. She was eventually seen by an infectious disease specialist, who suspected she had contracted a methicillin-resistant *Staphylococcus aureus* (MRSA) infection. She had a peripherally inserted central catheter (PICC) line placed in her left arm for administration of antibiotics, and during and following the insertion, Respondent experienced pain in her left arm. Respondent was referred to an orthopedist for incision and drainage of her right middle finger, and during the procedure cultures were taken and found positive for MRSA. Respondent was prescribed antibiotics and discharged with the PICC line still in place. The PICC line was removed six weeks later, and Respondent began occupational and physical therapy.

12(a). In 2006, Internal Medicine Specialist, Stanley J. Majcher, M.D., conducted a Medical/Legal Evaluation of Respondent. Dr. Majcher noted Respondent's self-reported history, which included:

As a result of exposure to an infectious work environment, [Respondent] developed recurrent infections involving the soft tissue structures of multiple parts of her body including her hands, upper extremities, axilla, and numerous other part[s] of her body. She developed recurrent abscesses which had to be drained. She had incision and drainage of an axillary abscess in 2005. She does not suffer from diabetes mellitus. She was treated with numerous antibiotics. She developed complications in the form of skin infections notably *Candida*. She required surgical treatment for abscess of the right hand, and she developed residual abnormalities whereby she has a "claw fist." She cannot close her fist completely. Her problems required hospitalization with insertion of a PICC) line on June 21, 2005. The line had been inserted . . . 8 weeks. She developed what are referred to as MRSA infections which refer to a very variant resistant infection with a micro-organism called *Staphylococcus*.

(Exhibit Q.)

12(b). Dr. Majcher opined that Respondent was temporarily totally disabled from her last day of work on June 17, 2005, until the date of his evaluation on January 27, 2006. He recommended that Respondent avoid exposure to the work environment where she developed her "recurrent skin infections." (Exhibit Q.)

13(a). On May 15, 2007, Orthopedic Surgeon, Gary K. Frykman, M.D., conducted an Agreed Medical Evaluation of Respondent. He noted the history of her injury as follows:

The patient states that on June 17, 2005, she awoke to the onset of pain and swelling in the right middle finger at the proximal interphalangeal joint. She denies an acute injury, but does indicate that she is exposed

to inmates with MRSA. (The patient reports that for a year prior she had developed multiple skin abscesses throughout her body.) She returned to work and reported her injury, and proceeded to perform her usual and customary duties. During her shift her right middle finger became increasingly painful. Once she had finished her work day she self-procured treatment at Kaiser Permanente. She was examined and started on a course of IV Rocephin and Keflex for the next four days. With no improvement, she was then referred to Dr. Ashley and Dr. Dionysian within the Kaiser Permanente practice.

The infection progressively became worse and she was admitted to Kaiser Lakeview Hospital in the Infectious Disease Department under the care of Arnold Henson, M.D., on June 21, 2005. She was placed on a PICC line. During the procedure to install the PICC the patient states that she experienced extreme pain throughout her left upper extremity, and states that the nurse made two attempts before finalizing its installation. She describes the procedure as extremely painful, and states that to date she still has pain in the left upper extremity from that procedure. Dr. Henson suspected the patient had contracted [MRSA] due to her exposure around known infected patients. The patient was referred to an orthopedist for possible incision and drainage of the right middle finger.

The following day, the patient underwent incision and drainage of the right middle finger, performed by Suzanne M. Ackley, M.D. During the procedure cultures were taken and found positive for MRSA. She was prescribed Vancomycin and later daptomycin. The patient was discharged on June 24, 2005, with plans to refer her to occupational therapy. The PICC line was removed six weeks later and she was given Zyvox. She was prescribed a trial of medication and started to clear up reaction and the reaction began to clear.

Over the course of the next several months the patient attended multiple sessions of occupational therapy with minimal benefit. In November of 2005, the patient was returned to modified duty with the instruction of no patient contact. The patient did not feel that she could return to her usual and customary work as she was [a] registered nurse which required patient contact.

(Exhibit S.)

13(b). Respondent complained of constant pain in her right middle finger and in her left upper extremity from her index finger to her neck. She reported decreased grip strength in both hands. Grip strength testing with the Jamar Dynamometer elicited measurements of

0/0/0 for both hands. Dr. Frykman noted, "In my opinion the patient is probably not making full effort on gripping the Jamar Dynamometer with either hand." (Exhibit S.)

13(c). Dr. Frykman's impressions were: healed cellulitis, right hand; post-op incision and drainage, right middle finger; left upper extremity pain following PICC line placement; possible C7 radiculitis; possible peripheral nerve neuropathy of superficial radial nerve; ankylosis, right, right hand; and bilateral upper extremity pain. Dr. Frykman noted:

Based on the medical records, the left upper extremity complaints are more prominent today than they seemed to have been over the last two years since her injury. In examining her left upper extremity, she did have some hypersensitivity along the radial aspect of the forearm, wrist, hand and index finger. This would be consistent with a C6 neuropathy or more likely a peripheral nerve condition of the lateral antebrachial cutaneous nerve or the superficial radial nerve of the forearm. This type of hypersensitivity has not been noted by any previous examiner in the records that I have reviewed. She also had zero grip strength in her left hand. I noticed it was 10 pounds previously by one examiner. There are no findings of a localized site of nerve entrapment in the arm, elbow or forearm that would be consistent with a needle stick injury to a peripheral nerve should this have occurred. The patient appears credible as the patient is a nurse. I do not have reason to doubt that something may have occurred when the PICC line was inserted. However, the considerable pain that she complains of now, the hypersensitivity, the lack of motion and grip strength do not fit with the discreet nerve injury from a needle stick into a nerve. (Emphasis added.)

(Exhibit S.)

14. On July 27, 2007, Respondent underwent an Agreed Medical Evaluation in Internal Medicine and Toxicology conducted by Prakash Jay, M.D. Dr. Jay issued his report on November 8, 2007. At that evaluation, Respondent reported that she could not use either of her hands. Dr. Jay noted that, as a result of the MRSA exposure, Respondent "has developed infections of the skin, as well as her hand." (Exhibit P.) Dr. Jay also noted that Respondent had symptoms of pain in her middle finger, left index finger and left arm which "needs to be evaluated by an orthopedic surgeon/hand surgeon to address her permanent impairment or disability." (Exhibit P.)

15(a). On June 17, 2008, Sahniah Siciarz-Lambert, M.D., conducted an Independent Medical Evaluation (IME) of Respondent at the request of CalPERS. The evaluation included a medical records review, patient history and clinical examination. Dr. Lambert noted Respondent's chief complaint as "infection of the middle finger." (Exhibit 9.)

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15(b). In her IME report, Dr. Lambert noted the following patient history:

[Respondent] states that she started working for the Youth Facility in 1998. She was hired as the infectious disease nurse and continued to work as such until she stopped working due to illness. According to [Respondent], through the years she repeatedly complained of not having bathroom facilities for the staff (*then she stated that she would have to walk very far to the bathroom facilities that were provided and because she had to walk by inmates, she was afraid to do so*). She states that this precluded her frequent use of the bathroom to wash her hands and this was the cause of her developing an infection on the middle finger.

[Respondent] goes on to state that, "At some point" she developed abscesses all over her body. She stated that she developed an episode of having abscesses in her scalp and she went to the emergency room, where she was treated with Keflex. This occurred on 12 to 14 different occasions. She was unable to provide dates for the visits to the emergency room for when the abscesses occurred.

On June 17, 2005, in the morning, she noticed that her right hand middle finger was swollen, but she went to work. By 2 pm, she states, "My hand was really big," but she finished her shift and went home at 6 pm. She went to see a physician at Lakeview Hospital Clinic at around 7 pm and was diagnosed with cellulitis. She was started on Rocephin and told to return the next day.

Over the next four days, she returned each day to the clinic and each day it was noted that the swelling had increased. On the second day, doxycycline was added to her medical regimen, however the swelling continued. It was on day five when she was referred to see an orthopedist who told her she needed to be admitted to receive treatment.

[Respondent] was seen by Dr. Hansen in the hospital for an additional three to four days, but she was diagnosed with MRSA (methicillin-resistant *Staphylococcus aureus*). Due to the diagnoses of MRSA, she was placed on vancomycin and she states that her liver reacted to the treatment. She did not provide details as to how she reacted. However, four days later she was discharged from the hospital with a PICC line and she received antibiotics for six to eight weeks.

During her treatment, she states that she experienced pain in the left antecubital fossa from the PICC line, but she was unsure as to whether she complained to her doctors or if she just dealt with the pain. She

states that when the PICC line was finally removed she continued to experience pain in the antecubital fossa, however, she was pointing to the second left finger of her hand. When asked, she said that the pain had been in the antecubital fossa but had dropped down to the second digit of the left hand.

[Respondent] reports that she has had treatment with an orthopaedic surgeon, physical medicine and rehabilitation, occupational therapy, and rehabilitation therapy, however the pain in her left arm/hand continues, especially with any type of movement. She indicates that she is not using either hand for any activity at any time because of the pain. One of her physicians, the name of whom she cannot recall, gave her a TENS unit, which she states she uses 24 hours per day, seven days per week. She states that this alleviates the pain. She was also told by a different specialist that there was no point in continuing physical therapy if she was not likely to improve.

According to [Respondent] she has "no force" in her right hand and no strength in the left hand. She is right-hand dominant. When asked if she ever moves her hand or uses her hand, she indicates that she does not.

(Exhibit 9.)

15(c). Respondent's grip strength was measured three times by Jamar dynamometer. For her right hand (her dominant hand), grip strength was measured at 0/0/0 pounds. For her left hand, grip strength was measured at 5/5/5 pounds.

15(d). Dr. Siciarz-Lambert observed:

[Respondent] is well-developed, mildly obese female who wishes to communicate her inability to use her hands both in the waiting area, when she is having her vital signs taken, and during the evaluation today. She is noted, however, to place full weight of her body on her right hand for support when changing from a sitting to standing position and when standing on the stool and repositioning herself onto the examination table.

(Exhibit 9.)

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15(e). On physical examination of Respondent's hands and wrists, Dr. Siciarz-Lambert noted:

Examination of the right middle finger reveals a small scar on the third digit lateral to the fourth digit. There are not abnormalities of the hand, wrist or elbow on the right. There is no disuse atrophy of the hands.

On the left side, the hand appears to be normal without any significant scars or deformity. *(Please note that [Respondent] is asked to perform Jamar testing for the examiner, separate from that which was tested in the waiting area, and she takes the Jamar instrument and holds her hands open, stating that she is pressing as hard as she can. There is no obvious contracture of the musculature of the hands or forearms with either hand. The Jamar recorded zero across the board.*

At this point the examiner asks [Respondent] to grip [the examiner's] hands and squeeze the examiner's three digits as hard as she can and she states that she will be gripping with fingers one, two and three on both hands. She is asked why and she indicates, "I'm so scared. I'm so scared of squeezing."

The examiner then begins to speak to [Respondent] while slowly opening and closing the right hand and then subsequently the left hand and it is obvious that she has full range of motion and the opening and closing of the hands by the examiner does not cause her any pain and she does not appear to be stiff.) There is intact sensation of the hands and Tinel's sign is negative, bilaterally. (Emphasis in original.)

(Exhibit 9.)

15(f). Dr. Siciarz-Lambert summarized her assessment as follows:

Right middle finger MRSA infection – resolved without significant evidence of decreased range of motion, albeit [Respondent] alleges that she does not use her hand for any activity. On examination, one notes that there is no disuse atrophy, no swelling, and no significant tenderness, but there is voluntary guarding and no effort demonstrated when she is asked to perform Jamar testing by the technician and by the examiner. There is no effort demonstrated when she is asked to perform hand gripping to the examiner and this is evidenced by the lack of contracture of the tendons and musculature of the forearms.

With regard to the left hand, she has no sign evidence of deformity and no significant tenderness to palpation, but there is voluntary guarding. When she is asked to relax and the examiner performs the range of

motion, she is able to move the fingers. This is pointed out to her and at this point her hands once again become stiff and she resists the movement, stating, "I'm scared."

It is important to note in this case that [Respondent] opens the door handle to enter the clinic area today. She is also noted by this examiner, when exiting the clinic altogether, she is able to pull open a heavy-framed door with her right hand, swinging it open with great ease in spite of the weight of the door. When exiting the clinic, the examiner happens to be exiting behind her and [Respondent] is noted to open the back of the SUV with the left hand, pull it open, and put her papers and purse inside and then she closes the door using her left hand. She opens the front passenger door with the right hand, before this scratching her head with the red, knitted cap with the right second digit.

(Exhibit 9.)

15(g). Dr. Siciarz-Lambert opined that Respondent was "exaggerating her current complaints." (Exhibit 9.) She noted:

[Respondent] is clearly able to use her hands during the evaluations when she is being discreetly observed using her hands to support herself, opening doors exiting, and opening the doors of her SUV, yet she presents stating that she does not use her hand for any activities. (Exhibit 9.)

15(h). Given the totality of her observations and findings, Dr. Siciarz-Lambert opined that was not unable to perform her job duties due to a physical condition, nor was she substantially incapacitated for the performance of her usual duties.

16. At the administrative hearing, Dr. Siciarz-Lambert testified credibly and reaffirmed the findings and opinions in her 2008 report. She stated that, when Jamar testing findings are markedly abnormal, as in this case, she typically will look for physical findings inconsistent or consistent with such a test result. She observed that Respondent placed the full weight of her body onto her right hand for support when repositioning herself onto the examination table and when going from sitting to standing. She also observed that Respondent used door handles in the clinic and when exiting the clinic, and that she opened her vehicle door using her right hand. Dr. Siciarz-Lambert noted on examination that Respondent did not have disuse atrophy (indicating the loss of use) in either hand. She further noted that, during the Jamar testing, she saw that Respondent was not contracting her arm muscles in an effort to move the Jamar device. Moreover, she noted that, while she was opening and closing Respondent's hands manually, this did not cause Respondent pain and the hands did not seem to be stiff, but were soft and pliable. Given the totality of her

18(b). In his 2011 report, Dr. Frykman noted that Respondent was “unable to [complete Jamar Dynamometer grip] test due to pain” for both hands. Dr. Frykman noted, “In my opinion the patient is probably not making full effort on gripping the Jamar Dynamometer.” His notations that Respondent’s complaints of pain “did not fit with the discreet nerve injury from a needle stick into a nerve” remained the same as in 2007. (See Factual Finding 13(c).) However, Dr. Frykman attempted to reconcile Respondent’s complaints of increased pain, noting:

[Respondent] complains that it appears that the use of her hands has deteriorated since I last saw her approximately four years ago. She does not report any subsequent injuries. She has apparently attempted to get some physical therapy. The patient has also developed diabetes mellitus since I last saw her. Diabetics seem to have more pain and lose sensation as a result of peripheral neuropathy.

(Exhibit S.)

19. According to Respondent, she continues to suffer from pain, numbness and tingling in both hands. She states that she cannot use a pen “too long,” and cannot easily open a can, jar or door by herself. Respondent also testified that since contracting MRSA, her “immune system” has gone “down” and she now has been sick more often, has trouble with asthma, and has developed diabetes. She also complains of psychiatric problems which she did not experience prior to 2005. However, as noted in Factual Finding 3(b), above, since none of these ailments was set forth in the application for disability retirement, they will not be considered in this decision as a stated basis for her application.

20. As set forth more fully below, the totality of the evidence did not establish that Respondent was substantially incapacitated for performance of her duties as an RN with the DOC based on the infection to her right middle finger.

LEGAL CONCLUSIONS

1. Respondent has not established that she is entitled to retirement for disability, as set forth in Factual Findings 2 through 20, and Legal Conclusions 2 through 5.
2. Government Code section 21151 provides, in pertinent part:
 - (a) 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.

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3. Government Code section 20026, states, in pertinent part:

“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.

4. “Incapacitated for the performance of duty,” means the “substantial inability of the applicant to perform her usual duties,” as opposed to mere discomfort or difficulty. (*Mansperger v. Public Employees’ Retirement System* (1970) 6 Cal.App.3d 873, 877; *Hosford v. Board of Administration* (1978) 77 Cal.App.3d 854.) The increased risk of further injury is not sufficient to establish current incapacity; the disability must exist presently. Restrictions which are imposed only because of a risk of future injury are insufficient to support a finding of disability. (*Hosford, supra*, 77 Cal.App.3d 854, 862 - 863.)

5(a). In this case, Respondent suffered from some physical complaints of pain in her right hand and left arm following her contracting MRSA in June 2005. However, the evidence did not establish that Respondent’s medical condition rendered her substantially unable to perform her usual duties.

5(b). In 2006, Dr. Majcher issued a report, following a medical/legal evaluation, in which he opined that Respondent was temporarily totally disabled from her last day of work on June 17, 2005, until the date of his evaluation on January 27, 2006. However, the reports of subsequent evaluators indicate that Respondent’s condition was not what she claimed it to be. In 2006, Dr. Wilson noted that Respondent’s Jamar grip test on the right was 0 and on the left is 10-10-10, and opined that, “Good effort was not made, demonstrated by lack of forearm contraction on the right side[,and that [t]his testing cannot be used to demonstrate disability. . .” In 2007, Dr. Frykman noted that Respondent had zero grip strength in her left hand during his Jamar testing, but that it was 10 pounds previously by Dr. Wilson, and that, consequently, Respondent was “probably not making full effort on gripping the Jamar Dynamometer.” He further noted that Respondent’s complaints of hypersensitivity had not been noted by any previous examiner in the records that he reviewed, and that “the considerable pain that she complains of now, the hypersensitivity, the lack of motion and grip strength do not fit with the discreet nerve injury from a needle stick into a nerve.” Dr. Frykman reiterated these opinions in his 2011 report. Furthermore, Dr. Siciarz-Lambert’s findings of exaggeration confirmed those of Drs. Frykman and Wilson. Dr. Siciarz-Lambert noted “no obvious contracture of the musculature of the hands or forearms with either hand” during the Jamar testing. She observed Respondent place the full weight of her body onto her right hand for support when repositioning herself onto the examination table and when going from sitting to standing, and also observed that Respondent use her right hand to open clinic doors and her vehicle door. Dr. Siciarz-Lambert noted on examination that Respondent did not have disuse atrophy in either hand and that manipulation of Respondent’s hands did not elicit pain or indicate stiffness. Given the foregoing, Respondent’s claims of disability are not credible.

5(c). The evidence did not establish that, at the time of her application for disability retirement, Respondent was incapacitated for the performance of her usual duties as a Registered Nurse with the Department of Corrections and Rehabilitation based on the infection to her right middle finger.

ORDER

WHEREFORE, THE FOLLOWING ORDER is hereby made:

The appeal of Respondent Milagros Oliver, seeking retirement for disability as a state safety member of CalPERS, is denied.

DATED: June 20, 2013



JULIE CABOS-OWEN
Administrative Law Judge
Office of Administrative Hearings