

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:

ANDREW CASTILLO,

Respondent,

and

DEPARTMENT OF CORRECTIONS AND REHABILITATION,

Respondent.

Case No. 2012-0987

OAH No. 2013060851

PROPOSED DECISION

This matter was heard before Dian M. Vorters, Administrative Law Judge (ALJ), Office of Administrative Hearings, State of California, on February 18, 2014, in Sacramento, California.

Rory Coffey, Senior Staff Attorney, represented the California Public Employees' Retirement System (CalPERS and complainant).

Andrew Castillo (respondent) was present and represented himself.

There was no appearance by or on behalf of the Department of Corrections and Rehabilitation (CDCR).

Evidence was received and the record closed on February 18, 2014.

ISSUE

Is respondent permanently disabled or incapacitated from performance of his duties as a Correctional Officer (CO) for CDCR, based upon Valley Fever (coccidiomycosis), hypertension, reactive airway disorder (asthma), diabetes, hypertensive heart disease, sleep disorder, and depression? There is insufficient evidence to support this finding.

CALIFORNIA PUBLIC EMPLOYEES'
RETIREMENT SYSTEM
FILED *Mar. 4th 2014*

FACTUAL FINDINGS

Respondent's Employment History

1. Respondent is currently 46 years of age. He began working for the CDCR in July 1997. His last date of employment was in August 2008. He filed his Application for Industrial Disability Retirement on July 25, 2011, which CalPERS denied on August 28, 2012.

Duties of a Correctional Officer

2. As stated in the State Essential Functions, a CO works at adult minimum and maximum security institutions. A CO wears protective equipment and clothing including a stab proof vest and breathing apparatus to prevent injury and exposure to blood and air borne pathogens. A CO must be able to use and maintain weapons, including a firearm and baton. A CO must be able to disarm, subdue, and restrain an inmate; defend self against an armed inmate; and search inmates for contraband. A CO must be able to operate a motor vehicle to patrol institutions and transport inmates to and from airports, hospitals, court, and other facilities. The CO operates indoors and outdoors in varying weather conditions and temperatures and on varying surfaces both wet and dry.

3. A CO must "remain functional with exposure to fumes, gases and various chemicals" such as pepper spray and tear gas. A CO must be able to defend self, staff, and inmates during incidents when chemical agents are deployed. A CO must have the mental capacity to be aware and alert in identifying security risks posed by inmates displaying a variety of behaviors including aggression, psychological manipulation, verbal harassment, actual and attempted suicide, and throwing bodily fluids. A CO must have the mental capacity to judge an emergency situation, and determine and carry out the appropriate use of force. Force can range from advising an inmate to cease an activity to firing a lethal weapon at an inmate to prevent great bodily harm or death to another person. A CO must have the mental ability to recall and accurately document an incident.

4. *Physical Requirements of Position/Occupational Title.* A CO must have the ability to perform various physical activities at the following frequencies:

a. A CO is expected to "occasionally" 1) Run in an all-out effort while responding to alarms or serious incidents, from a few yards to 400 yards, on varying surfaces including uneven grass, dirt, pavement, cement, and stairs, 2) Crawl and crouch during cell or property searches and when firing a weapon, 3) Brace while restraining or performing a body search, and, 4) press with legs/feet while driving.

b. A CO must "continuously" wear a 15 pound equipment belt.

c. A CO must "occasionally to frequently" 1) Ascend or descend stairs and tiers of stairs, ladders, and bunk beds during cell searches, and 2) push and pull while opening or closing locked gates and cell doors.

d. A CO must “occasionally to continuously” 1) Stand, sit while report writing or observing designated areas, 2) Reach overhead while performing cell or body searches, and 3) move their arms.

e. A CO must “continuously to frequently” 1) Stoop and bend while inspecting cells, searching inmates, and performing janitorial tasks, 2) lift and carry 20 to 50 pounds frequently and over 100 pounds occasionally such as when carrying, dragging, or restraining an inmate, 3) move their head and neck in all directions, 4) grasp and squeeze with the hands and wrists, and 4) twist the body in all directions while standing or walking.

Respondent's Disability Retirement Applications

5. On August 29, 2011, respondent filed his Disability Retirement Election Application with CalPERS. In his application, respondent provided the following information as requested:

- a. Respondent described his disabilities and when/how they occurred as “Valley Fever, hypertension, RAD [reactive airway disease], hypertensive heart disease, sleep disorder, depression. Inhaled cocci spoar [sic] during construction of Coalinga State Hospital.”
- b. Respondent described his limitations/preclusions as “Light or sedentary work only. Precluded from exposure to dust, fumes & respiratory irritants, emotionally stressful environments, heavy work.”
- c. Respondent stated that his injury affected his ability to perform his job in that the “Facility & area is dusty. Can’t be exposed to fumes so wouldn’t pass pepper spray training. Can’t lift inmates or climb stairs. Can’t handle a stressful situation which is what a CO must be ready for.”
- d. Respondent indicated that he was not working. He added that “All of the restrictions I have are all situations that a correctional officer must be prepared to do & are part of my job description.

6. By letter dated August 28, 2012, the Benefit Services Division of CalPERS notified respondent that, based upon the medical reports they had received, they had determined that respondent was not substantially incapacitated from performing his duties as a CO with CDCR on the basis of his stated physical or psychological conditions. CalPERS reviewed medical records prepared by Carl Marusak, M.D., Edward Giaquinto, Ph.D., Marilyn Benck, M.D., Timothy Reynolds, M.D., Diego Allende, D.C., Samuel Rush, M.D., and Paul Markovitz, M.D. The letter also notified respondent of his appeal rights. Respondent timely requested an administrative appeal of CalPERS’ decision.

Dr. Paul J. Markovitz, M.D.- Independent Psychiatric Medical Evaluation

7. CalPERS referred respondent to Paul J. Markovitz, M.D. for an Independent Psychiatric Medical Examination (IPME) based on respondent's complaints of depression and sleep issues. Dr. Markovitz is certified by the American Board of Psychiatry and Neurology. He maintains a psychiatric practice in Fresno. On April 26, 2012, Dr. Markovitz evaluated respondent, which included his review of the CO essential functions and relevant medical records, a physical examination, and evaluation. Dr. Markovitz prepared a report to CalPERS, dated April 26, 2012, and testified at hearing.

8. Respondent provided his work history to Dr. Markovitz. Respondent's chief complaint was "I can't work because I had Valley Fever and it ruined my lungs." Valley Fever is caused by a fungal (coccidiomycosis) infection of the lungs. Respondent had been working as a CO since July 1997, and contracted the infection first in 2004, and again in 2006. He attributed the infection to dusty working conditions at the prison. He required six months leave to recuperate after each occurrence of the disease. His symptoms included shortness of breath and easy fatigability caused by lesions in his lungs. It became problematic for him to perform his job duties. He reported no history of psychological issues before 2004. He recalled depressive episodes in 2004 and 2005 that persist. He stopped working in 2008.

9. Respondent also provided a social history. He served four years in the Marines (1986 to 1990) and then worked for seven years at the Central California Society for the Prevention of Cruelty to Animals before joining CDCR in 1997. He married in 1994, separated in 2005, and has two daughters ages 14 and 11. He has been transient since his marital separation, living with sisters and a girlfriend because of his lack of finances. He ate almost all of his meals at restaurants and admitted that this was not best for his diabetes or finances. In 1994, applicant was diagnosed with type I diabetes which he poorly controlled. His medical history included: Diabetes Mellitus Type I, Hypertension, Valley Fever (2004 and 2006) in remission, and headaches every morning for 30 minutes. He was prescribed insulin, hypertension medication (not taking), and an antidepressant (not taking). Respondent's first depressive episode occurred in 2004, followed by another in 2005, with continued symptoms.

10. Dr. Markovitz performed a mental status examination on respondent and documented his findings in his report. Respondent's mood was "mildly depressed" and he appeared indifferent to his depression. He reported concerns about his disability claim, his inability to work, and his inability to support his two daughters. These concerns impacted his mood, yet, he reported seeing his two children daily and his friends almost daily at the baseball batting cages where he hangs out. He also helped the baseball teams but afterwards felt "dizzy" and "torn up."

11. Respondent felt the State was out to get him and believed they were tracking him to show he is not really disabled. He stated, "The State is videotaping me, but I don't care. They won't find anything." His thoughts mostly centered on his breathing problems and he did not mention his depression unless prompted. He showed no signs of cognitive

impairment and reasonable concentration, abstract thinking, and fund of knowledge. Poor insight and judgment were evidenced by respondent stopping his anti-hypertensive and antidepressant medications, poor diabetic glycemic control, and inability to move his life forward since 2008. Respondent told Dr. Markovitz that his antidepressants were not helping so he stopped taking them several months prior. When Dr. Markovitz asked him why he did not change antidepressants if the first did not work, he had no response. He later told Dr. Markovitz that he could not find a Fresno psychiatrist who accepted worker's compensation insurance (WC).

12. *Diagnosis.* Dr. Markovitz provided the following diagnosis: Axis I: Major Depression, Dysthymia, Axis II: None elicited, Axis III Diabetes Mellitus, Type I, Hypertension, Headaches, Pulmonary lesions from Valley Fever infection (magnitude rated severe to inconsequential by various examiners), Axis IV: Pending disability, economic problems, housing issues, and Axis V: Currently 60.

Respondent showed "unusual thought processes" in his MMPI and interview. For example, he claimed he was depressed after his first bout of Valley Fever in 2004, because he could not provide for his family, so he deliberately had an affair, so that his wife of 11 years would find out and leave him, which she did in 2005. Dr. Markovitz questioned the authenticity of respondent's stated motivation to cheat since respondent returned to work in 2004 and remained for four more years. His Symptom Checklist-90 Revised (SCL-90R) test results indicated a significant level of psychiatric problems in all spheres measured, which was inconsistent with how he presented during the interview. For example, the "obsessionality subscale" was in the severe range but he denied any problems during the interview. His "hostility subscale" was also severe, but he characterized it as only a minor issue.

13. Dr. Markovitz's prognosis was that respondent had "some level of depression." Respondent's reason for not treating his depression was that there were no psychiatrists in Fresno taking Worker's Compensation. Dr. Markovitz rejected this assertion as "simply not true." In fact, he has a working relationship with a psychiatrist in Fresno who takes WC. Further, poorly controlled diabetes can increase the risk of depression. It is noted that Dr. Albertson wrote in his June 7, 2013 Pulmonary Clinic Note, "I have stressed the importance of getting better control of his diabetes with diet, exercise, and medication compliance."

According to Dr. Markovitz, respondent's "poor control of his diabetes, not taking his antihypertensive medication, and inability to move his life forward over the last 4 years all would suggest poor medical compliance and a poor prognosis for his depression treatment." However, with reasonable compliance and follow-up, respondent's prognosis was good and he should be mentally able to return to his CO position within six months.

14. In response to specific questions posited by CalPERS regarding respondent's psychological condition, Dr. Markovitz opined:

- a. *Are there specific duties member is unable to perform?* Yes, there are limitations. His mental acuity is impaired because of his depression. This would affect his ability to observe and identify security risks from aggressive or violent inmates, deal with psychological manipulation, verbal abuse, or unpleasant situations. He could respond with excessive violence. Dr. Markovitz opined that respondent was not presently capable of fully judging an emergency situation. Mental slowing from depression could place respondent at risk until his depression is fully treated. Finally, respondent's ability to recall and accurately document an incident was "mildly compromised." Referring to respondent's "convoluted story" of his affair, Dr. Markovitz opined that the same type of fabrication could exist in a stressful situation, particularly if some fault lies with respondent.
- b. *Is member substantially incapacitated for performance of his usual duties?* In Dr. Markovitz's opinion, respondent was substantially incapacitated for performance of his usual duties because of depression. He dated the disability to August 2008.
- c. *If incapacitated, is the incapacity permanent or temporary?* Dr. Markovitz assessed respondent's incapacity to be "temporary" and "less than six months."
- d. *Did member cooperate with examination or did you detect exaggeration?* Respondent put forth a "reasonable, but not best effort." Respondent's timeline of symptoms and exaggeration of answers to certain questions caused his responses to be "questionable" in some cases. For example, respondent's obsessionality scale and hostility scales were "markedly elevated" relative to his clinical interview. Likewise, his hostility scale was markedly elevated out of proportion to his answers to clinical questions. The MMPI suggested a bizarre thought process suggestive of an "underlying personality issue" that over-emphasizes certain details. "Nonetheless, once the depressive illness is treated, he should be able to return to his baseline level of functioning. If the personality construct is part of the problem, it will return to its pre-morbid level, too."
- e. *What part of disability, if any, is due to non-industrial or pre-existing conditions?* Dr. Markovitz had no information to suggest that respondent's disability was due to non-industrial or pre-existing conditions. However, incidents of depression are two to three times higher in poorly controlled diabetics.
- f. *Is the condition caused, aggravated, or accelerated by his employment?* Dr. Markovitz identified respondent's Valley Fever as a known stressor. Another possible stressor is respondent's inability to perform his job, but not the job itself.

15. Dr. Markovitz testified that in conducting IPMEs, he always gives the examinee the “benefit of the doubt.” Especially if the job involves safety such as a prison guard. So he tended to “over value” what respondent said. He recalled that respondent’s memory was good but not perfect, which would affect his recall on the job. He felt respondent was substantially incapacitated due to depression but not permanently. Based on the magnitude of respondent’s depression Dr. Markovitz felt that it should have been “fairly easy to treat.”

Dr. Samuel B. Rush’s Evaluation of Respondent

16. CalPERS also referred respondent to Samuel B. Rush, M.D., for an Independent Medical Examination (IME) based on his physical complaints. Dr. Rush has been a licensed physician in California since 1969. He is Board Certified in Internal Medicine. He maintains an active practice seeing older children and adults. He regularly treats cases of hypertension, diabetes, and pneumonia. He evaluated respondent on March 1, 2012. He reviewed the CO essential duties and relevant medical records, and examined and interviewed respondent. Dr. Rush prepared two IME reports, an original report dated March 1, 2012, and a supplemental report dated August 2, 2012; both reaching the conclusion that respondent was not substantially disabled for performance of his job. Dr. Rush testified at hearing.

17. Respondent reported to Dr. Rush that he contracted Valley Fever in 2004 and 2006, for which he had taken antifungal medication. He was no longer on antifungal medications, but reported lung tissue scarring from the Valley Fever. He developed Reactive Airway Disease (RAD) or asthma subsequent to contracting Valley Fever. His symptoms were a frequent cough and shortness of breath for which he was prescribed bronchodilators and anti-inflammatory medications. He also reported having Type I Diabetes for which he was prescribed insulin. However, he admitted that his blood sugars had not been under good control. Respondent stated that as a result of all the above, he developed depression for which he was prescribed antidepressants.¹ He was also taking medication to control cholesterol. He denied use of alcohol or cigarettes.

18. Dr. Rush noted a dry cough during the evaluation. Respondent had no specific physical/orthopedic limitations, and no gastrointestinal or genitourinary complaints. Respondent’s vital signs were: height 68 inches, weight 232, blood pressure 130/80, pulse 80 bpm/regular, oxygen saturation 99 percent with an oximeter, visual acuity 20/20 using both eyes. Dr. Rush examined respondent’s chest and lungs and found, “...no chest wall tenderness. Lungs are clear to auscultation. Respiratory rate has not increased. Oxygen saturation as mentioned above was 99 percent. There was no wheezing, rhonchi, or rales.”

¹ It is noted that at the time of Dr. Rush’s IME in March 2012, respondent had not been taking his prescribed antidepressants as reported to Dr. Markovitz in April 2012. (Factual Findings 9 and 11.)

The examination of respondent's cardiovascular functioning found, "Regular sinus rhythm with rate of about 80 bpm. There is [*sic*] no murmurs, rubs or gallop." In the extremities, the examination found "...no cyanosis, clubbing, or edema. Peripheral pulses are present and equal bilaterally." His musculoskeletal exam findings were normal on flexion and rotation. His neurological examination was normal. Dr. Rush performed a mental status examination and found, "The claimant is oriented to time, place and person. He answers questions appropriately. He does not appear depressed. He is quite cooperative."

19. Dr. Rush reviewed respondent's worker's compensation treatment records. He summarized the worker's compensation findings in his IME report. He noted that in his June 9, 2011 Agreed Medical Examination (AME) report, Timothy Reynolds, M.D. stated that respondent had reached maximum medical improvement (MMI). In his September 2, 2011 AME report, Dr. Reynolds found respondent to be "totally and permanently disabled for his pulmonary disease, hypertension, and sleep disorder." In Carl Marusak, M.D.'s August 29, 2011 AM report he found respondent to be "permanent and stationary" from a psychiatric perspective.

20. *Diagnosis.* Dr. Rush offered the following diagnostic impressions in his March 1, 2012 report and further explained them at hearing: 1) RAD, mild with good oxygen saturation and not short of breath at rest, 2) history of Valley Fever - "apparently treated and suppressed and hopefully cured," 3) history of high blood pressure, good control, on medication, no evidence of end-organ damage, 4) no findings of hypertensive heart disease, 5) history of depression - not clinically evident, deferred to mental health specialist, 6) Diabetes Mellitus, Type I, poor control per claimant, 7) history of high cholesterol, on medication, and 8) overweight, mild to moderate.

Dr. Rush testified that he saw no evidence of complications from respondent's diabetes, such as kidney failure, peripheral neuropathy (nerve damage in the extremities), and severe hypertension. And though respondent's RAD (asthma) diagnosis was supported in the record, it was not evident when Dr. Rush saw him. Dr. Rush explained that asthma can go away and recur. He agreed that a pulmonary function examination should be given to diagnose RAD. He did not perform a pulmonary function test because it was not part of the referral.

Dr. Rush saw no evidence of hypertensive heart disease and found no support for the diagnosis in the record.² He did not perform an electrocardiogram (EKG), which looks at the heart from 12 different angles, because that was not part of the referral. Dr. Rush conceded that an EKG would be important to diagnose hypertensive heart disease and did not recall being provided with any previously administered EKG records. However, he did review a report generated by Dr. Reynolds that summarized an EKG and echocardiogram taken in his

² It is noted that Dr. Reynold's diagnosis of hypertensive heart disease was based on a May 2010 echocardiogram which did not appear to yield definitive findings. (Factual Finding 27.)

office on May 10, 2011. Dr. Rush recalled that “no significant abnormalities were noted” and that respondent’s “ejection fraction” was 64 percent which is normal. The ejection fraction is a measurement of the amount of blood ejected with each heartbeat.

21. In response to specific questions posited by CalPERS regarding respondent’s condition, Dr. Rush opined that respondent was able to perform his job duties and was not substantially incapacitated for such performance. He believed that respondent was cooperative during the examination and had put forth his best effort with no exaggeration of complaints to any degree.

22. *Dr. Rush’s Supplemental IME Report.* CalPERS sent Dr. Rush additional reports from Drs. Markovitz, Marusak, and Reynolds. After reviewing these reports, there was no change in Dr. Rush’s opinion. He authored a supplemental report dated August 2, 2012, in which he maintained his original opinion that respondent was not substantially incapacitated for performance of his work.

23. At hearing, Dr. Rush was questioned about more recent reports including a Pulmonary Function Report dated April 29, 2013. A pulmonary function test is essentially a breathing test that measures the volume of the lungs. A spirometer and large tube measures the amount of air going in and out of the lungs. The report commented that respondent experienced “Uncontrolable [*sic*] cough throughout pre-BD portion of test...Difficulty obtaining an acceptable inspired limb of the FV loop.” Dr. Rush stated that the cough could have been due to asthma, bronchitis, or a cold, and he would not have continued the test under those circumstances.

24. At hearing, Dr. Rush also reviewed a Pulmonary Clinic Note dated June 7, 2013, authored by Timothy E. Albertson, M.D., to whom respondent reported shortness of breath upon minimal exertion, such as walking one flight of stairs. This was exacerbated by allergies and hot/dry weather. Respondent was using Advair and Albuterol four to five times a day. Dr. Albertson’s Clinic Note indicated that respondent’s blood pressure was 148/57, which Dr. Rush stated was high but “not in and of itself disabling.” He explained that hypertension can be due to several reasons and is often idiopathic (no definable cause). The condition can be modified by weight loss, salt restriction, and medication. Dr. Albertson’s impression of respondent’s pulmonary functioning was “Occasional and expiratory wheeze bilaterally posteriorly. No crackles.” Dr. Rush stated that his opinion was unchanged in that the impression was of “one point in time.” He confirmed that applicant was suffering “borderline hypertension” when he saw him in March 2012, but he did not find it to be disabling.³

25. At hearing, Dr. Rush reviewed a CT Scan with Contrast dated June 24, 2013. It showed “a small area of mild scarring” and post inflammatory changes in respondent’s

³ It is noted that at the time of Dr. Rush’s IME in March 2012, respondent was not taking his medication for hypertension as reported to Dr. Markovitz in April 2012. (Factual Findings 9 and 11.)

lung tissue. Dr. Rush stated that these findings were left over from respondent's Valley Fever. He stated that Valley Fever can be mild to fatal and all degrees in between. It is more common in the San Joaquin Valley and certain parts of Arizona. You can be cured, but will have the scars forever.

Worker's Compensation AME Reports

26. Respondent provided medical records from his worker's compensation file, including two AME reports from Timothy C. Reynolds, M.D.

27. Dr. Reynolds examined respondent on May 10, 2011, and generated an AME report dated June 9, 2011. A physical examination of respondent yielded a blood pressure of 140/89, pulse 83, weight 218, body stature overweight, and body mass index 35 (30 to 40 is considered obese). Respondent's chest examination found this lungs clear and diaphragmatic movement normal. It was noted that when he took a deep breath, he coughed. His heart examination was normal with "no abnormal rubs, murmurs, or gallops detected."

Dr. Reynolds summarized respondent's laboratory findings, which included an electrocardiogram taken in his office on May 10, 2011. His EKG note stated:

An electrocardiogram revealed a normal sinus rhythm with a rate of 76, a QRS axis of -22 degrees, normal intervals and no ectopy. This was an unremarkable electrocardiogram, without significant change compared to the previous electrocardiogram obtained in my office on 5/25/10.

Dr. Reynolds also summarized his echocardiogram (echo) findings. He noted slight changes from a previous echo obtained in May 2010. He concluded: "With left atrial dilation, left ventricular hypertrophy and history of hypertension, this current echocardiogram is *probably characteristic of hypertensive heart disease.*" (Italics added.)

Dr. Reynolds found respondent to be "temporarily totally disabled from August 2008 to May 10, 2011." Dr. Reynolds' disability finding was based on respondent's subjective complaints of "frequent slight to moderate shortness of breath" and "frequent moderate to severe fatigue." Objective factors were: 1) obesity, 2) hypertension, 3) hypertensive heart disease on the May 2010 echocariogram, 4) diabetes mellitus, 5) albuminuria, 6) primary pulmonary coccidioidomycosis, 7) reactive airways disease documented on the May 2010 pulmonary function test, and 8) self-reported Epworth Sleepiness Scale score of 19/24.

Dr. Reynolds recommended work restrictions as follows:

[Respondent's] RAD limits him to light work and precludes him from exposure to dusts, gases, fumes, and respiratory irritants. His hypertension, with hypertensive heart disease, prophylactically precludes him from performing heavy work

and from exposure to emotionally stressful environments. His sleep-disorder probably limits him to semi-sedentary work. However, his diabetes mellitus and his distant history of coccidioidomycosis probably require no work restrictions.

28. After reviewing the IME reports of Drs. Rush and Markovitz, Dr. Reynolds authored a Supplemental AME report dated October 26, 2012. Dr. Reynolds maintained his prior disability findings for worker's compensation and criticized Dr. Rush's disability retirement findings for failure to document respondent's respiratory rate, perform pulmonary function testing, and contemplate "many aspects of [respondent's] medical condition as documented in my numerous previous reports." Dr. Reynolds did not testify at hearing. However, at hearing, Dr. Rush did attempt to address Dr. Reynolds' concerns. (Factual Finding 20.)

29. The worker's compensation system and disability retirement system are distinguished. They exist for entirely different reasons and were established to attain "wholly independent objectives." (*Reynolds v. City of San Carlos* (1981) 126 Cal.App.3d 208, 212.) The main objective of worker's compensation is to "provide adequate compensation for employees, public or private, who are injured in the course and scope of their employment while [they] are disabled and incapable of earning a living." (*Id.* at p. 213.) Retirement boards, on the other hand, are "concerned only with the retirement of a limited class of public employees under a retirement system." (*Ibid.*) Retirement systems grant "additional compensation benefits to employees who are compelled to retire for service-connected disabilities." (*Ibid.*)

Hence, the question is not whether respondent was temporarily disabled for purposes of worker's compensation benefits, but whether when he filed for disability retirement, he was permanently disabled for substantial performance of his duties as a CO, such that he could not return to that job.

Respondent's Testimony

30. Respondent testified on his own behalf. He reiterated his history of work and illness. He joined the Marine Corps at age 18, serving four years. He was released in 1990 and worked as a State Humane Officer, Animal Control, from 1990 to 1997. He worked for CDCR from 1997 to 2008. He first contracted Valley Fever in 2004, and was on leave for six months. He contracted Valley Fever again in 2006, and was again on leave for six months. He contracted Valley Fever again in 2008, and never returned to the job. Respondent stated that the prison is a hub for Valley Fever. It is noted that nowhere else in the record did respondent report contracting Valley Fever in 2008. He stated that prior to working at the facility, he had no history of asthma, was outgoing, loved sports, played basketball and football, and anything involving running. After contracting Valley Fever, he could not do any of those activities since running caused him to cough.

31. Respondent stated that the first time he became ill in 2004, he lost 40 pounds in one month. He returned to work in July 2004, but could not exercise or run. He stated

that he “stuck it out” but was fatigued, tired, and was calling in sick. Some days he was required to work 16 hour shifts, which “wore me out.” In 2006, his condition “worsened.” He stated that as a CO, you need to “stay in shape.” In 2008, he “just couldn’t do it no more.” Currently, he stated he cannot walk a flight of stairs, has coughing spasms when he laughs, smells car exhaust, perfume, aerosol spray, bleach, being around lawn mowers, or anything with dust. He cannot take a full breath. Respondent stated, “I did not want this. I am down to nothing.” He lamented that he drives a 2005 pickup that is “unsafe to drive.” He sees his partners with homes, cars, and vacations. He stated that his primary complaint is “Valley Fever and the breathing.”

32. Respondent currently sees Diego G. Allende, M.D., for all of his prescription medications. His current medication regimen consists of four pills in the morning and six at night. He stated that he takes two medications for high cholesterol including Atorvastatin; Singulair, Advair Diskus, ProAir Inhaler, and Albuterol Inhalation Solution (for asthma), four insulin medications including Glocovash [sic], Lantus and NovaLog (for diabetes); and fish oil.

33. Respondent testified that Dr. Allende initially prescribed Bupropion and then Paxil to treat his depression. Then George P. Rowell, M.D., a Fresno-based psychiatrist, prescribed Zoloft. That prescription lapsed and at the time of hearing, respondent was not treating his depressive symptoms. He last saw Dr. Rowell in August 2013, and explained that he had difficulty being in Dr. Rowell’s office because “I can’t breathe.” However, he stated, “Dr. Allende wants me to go see a psychiatrist.” Respondent still has private insurance through his wife. Despite respondent’s insurance and medication options, he appears reluctant to treat his depression; the reason is unclear.

Assessment of Respondent’s Disability

34. In 2004 and again 2006, respondent contracted Valley Fever, recuperated for six months each time, and returned to work. Dr. Reynolds stated in his June 2011 AME report that “[Respondent’s] diabetes mellitus and his distant history of coccidioidomycosis [Valley Fever] probably require no work restrictions.” (Factual Finding 27.) Respondent no longer has Valley Fever and is not on antifungal medications. He does have hypertension, high cholesterol, diabetes, mild to moderate obesity, a history of RAD or asthma, and mild depression. His depressive symptoms were not evident to Dr. Rush, notwithstanding the fact that respondent had not taken antidepressants for several months prior to this IME. Further, his poor compliance in treating his other diagnoses is well documented. (Factual Finding 13.) Respondent does engage in outside activities. His statement that he could “not breathe” at his last psychiatrist’s office was consistent with his prior excuses for not seeking treatment for his depression. Finally, there is insufficient evidence of a diagnosis of hypertensive heart disease. (Factual Findings 20 and 27.)

35. The professional opinions of Drs. Rush and Markovitz are persuasive. Their findings, based on their physical/psychiatric examinations of respondent and review of his medical records, are given great weight. In April 2012, Dr. Markovitz found respondent to be temporarily disabled on the basis of depression. Respondent chooses not to treat his

depression. In March 2012, Dr. Rush found that respondent was not incapacitated for performance of his job duties based on internal medicine complaints. This despite inconsistent treatment compliance. Given all of the facts and medical evidence presented, respondent did not produce sufficient evidence of a permanent incapacity that would substantially interfere with the performance of his usual duties for CDCR.

LEGAL CONCLUSIONS

1. By reason of his employment, respondent is a state safety (patrol) member of CalPERS and eligible for disability retirement under Government Code section 20390.

2. To qualify for disability retirement, respondent must prove that, at the time he applied for disability retirement, he was “incapacitated physically or mentally for the performance of his ... duties and is eligible to retire for disability...” (Gov. Code, § 21156, subd. (a)(1).) As defined in Government Code section 20026:

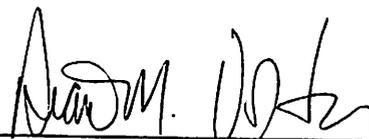
“Disability” and “incapacity for performance of duty” as a basis of retirement, mean disability of permanent or extended and uncertain duration, as determined by the board, or in the case of a local safety member by the governing body of the contracting agency employing the member, on the basis of competent medical opinion.

3. The burden is on respondent to present competent medical evidence to show that, as of the date he applied for disability retirement, he was substantially unable to perform the usual duties of a CO. (*Harmon v. Bd. of Retirement of San Mateo County* (1976) 62 Cal.App.3d 689, 691.) Respondent did not present competent medical evidence to establish that he is substantially incapacitated from performing the usual duties of a CO. There is competent medical evidence of ailments that can be controlled with proper medication compliance. Absent competent medical evidence to support his disability claim, respondent’s application for disability retirement must be denied.

ORDER

The application of respondent Andrew Castillo for disability retirement is DENIED.

DATED: February 28, 2014



DIAN M. VORTERS
Administrative Law Judge
Office of Administrative Hearings