

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:

BYRON L. STACEY,

and

CALIFORNIA DEPARTMENT OF
CORRECTIONS AND REHABILITATION,
CORRECTIONAL INSTITUTION
TEHACHAPI,

Respondents.

Case No. 2011-0577

OAH No. 2011100470

PROPOSED DECISION

Administrative Law Judge Ralph B. Dash heard this matter on January 14 and August 27, 2013, at San Luis Obispo, California.

Rory J. Coffey, Senior Staff Counsel, represented the California Public Employees Retirement System (CalPERS).

Earl Dove, Attorney at Law, represented Byron L. Stacey (Respondent).

There were no other appearances.

The matter was set for a third day of hearing on February 12, 2014. On February 3, 2014, the parties filed a joint request to submit the matter on the record already established. On February 26, 2014, the Administrative Law Judge requested the parties to file written closing argument and held the record open until March 24, 2014, for the parties to do so. Respondent timely filed his written closing argument which was marked for identification as Exhibit A-32. CalPERS failed to file a written closing argument and the record was closed and the matter deemed submitted on March 24, 2014.

Evidence having been received and the matter having been submitted, the Administrative Law Judge makes the following Proposed Decision.

FINDINGS OF FACT

1. Mary Lynn Fisher made the Statement of Issues in her official capacity as the Chief of the Benefits Division of CalPERS.

2. On April 8, 2010, Respondent filed his application with CalPERS for disability retirement. On March 23, 2011, CalPERS denied the application. Respondent timely appealed the denial and this hearing ensued.

3. On October 29, 2008, Respondent, who had been a correctional officer for nine years, worked in that capacity at the California Correctional Institution (CCI) located in Tehachapi. He was on "yard duty" when he heard screaming coming from the dental clinic. He immediately responded and once at the scene he was attacked by an inmate. Respondent was involved in a ferocious struggle with the inmate whom he ultimately was able to subdue. In the course of the struggle Respondent suffered injuries to his knees, neck, left shoulder, left arm, and left hand.

4. CCI is one of three "supermax" prisons in California, housing the "worst of the worst" offenders. Respondent's job description (Exhibit 12) makes it clear that, as a correctional officer, he was required to have the strength and dexterity necessary to deal with violent felons, including coming to the aid of his fellow officers. The job description reads, in part:

The Correctional Officer provides security and directs inmates during work assignments and patrols assigned areas for evidence of forbidden activities, infractions of rules and unsatisfactory attitudes or adjustments of prisoners. Correctional Officers employ weapons of force to maintain order among prisoners when necessary.

[¶] . . . [¶]

Correctional officers must be able to lift/carry in the light (20 pound maximum) to medium (50 pound maximum) range frequently throughout the workday and in the very heavy range (lifting over 100 pounds) occasionally. Items may include inmates weighing 80 to 400 pounds

Correctional Officers must be able to lift/carry an inmate and physically restrain the inmate to the floor. Correctional Officers must be able to drag/carry an inmate out of a cell. Correctional Officers must be able to perform lifting/carrying activities while working in a very cramped space. . . . Generally, several Correctional Officers work together when controlling an inmate for restraint.

[¶] . . . [¶]

Correctional Officers must be able to move or use their head/neck while performing their regular duties including observing and the surveillance of inmates. Neck movements include both side to side as well as flexing downward and backward. Head/neck movements become awkward while conducting cell searches, or looking under, over and around things in a 10' x 10' cell or other cramped spaces.

[¶] . . . [¶]

Correctional Officers must be able to move/use as well as grasp and squeeze with their hands and wrists while performing their regular duties. This includes hand and wrist movements opening and closing locked gates and cell doors, applying restraint devices, operating a typewriter, computer, or telephone unit, loading and unloading weapons, and operating radios and other communications devices. Grasping and squeezing is required while operating a spotlight or while using weapons or driving a vehicle.

Fine finger dexterity is require in the performance of clerical type duties and in the loading and unloading of weapons, searching of inmates and in the operation of various communications devices.

5. Respondent's knee problems appear to have resolved, albeit with residual chronic pain from chondromalacia patella, a softening of the kneecap cartilage. He still has weakness in his left hand, fingers and arm, as well as having pain in the neck to the extent that he avoids tilting his head back. He cannot lift 100 pounds, an activity described in the job description as occurring "occasionally," nor can he carry inmates weighing "80 to 400 pounds." Respondent "pays a price in pain for everything [he] does." He cannot subdue an inmate, an activity in which he was involved "15 to 20 times" in his nine years as a correctional officer. Respondent stated that he is "not even close" to being able to perform the duties of a correctional officer and that he would pose a threat to other correctional officers because he could not properly respond to an inmate altercation.

6. On October 12, 2009, Respondent was sent to Quest Imaging for a magnetic resonance imaging (MRI) study of his cervical spine. The results of this MRI are critical to the determination of this case as the MRI shows an objective finding for Respondent's subjectively described neck, arm and hand pain and numbness. As more fully discussed below, Complainant's expert stated that there was no such objective finding (he had failed to review the MRI) and he thus found no reason to determine that Respondent was substantially incapacitated from the performance of his regular duties as a Correctional Officer.

7. The MRI report (Exhibit A-29) reads, in part, as follows:

At the C6-C7 level, there is a left paracentral protrusion effacing the left lateral recess. This measures approximately 4 mm in greatest AP dimension and 6 mm in greatest craniocaudal dimension. This appears to contact the exiting C7

nerve root at this level and likely impinges upon the left C8 nerve root in the lateral recess. This contacts, but does not deform the anterior left aspect of the cervical spinal cord at this level. This causes moderate to severe narrowing proximally of the left neural foramen at this level.

8. Under Government Code section 11425.50, subdivision (c), “. . . The presiding officer's experience, technical competence, and specialized knowledge may be used in evaluating evidence.” In addition, under Government Code section 11515, official notice may be taken “of any generally accepted scientific or technical matter within the [Board’s] special field.” This Administrative Law Judge has been a member of the Medical Quality Hearing Panel (Government Code section 11371) for many years and has conducted numerous hearings on behalf of the Medical Board. On several prior occasions, expert witnesses have testified in conformity with the following matters, all of which are officially noticed under Government Code section 11515:

- a. Compression of the C6 nerve root can lead to weakness in the biceps and wrist extensors, with pain and/or numbness radiating down the arms into the thumb.
- b. Compression of the C7 nerve root can lead to pain and/or numbness that radiates down the arm and into the middle finger.
- c. Compression of the C8 nerve root can lead to hand dysfunction, where the patient would feel clumsier as the nerve that supplies the small muscles of the hand with nutrients is compressed. Pain and/or numbness may also radiate down the arm and to the outside of the hand and fingers.

9. On February 7, 2011, CalPERS had Respondent evaluated in an “Independent Medical Evaluation” by Brendan McAdams, M.D., a Board Certified orthopedic surgeon, who prepared a report that same day (Exhibit 7, 2011). Dr. McAdams did not recall evaluating Respondent but believes he spent a total of 45 minutes doing a medical record review, including the records of Respondent’s long time treating physician, and performing his own clinical evaluation. Dr. McAdams found that Respondent had no disability at all, particularly with his knees. He found no problem with Respondent’s cervical spine “but found no good answer for the numbness in [Respondent’s] fingers,” other than “degenerative arthritis in the cervical spine” based on Respondent’s “described clinical pattern.” Dr. McAdams “did not doubt [Respondent’s] credibility.”

10. Although the MRI report of Respondent’s cervical spine is described numerous times throughout the medical records, Dr. McAdams stated he had never seen it. The first day of hearing was adjourned and a second day of hearing added so that Dr. McAdams could review the MRI report and opine thereon before Respondent presented his case-in-chief. In preparation for the second day of hearing, Dr. McAdams reviewed “one and one-half inches including two depositions” of Respondent’s records. He prepared a supplemental report dated March 6, 2013 (Exhibit 15). Apparently, Dr. McAdams still had

not reviewed the MRI report as of the date he wrote Exhibit 15, although he noted that Respondent's treating physician described "the MRI reading of nerve root compression at C6-7."

11. Dr. McAdams found nothing in the "one and one-half inches" of records he reviewed before he wrote Exhibit 15 that changed his opinion. In Exhibit 15, Dr. McAdams began to express his bias against and dislike for Respondent's treating physician, Dr. Moelleken. In Exhibit 15, Dr. McAdams, for no apparent reason, stated, "After careful review of these medical records, I find that there is considerable amount of over-treating [Respondent] particularly of chiropractic treatment, pain management treatments, and physical therapy in the same office of Dr. Moelleken. Furthermore, it is my understanding that [Dr. Moellekin] has prescribed medications and dispensed medications through his office. I do not have his current billings."

12. As of the beginning of the second day of hearing, Dr. McAdams still had not seen the MRI report. When it was shown to him while he was giving testimony, he reviewed it briefly and stated that it did not change his opinion, although he did agree that the nerve root contact at C7 was "consistent with" the complaints Respondent had made regarding his neck, arm and hand problems. Dr. McAdams then stated, without any question pending, that "some of us have worse stuff than this" in reference to the MRI findings.

13. On the second day of hearing, Dr. McAdams' bias against and contempt for Dr. Moelleken became more readily apparent. Dr. McAdams agreed that a doctor who sees a patient a number of times is in a better position to make an accurate diagnosis than one who sees that patient for one brief visit. However, with respect to Dr. Moellekin, Dr. McAdams stated that he would "never defer to this specific treating physician," placing great emphasis on the word "this." Then Dr. McAdams gratuitously explained his reasons for never deferring to Dr. Moellekin by stating that over the years he had reviewed many of Dr. Moelleken's records, "and I know what he charges." Dr. McAdams stated that Dr. Moelleken "consistently overcharges" and that Dr. Moellekin would charge "\$360 for 30 pills he dispenses out of his office," and he uses physician's assistants "excessively" for evaluation of patients. A reasonable inference drawn is that Dr. McAdams' bias against Respondent's treating physician may have affected his ability to fairly evaluate Respondent. Accordingly, Dr. McAdams' testimony is given little weight.

14. For the past five years, Respondent has been treated by Alan Moelleken, M.D., a Board Certified orthopedic surgeon who specializes in spine injuries, and who conducted an initial evaluation of Respondent on October 17, 2009. On August 22, 2012, Dr. Moelleken was deposed (Exhibit A-8, one of the two depositions Dr. McAdams referred to in Exhibit 15). Dr. Moelleken's diagnoses and other findings are exactly opposite of those of Dr. McAdams. According to Dr. Moelleken, Respondent's medical condition incapacitates him from the performance of his duties as a correctional officer. Furthermore, as the injuries are degenerative in nature, they are permanent. Respondent will not "recover" from them. These injuries existed at the time Respondent filed his request for disability retirement, and they continued to exist as of the date of the hearing. The following excerpt from Exhibit A-

8) summarizes Dr. Moelleken's findings, supports Respondent's direct testimony, and refutes Dr. McAdams' testimony. Commencing at page 7, line 19 of Exhibit A-8, the following evidence from Dr. Moelleken was elicited:

- Q: Just to clarify, then, you've treated [Mr. Stacey] from, essentially, October 17, 2009, through the present, in relation to the knees, the cervical spine and the upper extremity?
- A: Yes.
- Q: Okay.
- A: And when I say upper extremity, that includes the shoulder, left arm, left hand, as well as the cervical spine. . . . And his diagnoses for the knees include bilateral knee chondromalacia patella and bilateral knee arthralgia.
- Q: I understand. And, Doctor, in regards to the cervical spine, what are your diagnoses?
- A: The main one is cervical radiculopathy . . . if we look at his MRI, there are some degenerative changes. So one of his diagnoses would be degenerative disk disease cervical spine. He has disk protrusions, especially C6, C7, with nerve root compression as well, which is causing his radiculopathy. . . . I think most of the left upper extremity problem is not coming from the upper extremity itself, but coming from the cervical spine because of the nerve compression. So this man feels it shooting down his left arm even though most of his problem is not in the left arm.
- Q: I understand, Doctor. And I appreciate that analysis there. There's one thing I want to point to in Dr. McAdams' report, and that's dated February 7, 2011 [Respondent's Exhibit 5]. I call your attention to page 12 (*sic*). And, really briefly, he was asked about the diagnosis. And Dr. McAdams basically said there is no diagnosis. Would you disagree with Dr. McAdams' opinion? [Dr. McAdams stated, at page five of Exhibit 5: "No orthopedic diagnosis. Alleged pain is not corroborated by objective findings."]
- A: I don't see where he says there's no diagnosis on page five.
- Q: Under the heading "Impression," he says, "No orthopedist has" - -
- A: Okay, you're actually correct. Yeah, I think that's highly incorrect. Here's an individual who has pain in his neck, and the pain radiates

down his left upper extremity. He had the most objective test which you can get, which is an MRI. And he's got very significant nerve compression of his nerve going down the left arm into the hand. So when he says alleged pain is not corroborated by objective findings, it seems that he's ignoring the most important objective finding of all, which is the MRI. That shows nerve compression.

....

Q: Now, in regards to work restrictions, what work restrictions would you place on this applicant, in regards to the cervical spine in specific?

A: Well, with respect to the cervical spine, he should avoid prolonged motions of the neck. Because, if he were to move his neck too much, he's basically stressing the pinched nerve. And he already has a diseased disk that will cause more wear and tear on that level and could lead to more problems. So he has a disability precluding prolonged motions of the neck. He also should avoid heavy lifting because of the same type of reasoning. He should avoid more than occasional work above or at the shoulder level where he has to lift his neck up. Extension is not good for him. He should avoid extreme - -

Q: Please limit your restrictions in regards to the cervical spine.

A: He should avoid prolonged flexion of the neck or keyboarding or computer work as well.

Q: I understand. Okay. I appreciate that. Pointing to Dr. McAdams report, this is on page six, under item number five, Dr. McAdams states, "There is no disability that I determine." I'm assuming you would disagree with that statement, would that be accurate?

A: Yes. I disagree with that.

Q: Just to clarify, your assessment of his disability here is based on your treatment of the patient as well as objective findings such as the MRI, correct?

A: Yes. It's based on my treatment. It's based on my evaluations, my review of the records, my seeing the applicant repeatedly over the years. It's also based on the fact that I'm a spine specialist and this is what I do, and this guy has cervical radiculopathy.

....

Q: How many correctional officers would you say that you've treated over the years?

A: Many. I would say hundreds.

Q: So would it be fair to say that you are familiar with the job duties of a correctional officer?

A: Yes.

Q: Now, Doctor, based on the restrictions and impairment that you discussed previously, do you feel that Mr. Stacey is substantially incapacitated from his usual customary duties as a correctional officer?

A: Yes.

Q: And why, in specific, is he substantially incapacitated from his usual and customary duties?

A: Well, as a correctional officer, his job requires inmate contact. And if you have a problem such as his and you're having neck pain, you're having pain traveling down your arm, nerve pain, it would put you at a disadvantage in the event of an altercation. So first and foremost, he would risk putting his co-workers at risk if he were to have to deal with an emergent situation, a physical situation, involving an inmate. Secondly, he would put himself at risk if that were to happen.

And in addition to the issue of an altercation, he has some limitations and potentially qualifying with his weapon and doing some of the other tasks that he would have to do. Just with respect to the cervical spine.

Q: I understand. Doctor, I would also throw this out for you. Heavy lifting, from your understanding, is part of the job of a correctional officer, correct?

A: Yes.

Q: And in your opinion, he's precluded from heavy lifting?

A: Correct.

Q: Are you able to put a weight limit on what he should be able to lift?

A: I think the absolute most would be 40 pounds that he should lift. And that would only be on a very rare basis.

Q: I understand. And what complications would you expect should he lift greater than 40 pounds?

A: Well, he already has a disk problem. So if he were to lift more, he would be at risk in having his disk protrusion, which now measures, looking at the report, 4 millimeters by 6 millimeters. He would be at risk of having that increase in size and severity.

Q: Okay. I understand, Doctor. Again, I'll point your attention to Dr. McAdams report, at this time on page 5. Item number two under the discussion heading, he's asked about his ability to perform his usual and customary duties. Dr. McAdams says, "It is my opinion that he is not substantially incapacitated for the performance of his usual and customary duties." Do you disagree with that opinion?

A: I do. He doesn't really give his reasoning behind a lot of these opinions, so it's hard for me to discuss his reasoning. In other words, I don't really know how he arrived at that opinion. But in an individual with moderate to severe nerve compression, with radiating pain, I don't know what you're looking for in order to determine if somebody is incapacitated or not if you don't factor that kind of thing in.

Q: I understand. And I think you've made your opinion fairly clear here today. Just a couple more questions.

Now Doctor, you've been treating Mr. Stacey since 2009. Since the time that you treated him, has he ever returned to work during that period of time?

A: I'd have to look at each report to tell you for sure, but I don't recall any time when he has returned to work.

Q: And, Doctor, how would you characterize the development of his condition since 2009 to the present?

A: Well, it seems like there really has been no improvement.

Q: So the objective findings that you see today were present essentially in 2009?

A: Let me pull up the 2009 report here. Well, initially in 2009 he had a sensory deficit, meaning his sensation was involved. He had weakness of his C6 and C7 muscles, meaning his motor was involved. He had left-sided reflex abnormalities. He had a positive spurling's test, all of

which are evidence of cervical radiculopathy. So, then, let's pull up his most recent evaluation so I can compare the two and answer your question.

More recently he has limited motion. He continues to have a sensory deficit. He continues to have a motor deficit as well. So I'd say, yes, his symptoms have persisted.

Q: So it would be fair to say that throughout the process, he was substantially incapacitated from returning to work from 2009 clearly. Would that be accurate?

A: Yes.

Q: Okay. And that status has really kind of continued throughout. It doesn't appear that there's any change in his condition. Is that a fair characterization?

A: Yes.

15. In evaluating the medical evidence and Respondent's testimony in light of the job description set forth in Finding 4, it is readily apparent that Respondent cannot perform the duties that would be required of him as a correctional officer. Respondent cannot "lift or carry an inmate out of his cell." He cannot, "move or use [his] head/neck while performing [his] regular duties including observing and the surveillance of inmates." With the numb fingers on one hand, he cannot effectively "move/use as well as grasp and squeeze with [his] hands and wrists while performing [his] regular duties. This includes hand and wrist movements opening and closing locked gates and cell doors, applying restraint devices, operating a typewriter, computer, or telephone unit, loading and unloading weapons" These disabilities are of a long standing nature, being constant from the date of Respondent's application for disability retirement to the date of this hearing. In short, Respondent is permanently incapacitated for the performance of the duties of a correctional officer.

16. The Department of Corrections and Rehabilitation, Tehachapi Correctional Institution, neither appeared in this matter nor did it file any objection to Respondent's application for disability retirement.

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LEGAL CONCLUSIONS

1. The burden of proving an incapacitating condition is on the applicant for a disability retirement. (*Rau v. Sacramento County Retirement Board* (1966) 247 Cal.App.2d 234, 238.)¹

2. The standard of proof in this proceeding is “preponderance of the evidence,” meaning that Respondent is obliged to adduce evidence that has more convincing force than that opposed to it. (Evid. Code, § 115; *Glover v. Board of Retirement* (1989) 214 Cal.App.3d 1327, 1332; *Lindsay v. County of San Diego Retirement Board* (1964) 231 Cal.App.2d 156, 161-162; *Rau v. Sacramento County Retirement Board* (1966) 247 Cal.App.2d 234, 238.)

3. A state safety member of CalPERS shall be retired for disability regardless of age or amount of service if incapacitated for the performance of duty as the result of an industrial disability. (Gov. Code, § 21151, subd. (a).) A CalPERS member may file an application for disability retirement (Gov. Code, § 21152) while in state service, within four months after the discontinuance of state service or while on an approved leave of absence, or while the member is physically or mentally incapacitated to perform duties from the date of discontinuance of state service to the time of application (Gov. Code, § 21154).

4. On receipt of an application for disability retirement from a member, CalPERS shall order a medical examination of the member who is otherwise eligible to retire for disability to determine whether the member is incapacitated for performance of duty. (Gov. Code, § 21154.) If the medical examination and other available information show to the satisfaction of CalPERS that the member is incapacitated physically or mentally for the performance of his or her duties and is eligible to retire for disability, CalPERS shall immediately retire him or her for disability. (Gov. Code, § 21156.)

5. “Disability” and “incapacity for performance of duty” as a basis of retirement mean disability of permanent or extended and uncertain duration based on competent medical opinion. (Gov. Code, § 20026.) Incapacitated for the performance of duty means the substantial inability or incapacity of the applicant to perform his or her usual job duties. (*Mansperger v. Public Employees’ Retirement System* (1970) 6 Cal.App.3d 873, 877.)

6. The preponderance of the competent medical evidence, together with the testimony of Respondent, has established that, as of the date of his retirement application, Respondent was, and still is, physically incapacitated for the performance

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¹ *Rau* involved the County Employees Retirement Law. That statute contains a provision (Gov. Code, § 31724) similar to the Government Code provisions applicable here.

his usual and customary duties as a Correctional Officer. Good cause exists to grant Respondent's application for disability retirement. This conclusion is based on all Factual Findings and all Legal Conclusions.

* * * * *

ORDER

WHEREFORE, THE FOLLOWING ORDER is hereby made:

Byron L. Stacey's April 8, 2010 application for disability retirement is granted.

Date: 4-10-14



RALPH B. DASH
Administrative Law Judge
Office of Administrative Hearings