

ATTACHMENT A
THE PROPOSED DECISION

FACTUAL FINDINGS

Duties of a Hospital Police Officer

1. At the time of her application for disability retirement, respondent was employed as a Hospital Police Officer for the Department of Mental Health, Coalinga Secure Treatment Facility. The Department of Mental Health's Job Description/Duty Statement (duty statement) describes the essential duties and responsibilities of the job classification as follows:

MAJOR TASKS, DUTIES, AND RESPONSIBILITIES

Under general supervision, patrols an assigned area on foot or in a vehicle, or is assigned to a particular post or administrative assignment with the intent of protecting life and property, preventing crime, maintaining order, enforcing laws, rules or regulations, conducting investigations, locating witnesses, apprehending offenders, writing reports, providing public assistance and testifying in court or other hearings. Police Officers work various hours and shifts.

50% Operational Procedures. Provides the basic principles and practices of law enforcement and maintains an environment that is as free from crime and disorder as possible. Answers calls for service and institutes necessary enforcement procedures in accordance with the law, department and hospital rules and regulations.

20% Support Procedures. Support the function of treatment and evaluation in a maximum security forensic facility and serve members of our community.

20% Administrative Procedures. Duties are performed in a manner that demonstrates the highest level of professional values, ethics, pride, knowledge and dedication to our profession.

10% Interpersonal Relationships. Maintains open communications with all hospital disciplines. Qualified and certified bilingual interpreters will utilize their skills during the performance of their duties.

2. The physical requirements of the job include:

Ability to make arrests while utilizing the minimal and proper amount of force in compliance with departmental policy and law.

Ability to safely operate a motor vehicle under normal and emergency conditions.

Qualify in the use of defensive tools/weapons as prescribed by the Chief.

Demonstrates proper and appropriate use of all safety equipment assigned to him/her including the rules governing the use of metal handcuffs, pepper spray and baton.

Possesses and maintains sufficient strength, agility and endurance to perform during physically, mentally, emotionally stressful and emergency situations encountered on the job, and sufficient hearing and vision to effectively perform the essential function of the job.

3. At hearing, respondent did not dispute the duties of a hospital police officer as set forth in the department's duty statement.

Respondent's Employment History

4. Respondent began her employment as a hospital police officer in 2005. At the time respondent filed her application for disability retirement, she was employed as a hospital police officer at Coalinga State Hospital. By virtue of her employment, respondent is a state safety member of CalPERS subject to Government Code section 21151. Respondent stopped work on July 23, 2009. She returned to work with light duty in early 2012.

Respondent's Disability Retirement Application

5. On April 11, 2011, CalPERS received respondent's Disability Retirement Election Application (application). In response to the application's question about her specific disability, and when and how it occurred, respondent stated, "Pain & Pressure that builds in my lower right side of my back with increasing pressure limits mobility in my right leg[.]" Respondent did not provide an explanation for when and how her specific disability occurred. Respondent further additional information in support of her application, stating, "Still having pain & swelling of left leg even after having surgery."

6. On December 23, 2011, Mary Lynn Fisher, Chief of the Benefit Services Division, notified respondent that her application had been denied based upon a finding that her orthopedic (back, right leg and left leg) conditions were not substantially disabling. Respondent timely appealed the denial.

Respondent's Injuries, Treatment and Assistance

7. On July 23, 2009, respondent got up to walk and caught the toe of her boot in an electrical cord, falling forward onto her knees. Her left foot and knee swelled, and she hurt her lower back. Respondent was taken off work until February 27, 2012.

8. Respondent reported the injury to her supervisor and elevated the leg. She was seen at urgent care and told no x-rays could be obtained until the swelling diminished and was placed on Motrin and advised to elevate and ice the leg. She was then referred to job care where she was treated by D. Lancy Allyn, M.D., who ordered x-rays and told her there was no fracture.

9. After conservative management, a magnetic resonance image (MRI) of respondent's left knee was taken. The MRI showed respondent had a tear in the lateral meniscus. She was taken to surgery sometime in October 2009 and had a partial lateral meniscectomy done using an arthroscopic approach. The knee was improved. However, if she was on her feet for a little while, she would have a little tinge. If not for her left knee, respondent could do the job.

10. Post-surgically, respondent underwent some physical therapy and conservative non-surgical management on her left foot. Her left foot improved and became stable.

11. Respondent's lower back continued to bother her after the accident. She had an MRI taken of her lumbar spine. The MRI showed that she had minimal degenerative disc disease. There was no disc protrusion, no spinal stenosis or foraminal stenosis, and no impingement of the nerves. Respondent felt she was making no improvement, and switched her care to Charles H. Touton, M.D., in April or May 2010. Respondent was referred to a spine specialist, who suggested the main problem was her pelvis, not the spine, and recommended pain management. Respondent had injections in the sacroiliac (SI) joint and piriformis which made her worse. The pain shooting down her leg increased. Respondent also had an electromyography (EMG) and nerve conduction examination performed, which resulted in negative findings.

12. Respondent last saw Dr. Touton on February 22, 2012. He recommended that respondent could return to work with no lifting, pushing or pulling more than 20 pounds, no running, no extended walking or sitting. Respondent returned to work, and was put on light duty in an administrative position.

Video Surveillance Activity

13. CalPERS investigator Troy Shinpaugh conducted surveillance of respondent's activities for five days in July 2011, and six days in August 2011, after respondent submitted her application on April 11, 2011. Investigator Shinpaugh primarily videotaped respondent's activities as she entered and exited her vehicle at her residence and other locations. He also videotaped respondent walking out of her residence to the street on several occasions. She was also videotaped as she shopped in Target. The video showed respondent having no difficulties in entering and exiting her vehicle, or walking to and from her home from the driveway.

CalPERS' Expert - Mohinder Nijjar, M.D.

14. On November 15, 2011, Dr. Nijjar conducted an independent medical examination of respondent at the request of CalPERS due to her left foot, left knee and lower back pain from the incident on July 23, 2009. Dr. Nijjar is a board certified orthopedic surgeon. He testified at hearing. Dr. Nijjar reviewed respondent's medical, social, occupational and treatment history, performed a physical examination and prepared a report dated November 15, 2011. Dr. Nijjar described respondent's current complaints as follows:

Left foot - occasional slight pain. Otherwise she is asymptomatic.

Left knee - occasional twinge of pain. It does not buckle under her. It does not swell and has no other complaints in relation to her left knee.

Lower back - constant pain in the lower back rated as 6-8/10. It radiates to the right lower extremity through the buttocks area to the back of the thigh up to the knee area. This radiation may be once daily or so. The pain increases with prolonged sitting, standing, walking, bending and certain turning at the lower back. The pain is relieved with medication and rest.

Psychiatric - respondent indicated that she has some psychological issues following her injury.

Dr. Nijjar noted that "there was a mild exaggeration of her complaints."

15. On physical examination, Dr. Nijjar noted that respondent ambulated without a limp. She would start crying, then sober up and change moods during the evaluation. Dr. Nijjar noted that respondent's cranial nerves II through XII showed a normal examination. Examination of the cervical spine showed no deformity and no localized tenderness. Respondent's range of motion of the cervical spine in flexion, extension, left and right lateral bending, left and right lateral rotations were normal.

Dr. Nijjar performed a neurologic examination on respondent's upper extremities. Her biceps, triceps and brachioradialis reflexes were 2+ positive on both sides. Sensations in the upper extremities to pin prick and pinwheel did not show any dermatomal loss of sensation. Motor strength tested in the upper extremities related to muscles around shoulders, elbows, hands and wrists was 5/5.

Thoracic spine examination showed the normal contour was maintained. There was no localized tenderness, or visible or palpable masses present. Range of motion in flexion, extension, left and right turning was normal.

Examination of the lumbar spine showed respondent had a slight straightening of the lumbar curvature. There was minimal tenderness, which extended along the midline and on to the right side of the spine in the paraspinal area. No specific tenderness was noted over the sacropinous ligaments. No tenderness was noted over the SI joints. Respondent had no tenderness over the sciatic notch.

Respondent tested negative for sacroilitis and had a range of motion in the lumbar spine restricted by five percent of the range in extension, left and right lateral bending. Respondent indicated that she felt pain the final 30 percent of the range in all directions.

Motor strength testing in the muscle groups of the lower extremities was grade 5/5 in muscles around the hips, knees and extensor hallucis longus (EHL) muscle bilaterally.

16. Examination of respondent's left knee showed no deformity. Dr. Nijjar noted no effusion in the knee joint or hypertrophy. Respondent had excellent medial and lateral stability of the knee joint tested in 30 degrees, full extension and 30-degree flexion. Dr. Nijjar found respondent had a normal anterior and posterior stability of the knee joint. There was normal range of motion in the left knee joint.

17. Respondent's left foot and ankle examination showed no deformity. No masses were visible or palpable. No effusion, tenderness or deformities were noted in the joints of the foot. Range of motion was normal. Neurologic and vascular examination of the foot was normal.

18. Dr. Nijjar provided the following diagnoses after his independent medical examination:

(1) History of sprain/strain of the left foot, resolved. Normal exam on today's encounter.

(2) History of sprain/strain of the left knee with lateral meniscal tear, status post arthroscopic partial menisectomy. Today one appreciates a normal left knee exam. No residuals.

(3) Sprain/strain of lumbar spine superimposed on degenerative disc disease. Although she complains of radiation to the right lower extremity, this was not evident today.

(4) Possible psychiatric component. This is deferred to the appropriate mental health specialist.

19. Dr. Nijjar concluded that from an orthopedic point of view, respondent can perform her usual duties, and is not substantially incapacitated. His testimony confirmed that respondent's symptoms were more than what the evidence showed.

Fitness for Duty Examination by Marjorie Oda, M.D.

20. Dr. Oda is an orthopedic doctor with the Newton Medical Group in Oakland, California. Dr. Oda conducted a fitness for duty examination on respondent on March 29, 2012. Respondent's complaints to Dr. Oda were as follows:

Left knee – it is only painful if respondent walks a lot. She can squat but has difficulty getting up because of her back. She also has pain in her left knee in cold weather. It occasionally swells, but is not unstable.

Right leg – respondent's low back pain, which is 8-10 and constantly present, radiates into the right leg. The right leg pain is not constant. The pain mainly radiates from respondent's right hamstring to the inside of her right ankle. It feels like pressure is building like a muscle spasm. She has difficulty with stairs, having to lead with her left leg because her right leg is weak. She sits on her left buttock because of the pain in her right leg. She has no problems kneeling and squatting but has difficulty getting up. She has no problems entering and exiting a car. The pain keeps her awake at night. Her back is a limiting factor in her ability to walk a long distance, climb stairs or sit for long periods.

21. Dr. Oda evaluated respondent from an orthopedic perspective, and to determine her ability to return to her usual and customary duties as a hospital police officer. After examining respondent and reviewing her medical records, Dr. Oda noted that, "from the perspective of her orthopedic surgeon, Dr. D. Lancy Allyn ... and the independent evaluator, Dr. Mohinder Nijjar, at least from the perspective of the left knee and ankle, she would have no problem performing the job."

22. With respect to respondent's back, Dr. Oda found no evidence of lumbar radiculopathy. She also noted that the MRI showed minimal degenerative disc disease without any protrusion, spinal canal or foraminal stenosis or impingement.

23. As with Dr. Nijjar, Dr. Oda also found some mild exaggeration of symptoms, suggesting respondent's preoccupation with her physical symptomatology. Dr. Oda reviewed the surveillance tapes, noting in general that respondent had no difficulty in ascending or descending one or two curbs with the right leg and no difficulty getting out of her vehicle getting in and out with her right leg.

24. Dr. Oda had significant concerns in that there were complaints, per Dr. Allyn, following respondent's knee surgery. For example, on November 10, 2009, respondent could do nothing except stay at home in bed most of the time. This is not consistent with the magnitude of the injury. Dr. Touton did an extensive workup in 2011, and did not find an exact source of respondent's discomfort. Dr. Oda concluded it would be reasonable to encourage respondent in a "work hardening" program because respondent has become substantially deconditioned. Dr. Oda noted that respondent has not significantly physically rehabilitated herself, and that successful completion of a work hardening program should be followed by a functional capacities evaluation. Dr. Touton indicated that respondent was unable to run and recommended no contact with patients and inmates. Dr. Oda noted that not running would preclude respondent from returning to her usual and customary duties.

25. Dr. Oda diagnosed respondent with: (1) Status post partial left lateral meniscectomy; and (2) lumbosacral strain.

26. Dr. Oda concluded that respondent was not able to perform the essential functions of a hospital police officer. She reasoned that respondent is not able to do lifting from 51 to 100 pounds. However, such a lifting requirement is not included in respondent's job duties. Dr. Oda later changed her conclusion by stating that a final determination of respondent's ability to perform the essential functions of her job can be made after respondent fully participates in a work hardening program under the direction of Dr. Touton. A firm determination could be made in six to 12 weeks, depending on respondent's ability to cooperate in a structured program of gradually increasing physical activity. Due to the incorrect assumption by Dr. Oda that respondent was required to lift 51 to 100 pounds, and her inconclusiveness regarding respondent's ability to perform the essential functions of her job, her determination is given little weight.

Qualified Medical Examination on March 7, 2012

27. George S. McCan, M.D., performed a qualified medical examination on respondent on March 7, 2012. Dr. McCan reviewed respondent's medical records and conducted a physical examination. Examination of respondent's thoracic, lumbar spine, and back, left knee, and left foot and ankle appeared normal with no pain. Dr. McCan noted that respondent's MRI dated September 25, 2009, revealed lumbar degenerative disc disease, consistent with Dr. Nijjar and Dr. Oda's findings. Dr. McCan diagnosed respondent with: (1) low back strain; (2) lumbar degenerative disc disease, pre-existing; (3) left knee contusion and strain; (4) tear lateral meniscus left knee, status post arthroscopic partial lateral meniscectomy; and (5) strain, left foot. Dr. McCan concluded that respondent's low back, left knee and left foot reached maximum medical improvement and are permanent and

stationary. He did not address the issue of whether respondent is permanently disabled from performing the usual duties of a hospital police officer.

Discussion

28. Two evaluating physicians, Dr. Nijjar and Dr. Oda, agree that respondent exaggerated her symptoms without any objective findings. Neither found any evidence of lumbar radiation to her right leg. Both indicated that respondent's back pain is the result of degenerative disc disease. Dr. Nijjar indicated that respondent's left knee was normal post-surgery. Dr. Oda indicated that the left knee was not unstable. Dr. Nijjar persuasively concluded that respondent is not permanently disabled or incapacitated from performing the usual duties of a hospital police officer. Dr. Oda indicated more time was needed to make a firm determination of whether respondent was able to perform the essential functions of her job. Dr. McCan did not address the issue. The above matters as well the medical record having been considered, respondent has not established through competent medical evidence that, at the time of application, she was permanently disabled or incapacitated from performing the usual duties of her position as a hospital police officer.

LEGAL CONCLUSIONS

1. Respondent has the burden of proof to establish by a preponderance of evidence that she is "incapacitated for the performance of duty,"¹ which courts have interpreted to mean "the substantial inability of the applicant to perform his usual duties." (*Mansperger v. Public Employees' Retirement System* (1970) 6 Cal.App.3d 873, 877.) Discomfort, which may make it difficult to perform one's duties, is insufficient to establish permanent incapacity from performance of one's position. (*Smith v. City of Napa* (2004) 120 Cal.App.4th 194, 207, citing *Hosford v. Board of Administration* (1978) 77 Cal.App.3d 854, 862.) Furthermore, an increased risk of further injury is insufficient to constitute a present disability, and prophylactic restrictions on work duties cannot form the basis of a disability retirement. (*Hosford, supra*, 77 Cal.App.3d at p. 863.)

¹ Although no court construing CalPERS law has ruled on this issue, courts applying the County Employees' Retirement Law have held that the applicant has the burden of proof. (*Harmon v. Board of Retirement of San Mateo County* (1976) 62 Cal.App.3d 689, 691.) CalPERS may rely on decisions affecting other pension plans when the laws are similar. (*Bowman v. Board of Pension Commissioners for the City of Los Angeles* (1984) 155 Cal.App.3d 937, 947.) In this case, Government Code section 31724 (County Employees' Retirement Law) is similar to Government Code section 21151 (California Public Employees' Retirement Law), and the rule concerning the burden of proof is therefore applicable. Furthermore, Evidence Code section 664 creates the general presumption that a public agency has performed its official duty. Here, CalPERS has fulfilled its duty to determine respondent's eligibility for disability retirement, and the burden falls on respondent to rebut the presumption of Evidence Code section 664 by proving incapacitating disability.

2. Pursuant to Government Code section 21150, members incapacitated for the performance of duty shall be retired for disability. Government Code section 20026 provides that “‘Disability’ and ‘incapacity for performance of duty’ as a basis of retirement, means disability of permanent or extended and uncertain duration, as determined by the board... on the basis of competent medical opinion.” In *Mansperger, supra*, 6 Cal.App.3d at p. 873, the court construed the term “incapacitated for the performance of duties” to mean a substantial inability to perform the employee’s usual duties. (*Id.* at p. 876.) As the court explained in *Hosford*, prophylactic restrictions imposed to prevent the risk of future injury or harm are not sufficient to support a finding of disability; a disability must be currently existing and not prospective in nature. (*Hosford, supra*, 77 Cal.App.3d at p. 863.) An applicant for disability retirement must submit competent, objective medical evidence to establish that, at the time of application, he or she was permanently disabled or incapacitated from performing the usual duties of his or her position. (*Harmon v. Board of Retirement* (1976) 62 Cal.App.3d 689, 697 [finding that a deputy sheriff was not permanently incapacitated from the performance of his duties, because “aside from a demonstrable mild degenerative change of the lower lumbar spine at the L-5 level, the diagnosis and prognosis for the [the sheriff’s] condition are dependent on his subjective symptoms.”].)

3. *Mansperger, Hosford* and *Harmon* are controlling in this case. The burden was on respondent to present competent medical evidence to show that, as of the date she applied for disability retirement, she was substantially unable to perform the usual duties of a hospital police officer due to her orthopedic (back and left knee) condition. Respondent did not present sufficient evidence to meet this burden.

4. In sum, respondent failed to show that, when she applied for disability retirement, she was permanently and substantially incapacitated from performing the usual and customary duties of a hospital police officer for the Department of Mental Health, Coaling Secure Treatment Facility. Her application for disability retirement must, therefore, be denied.

ORDER

The application for disability retirement filed by respondent Nicolette Savacool is DENIED.

DATED: October 14, 2014



DANETTE C. BROWN
Administrative Law Judge
Office of Administrative Hearings