

ATTACHMENT A
THE PROPOSED DECISION

BEFORE THE
BOARD OF ADMINISTRATION
CALIFORNIA PUBLIC EMPLOYEES' RETIREMENT SYSTEM

In the Matter of the Involuntary Reinstatement
from Disability Retirement of:

EUGENE M. HENRICH,

Respondent

and

CALIFORNIA CORRECTIONAL CENTER,
CALIFORNIA DEPARTMENT OF
CORRECTIONS AND REHABILITATION,

Respondent.

Case No. 2011-1110

OAH No. 2014010141

PROPOSED DECISION

Administrative Law Judge Coren D. Wong, Office of Administrative Hearings, State of California, heard this matter on August 28, 2014, in Sacramento, California.

Cynthia A. Rodriguez, Senior Staff Attorney, represented the California Public Employees' Retirement System (CalPERS).

Attorney Richard E. Elder, Jr., of the law firm Elder and Berg represented respondent Eugene M. Henrich, who was present throughout the hearing.

No one appeared for or on behalf of respondent California Correctional Center, California Department of Corrections and Rehabilitation.¹

¹ Respondent California Correctional Center, California Department of Corrections and Rehabilitation, was duly served with the Accusation and Notice of Hearing. A Notice of Defense was not filed on its behalf. Its default was entered, and the matter proceeded as a default proceeding against this respondent pursuant to Government Code section 11520, subdivision (a).

Evidence was received, and the record was left open for the parties to submit written closing arguments. On October 17, 2014, the parties submitted their respective closing briefs, the record was closed, and the matter was submitted for written decision.²

SUMMARY

Respondent's application for industrial disability retirement was approved by CalPERS based on an orthopedic (bilateral foot) condition, and he was retired for disability effective June 5, 2006. CalPERS subsequently conducted a review of respondent's medical condition and determined that he is no longer permanently and substantially incapacitated for the performance of the usual job duties of a Correctional Officer with the California Correctional Center, California Department of Corrections and Rehabilitation, and should be reinstated to his former position. Respondent appealed CalPERS's determination. As discussed below, CalPERS failed to demonstrate that, upon the basis of a medical examination, respondent is no longer permanently and substantially incapacitated for the performance of the usual job duties of a Correctional Officer and should be reinstated to his former position. Therefore, his appeal should be granted.

Procedural Background

1. Respondent was employed as a Correctional Officer by the California Correctional Center, California Department of Corrections and Rehabilitation. By virtue of his employment, he was a state safety member of CalPERS.
2. On May 4, 2005, respondent signed an application for industrial disability retirement and submitted it to CalPERS. He alleged that he was disabled based on an injury to his left foot.
3. On June 5, 2006, CalPERS sent correspondence to respondent notifying him that his application had been approved and he had "been found substantially incapacitated for the performance of [his] duties as a Correctional Officer with the Department of Corrections California Correctional Center, *and* substantially incapacitated for the performance of the usual duties of the position for other California public agencies and CalPERS, based upon [his] orthopedic (bilateral foot) condition(s)." (Italics in original.) His industrial disability retirement was "effective immediately." Respondent was 44 years old as of the effective date. He was 53 years old as of the date of hearing.
4. Sometime prior to June 15, 2011, CalPERS sent respondent correspondence advising him that his award of industrial disability retirement was being reviewed to determine if he continued to qualify for industrial disability retirement. He was told to report

² On November 3, 2014, complainant submitted CalPERS' Reply Brief without seeking leave to do so or requesting that the record be reopened. Therefore, the brief was not considered.

to Mohinder Nijjar, M.D., a board-certified orthopedic surgeon, for an Independent Medical Examination (IME).

Essential Job Duties and Functions of a Correctional Officer

5. The essential functions of respondent's position as a Correctional Officer with the California Correctional Center, Department of Corrections and Rehabilitation, include the following:

- Must be able to work in both minimum and maximum security institutions as well as male and female institutions
- Must be able to perform the duties of all the various posts
- Must be able to work overtime. Overtime is mandatory and could be 8 hours at one time, and on very rare occasions up to 16 hours in situations such as a riot
- Must be able to wear personal protective equipment (stab proof vests), and clothing and breathing apparatus to prevent injuries and exposures to blood/airborne pathogens
- Must range qualify with departmentally approved weapons, keep firearm in good condition, fire weapon in combat/emergency situation
- Must be able to swing baton with force to strike an inmate
- Disarm, subdue and apply restraints to an inmate
- Defend self against an inmate armed with a weapon
- Inspect inmates for contraband, conduct body searches
- Read and write and count
- Walk occasionally to continuously
- Run occasionally run in an all-out effort while responding to alarms or serious incidents, distances vary from a few yards up to 400 yards, running may take place over varying surfaces including uneven grass, dirt areas, pavement, cement, etc. running can include stairs or several flights of stairs maneuvering up or down
- Climb occasionally to frequently ascent/descent or climb a series of steps/stairs, several tiers of stairs or ladders as well as climb onto bunks/beds while involved in cell searches, must be able to carry items were climbing stairs
- Crawl and crouch occasionally crawl or crouch under an inmate's bed or restroom facility while involved in cell searches, crouch while firing a weapon or while involved in property searches
- Stand occasionally to continuously stand continuously depending on the assignment

- Sit occasionally to continuously sit while performing recordkeeping or report writing activities, observing designated areas
- Possess a valid driver's license in order to operate a motor vehicle to patrol institutions, transport inmates to or from airports, hospitals, court, or other facilities, etc.
- Stoop and bend occasionally to frequently stoop and bend while inspecting cells physically searching inmates from head to toe, and while performing janitorial work including mopping [sic] and cleaning
- Lift and carry continuously to frequently lift and carry in the light (20 pound maximum) to medium (50 pound maximum) range frequently throughout the workday and in the very heavy lifting range (over 100 pounds) occasionally, lift and carry an inmate and physically restrain the inmate including wrestling an inmate to the floor drag/carry and inmate out of the cell, perform the lifting/carrying activities while working in very cramped space
- Continuously wear equipment belt weighing 15 pounds
- Pushing and pulling occasionally to frequently push and pull while opening and closing the locked gates and cell doors throughout the workday pushing and pulling may also occur during an altercation or the restraint of an inmate
- Reaching occasionally to continuously reach overhead while performing cell or body searches, etc.
- Head and neck movements frequently to continuously throughout the workday. Move or use head/neck while performing his regular duties including observing and the surveillance of inmates, neck movements include both side to side as well as flexing downward and backward
- Arms movement occasionally to continuously
- Hand and wrist movements frequently to continuously move/use as well as grasp and squeeze with their hands and wrists while performing their regular duties Fine finger dexterity is required when report writing (i.e. incident reports) and in the loading and unloading of weapons, searching of inmates and in the operation of various communication devices Move/use hands and wrists independently of each other
- Bracing occasionally brace while restraining and inmate, during an altercation or while performing a body search
- Press occasionally press with his legs/feet while driving a vehicle
- Twisting of the body frequently to continuously twist his body in all directions while performing his regular duties twisting

may take place with the body in an upright position while either standing or walking

- Vision acuity of 20/60 or better in each eye without correction and corrected vision of 20/20 in each eye
- Hearing acuity must meet standards as set forth in the California Department of Corrections and Rehabilitation's hearing protocol
- Perform regular duties indoors or outdoors, or a combination of indoors or outdoors
- Remain functional with exposure to fumes, gases and various chemicals, such as but not limited to pepper spray and tear gases Must be able to defend self, staff, and inmates during incidents when chemical agents are being deployed
- Must have mental capacity to be aware/alert in their observation/identification of security risks Correctional Officers are at risk to a variety of inmate behaviors, including but not limited to aggressive or violent inmates, psychological manipulation, or verbal abuse/harassment Correctional Officers must also have mental capacity for exposure to very unpleasant situations including inmates who have attempted or committed suicide by hanging themselves in their cell or slashing the risk, or inmates who throw bodily fluids at them
- Must have the mental capacity to judge an emergency situation, determine the appropriate use of force, and carry out that use of force Use of force can range from advising and inmate to cease an activity to firing a lethal weapon at an inmate when another life is threatened with great bodily harm or death
- Must have the mental ability to recall an incident in order to accurately document the incident in writing

The Physical Requirements Information for that position indicate that a Correctional Officer is required to sit, run, crawl, kneel, squat, bend neck, bend waist, and reach above shoulder "Occasionally Up to 3 hours." Additionally, he is required to climb, twist waist, and reach below shoulder "Frequently 3-6 hours," and to stand, walk, and twist neck "Constantly Over 6 hours."

6. At hearing, respondent explained that overtime was a common occurrence because of the reduction in the number of correctional officers due to budget constraints. Typically, an announcement would be made over the radio about 30 minutes prior to the end of each shift stating the number of positions on the next shift that needed to be filled with overtime and asking for volunteers. If there were not enough volunteers, the positions would be filled based on a correctional officer's relative position on a seniority list, with the more junior correctional officer being selected over the more senior. Respondent estimated that he worked overtime once every two weeks during his last year of employment.

CalPERS's Sub Rosa Investigation

7. Troy Shinpaugh, an Investigator with CalPERS, conducted a sub rosa investigation of respondent on May 24 through 26, and June 1 through 3, 2011, during which he observed, documented, and videotaped respondent performing various daily activities.

8. Investigator Shinpaugh prepared a written report of his investigation. While his report for the most part documents his having observed respondent participate in normal daily activities that were not inconsistent with his disabled status, Investigator Shinpaugh also documented respondent playing golf for several hours on May 26, and on June 2 and 3, 2011. Respondent walked the golf course on each occasion, as opposed to riding in a golf cart, and pushed or pulled his golf clubs on a golf caddy.

9. Investigator Shinpaugh also searched social media and found respondent's Facebook page. He reviewed postings of respondent's hunting trips and home improvement projects.

10. At hearing, Investigator Shinpaugh explained that he saw respondent walking "mostly on grass" while golfing. He also stated that he did not know how much of the work on the home improvement projects was actually performed by respondent, as opposed to other people who may have been helping him.

11. Respondent testified that walking on a golf course is very different and easier than walking at work because the former environment consists of grass, whereas the latter consists of cement or asphalt. Additionally, he explained that all his hunting trips are "guided trips" which involve guides who select the area in which they are going to hunt, drive the participants to the area where the animals being hunted can be found, and then stop the vehicle after finding the animals to allow the participants to get out and shoot the animal. The guides then drive the participants and their "catch" back to where they started from. Therefore, respondent explained they walk, at most, "not very far."

Lastly, respondent admitted completing "some" home repair projects by working a couple of hours each day. He said he received a lot of help from his wife and their five children.

Medical Evidence

12. Respondent saw Dr. Nijjar on June 15, 2011, for an IME. After the IME, Dr. Nijjar prepared a report.

13. Dr. Nijjar provided the following history of respondent's injury in his report:

On 03/28/2013 [*sic*], the member reported that he was running in the yard and felt pain and discomfort in the left foot. Apparently once that was reported, the member was referred to

an Industrial Clinic and was evaluated. A diagnosis of plantar fasciitis was made. The member was treated with medication, therapy, and orthoses. Conservative treatment did not help.

The member had second opinions and ended up undergoing surgical intervention because the member reported that he could not return to work because of the pain in the left foot. However down the line, he reported that his right foot has started to hurt as a consequence of injury to the left foot. However, the left foot was further treated with surgical intervention in the form of plantar fascial release and post-surgically he apparently did not get any better and continued to have problems with the pain and has never returned to work. He has been considered completely unable to go back to work. However, his occupational injury was settled and the member had an award for vocational rehabilitation.

The member continued to complain of pain in the foot and has been evaluated several times, however, the member continued to follow with his treating physician, Dr. McMillan who has been providing him with some pain medications. He sees that physician two to three times a year. Dr. McMillan has been keeping him off work ever since.

He also wrote the following about respondent's current complaints as of the date of the IME:

The member's current complaints are pain in the left foot, pain is constant, and pain is from the heel to the big toe. It gets worse with standing over two hours, walking more than 30 to 45 minutes. He indicates that it swells up on the inner side of his foot every day.

14. Dr. Nijjar's summary of the medical records reviewed as part of his IME is consistent with the history of treatment for plantar fasciitis respondent described while providing the history of his injury as noted above. The summary includes a June 20, 2005 Disability Evaluation by Vincent C. Merino, DPM, which included the diagnoses of "Entrapment neuritis, medial infracalcaneal nerve, left heel."

15. Dr. Nijjar summarized his physical examination of respondent's lower extremities as follows:

Examination of the left foot and ankle shows that the member has a small surgical scar. There is localized tenderness noted over the calcaneus posteriorly and anteriorly. Both calcaneal

tuberosities do not show any tenderness. Speed's test for plantar fasciitis is negative. The member has no thickening or nodular appearance of the plantar fascia. The member has no tenderness, deformity, or swelling in relation to the midtarsal joints of the foot. The member has no area of anesthesia or hypoesthesia over the inner aspect of the foot, outer aspect of the foot, or the plantar aspect of the foot.

The member can stand on the toes, and can walk on the heels. He has no deformity in relation to the toes and no swelling or edema is identified in the left foot.

The ankle joint examination shows no fusion in the ankle joint. There is good stability. Anterior drawer sign/posterior drawer signs are negative. The member has full range of motion in dorsiflexion, plantar flexion, inversion, and eversion of the foot. The right foot and ankle examination is normal.

16. Dr. Nijjar provided the following diagnoses for respondent: "1. Plantar fasciitis of left foot, status post surgical decompression" and "2. Mild plantar fasciitis of right foot resolved." He also opined that there are no specific job duties that respondent cannot perform because of any physical condition:

After conducting my physical examination and review of the medical records, I find no objective evidence that would prevent Mr. Henrich from performing his usual job duties. This is based on the fact that he has only subjective findings, that he has pain but objectively there are no findings in the foot at this time which would prevent him from performing all of the duties mentioned in his job description.

This is also based on the video surveillance which I reviewed myself. The video surveillance showed no pain behavior demonstrated by the member during golfing or other activities.

17. Dr. Nijjar was provided additional medical records for review after he prepared his IME report, and prepared supplemental reports explaining that the additional records did not change his original opinion on either occasion. He provided the following discussion in his April 11, 2012 supplemental report:

This is a gentleman who had plantar fasciitis in 2004, had surgery on the left foot in 2005. He had some pain postoperatively. The podiatrist took a second opinion of another podiatrist that was Dr. Moreno. After the surgical release it was considered that there may be entrapment neuropathy, but I did

not find any attempt by any of the physicians to have conduction studies done or EMG studies done for the lower extremity to rule out if there was entrapment or not. It would be my assumption electrical tests would have been carried out in 2005 or 2006 however no test results are available from that time.

I see no original electrical test report but a general physician mentioning in a report that narrow diagnostic studies showed there was a delayed latency in lateral plantar nerve, that means entrapment neuropathy that could cause some pain in the foot.

In my medical opinion random one study, with low specificity and sensitivity cannot be considered diagnostic of a condition which has never been a diagnosis.

Please have the physicians submit:

- 1) Original nerve conduction studies before performed in 2005 or 2006.
- 2) Was there any repeat study?
- 3) Send original of current studies so that localization can be identified at what level the patient has entrapment of lateral plantar nerve, and that should be managed surgically or non-surgically depending on how much delay in conduction of the lateral plantar nerve is present.
- 4) Compare the studies and find out if those are consistent.

However, that should not prevent this patient from performing regular duties and that is further confirmed that measurements done by Dr. Smalley, the treating podiatrist at this time client did not show any atrophy of the muscles in the calf will indicate full use of left lower extremity. Otherwise, with persistent significant pain level, he would have atrophy of the calf muscle over ten years with inability to fully use the left lower extremity.

With that consideration at this time, I see no reason to change any of my opinions I have already expressed. However, if you provide me with an original study done for conduction of the plantar nerves in 2006 and then 2012, and if the comparison shows there was a persistent compression neuropathy then I may change my opinion.

18. At hearing, Dr. Nijjar clarified that the focus of his IME was on respondent's plantar fasciitis in the left foot, which he explained had been resolved by surgery. He further explained that plantar fasciitis generally resolves itself without any surgical intervention. Of

those cases that require surgery, 80 percent of them resolve after surgery, and recurrences are rare.

In sum, Dr. Nijjar explained that he found no objective evidence that respondent was still suffering from plantar fasciitis in his left foot such that he was unable to perform his job duties as a Correctional Officer. Dr. Nijjar stated that a nerve conduction study showing left lateral neuropathy would not constitute “objective evidence” of plantar fasciitis. Furthermore, the video surveillance of respondent playing golf showed him walking for several hours without any “signs of pain.”

19. Vincent C. Marino, DPM, a board-certified podiatric surgeon and podiatric orthopedist, first treated respondent on December 2, 2004, as part of a panel qualified medical examination. At that time, he diagnosed respondent with plantar fasciitis in the left foot, and concluded that respondent was not yet permanent and stationary. He evaluated respondent again on June 20, 2005, and diagnosed him as: “1. Status post partial plantar fasciotomy, left foot. 2. Recurrence of plantar fasciitis, right foot. 3. Entrapment neuritis, medial infracalcaneal nerve, left heel.” His diagnosis remained the same one year later, although he characterized the plantar fasciitis in the right foot as “chronic.”

20. Dr. Marino last evaluated respondent on February 20, 2014. He wrote the following about respondent’s sensory appreciation in his report documenting that evaluation:

His neurological exam continues to show paresthesia on compression over the tarsal canal of the left foot radiating along the course of the lateral plantar nerve. There are continued areas of hyperesthesia and dysesthesia as well as hypoesthesia along the course of the lateral plantar nerve distribution. His symptoms are consistent with continued neuritis of the lateral plantar nerve left foot with tarsal tunnel syndrome.

21. Dr. Marino diagnosed respondent with “Chronic plantar fasciitis, right foot” and “the lateral plantar nerve damage and neuropathy left heel, secondary to partial plantar fasciotomy.” He also opined that respondent remains permanently and substantially incapacitated for the performance of his usual duties as a Correctional Officer.

22. At hearing, Dr. Marino explained the basis of his opinion that respondent is substantially incapacitated as follows:

Firstly, the first problem he has going on that is causing this incapacitation would be he has what we call a neuropathy or nerve damage to a nerve on the bottom of his left foot, particularly the left heel, which occurred as a result of the surgery performed for his plantar fasciitis of the left foot.

The second problem he has that is ongoing is that he now also experiences plantar fasciitis to the right foot that will at times be exacerbated or increase in severity depending on the amount of time that he's on his feet.

He further explained:

He had plantar fasciitis of the left foot. He was appropriately treated with conservative care ad nauseam. He then underwent surgical intervention. The surgery was performed through what we -- through an approach from the bottom of the heel, not a common way to do it because of some possible complications, but an acceptable way to do it in terms of the literature.

That surgery alleviated over time his plantar fasciitis symptoms to his left heel. But what happened as a complication from that surgery is he developed pain to the left lateral heel because they nicked a nerve. And as a result of cutting or nicking of the nerve and the secondary scar tissue that forms, he has chronic nerve pain there. That still prevents him from putting weight on his left heel on hard services for prolonged periods of time. It also prevents him from doing the things such as running, jumping, and repetitively climbing on hard surfaces, and pushing off. And as a result of that, he has to shift his weight. That is evidenced by the MRI findings showing he has, actually, inflammation underneath one of the small bones underneath the big toe joint of the left foot because he's putting most of his weight on the front of his left foot on the bottom instead of his heel.

It's also evidenced by the fact that he has pain on the right foot, particularly the right heel, from shifting of his weight, for he has plantar fasciitis on that foot now as well. The degrees of the -- of pain for that foot vary based on how much weight he's putting on his left foot at any given time.

23. Dr. Marino was critical of Dr. Nijjar's hearing testimony, explaining the following:

Well, firstly, Dr. Nijjar's anatomical description of the plantar fascia was factually inaccurate. The plantar fascia does not just merely attach to the medial calcaneal tubercle as he said. There is actually three bands of the plantar fascia. The plantar fascia is like a suspensory ligament that runs from the ball of the foot to

the heel. It starts with the heel. It fans out in a fan shape to insert along the ball of the foot.

You have three bands, the medial band, the central band, and the lateral band. Any or all of those can be involved when you have a case of plantar fasciitis. The fact that Dr. Nijjar, when he examined -- allegedly examined Mr. Henrich, stated that he had no pain on palpation to the medial calcaneal tubercle. I would not expect there to be any because he had plantar fascia release, which, in and of itself, was successful.

The problem is the resultant complication that occurred was the scarring of the lateral plantar nerve which runs directly under the plantar station. So when the surgeon released or cut the plantar fascia, they nicked the lateral plantar nerve. That is what the EMG and nerve conduction actually studies unequivocally demonstrate.

[¶]...[¶]

My understanding was that Dr. Nijjar was focusing predominantly on the history of the left foot plantar fasciitis, which is pain underneath at the exertion of the plantar fascia into the heel or midsubstance. He did note in his report that Mr. Henrich had complained that he had pain along the lateral aspect of the heel out to the great toe. That is what these objective findings support. What I failed to see that Dr. Nijjar appreciated was that there were other parts within the foot that were subsequently problematic, secondary to the treatment that was given to Mr. Henrich for his original plantar fasciitis.

Dr. Nijjar stated, "No. There is no plantar fasciitis of the left foot." And I would agree with that. That's not the problem. The problem is everything else that I've gone over. But he, for some reason, didn't -- either didn't look at that or was guided by letters or questions that focused only on one specific small portion of the foot.

[¶]...[¶]

I also, you know, I also was -- you know, I listened to Dr. Nijjar's as well, because you had asked me what else I disagree with and this comes into it. He examined the circumference of his calf muscles. Well, I expect his calf muscles to be symmetric at this point in time -- or at that point in time that he

examined him because he already had adapted to his disability. He still is doing as much as he can. The calf -- the ankle is still flexing. The calf muscle is still working. They will be symmetrical at that point because they will have balanced out.

Within a year of surgery, he probably had atrophy. I don't remember what my report said. But after that, eventually patients do come to equalize out. They learn to balance their ability to bear weight.

[¶]...[¶]

I think the only other thing I have to add, based on Dr. Nijjar's original report from 2011, is that his noticing no tenderness at the calcaneus tuberosities of the left foot does not surprise me. And like I already said, I wouldn't expect there to be any. He then goes into something about noticing nodule appearance, and I expect that. But I don't see any examination of his right foot, which is where the plantar fasciitis exists. I don't know how much of the right foot he actually examined. That will be the only other thing --.

24. The video surveillance of respondent golfing and information posted on respondent's Facebook page about hunting trips he has taken did not cause Dr. Marino to change his opinion about respondent's disability status. He explained at hearing:

It doesn't. Actually, I -- in the times I've seen Mr. Henrich, I've encouraged him to do as much as he can within the limits that he feels he can do it. He told me that he golfs, and I actually suggest -- it was a good idea. It's a soft surface. It's something he can do that's physical. He has a family history of heart disease. And it's well documented that family history heart disease does run down the family tree. So I encouraged him not to become sedentary and sedate and to do as much as he can that's physical to the extent he's able to do it.

The video I saw of him playing golf, that doesn't really impress me. I mean, I have patients, hundreds of patients, with plantar fasciitis, some of whom actually can still run for short periods. It all depends on the extensiveness, but the fact that they do something is important to their general health. The video actually did also show him limping at times. So he does live with his pain, which is what people in his case, such as -- he has chronic pain. That's what pain management -- we encourage

people to do -- is to live with your pain, learn to live within your pain.

The fact that he goes hunting and utilizes vehicles to do most of the work for him -- he gets to a spot. He walks about -- a few minutes and, you know, the animal is there, and he's able to participate in that. He's able to climb a tree and sit for hours. I don't expect that to be a problem. But if you're trying to do repetitive climbing up and down all day or over 20 and 30 times a day, that would be a problem.

Discussion

25. As discussed below, complainant has the burden of producing evidence that, based upon a medical examination, respondent is no longer permanently and substantially incapacitated for the performance of his usual job duties as a Correctional Officer with the California Correctional Center, California Department of Corrections and Rehabilitation, and should be reinstated in his former position. Dr. Nijjar's IME report and hearing testimony did not constitute persuasive medical evidence that respondent is no longer permanently and substantially incapacitated. His June 15, 2011 physical examination was focused on the plantar fasciitis in respondent's left foot, and overlooked respondent's complaint that the "pain is from the heel to the big toe." Dr. Marino's testimony about the complications respondent experienced from his prior surgery and the resulting pain in his feet was corroborated by an MRI and nerve conduction study, and was persuasive.

26. Investigator Shinpaugh's sub rosa investigation does not constitute medical evidence that can properly support a determination that a member previously retired for disability is no longer disabled and should be reinstated in his former position. Furthermore, complainant introduced no persuasive evidence establishing that the activities respondent engaged in were inconsistent with his disabled status. On the other hand, Dr. Marino's testimony explaining why respondent's golfing and hunting trips were not inconsistent with his disabled status was persuasive.

27. When considering all the evidence, complainant failed to meet its burden of demonstrating that, based upon a medical examination, respondent is no longer permanently and substantially incapacitated for the performance of his usual job duties as a Correctional Officer with the California Correctional Center, California Department of Corrections and Rehabilitation, and should be reinstated to his former position. Therefore, respondent's appeal from CalPERS's determination to the contrary should be granted.

///

///

LEGAL CONCLUSIONS

Burden/Standard of Proof

1. Complainant has the burden of proving by a preponderance of the evidence that respondent is no longer permanently and substantially incapacitated for the performance of his usual job duties as a Correctional Officer with the California Correctional Center, California Department of Corrections and Rehabilitation, and should therefore be reinstated in his former position. (*In the Matter of the Application for Reinstatement from Industrial Disability Retirement of Willie Starnes* (January 22, 2000, Precedential Decision 99-03) <<http://www.calpers.ca.gov/eip-docs/about/leg-reg-statutes/board-decisions/past/99-03-starnes.pdf>>.)

Applicable Law

2. Respondent was a safety member of CalPERS by virtue of his employment as a Correctional Officer with the California Correctional Center, California Department of Corrections and Rehabilitation. He was granted disability retirement effective June 5, 2006, based on an orthopedic (bilateral foot) condition pursuant to Government Code section 21151, subdivision (a), which provides the following:

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.

3. “Disability” and “incapacity for performance of duty” are defined in Government Code section 20026, which provides:

“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.

(See, *Mansperger v. Public Employees’ Retirement System* (1970) 6 Cal.App.3d 873, 876 [“We hold that to be ‘incapacitated for the performance of duty’ within section 21022³ means the *substantial* inability of the applicant to perform [his] usual duties.”]; italics original.)

³ Predecessor to Government Code section 20026.

4. When a member has been retired for disability prior to the minimum age at which he can voluntarily retire for service, CalPERS may require the member to undergo a medical examination to determine if he is still disabled.

The board, or in case of a local safety member, other than a school safety member, the governing body of the employer from whose employment the person was retired, may require any recipient of a disability retirement allowance under the minimum age for voluntary retirement for service applicable to members of his or her class to undergo medical examination, and upon his or her application for reinstatement, shall cause a medical examination to be made of the recipient who is at least six months less than the age of compulsory retirement for service applicable to members of the class or category in which it is proposed to employ him or her. The board, or in case of a local safety member, other than a school safety member, the governing body of the employer from whose employment the person was retired, shall also cause the examination to be made upon application for reinstatement to the position held at retirement or any position in the same class, of a person who was incapacitated for performance of duty in the position at the time of a prior reinstatement to another position. The examination shall be made by a physician or surgeon, appointed by the board or the governing body of the employer, at the place of residence of the recipient or other place mutually agreed upon. Upon the basis of the examination, the board or the governing body shall determine whether he or she is still incapacitated, physically or mentally, for duty in the state agency, the university, or contracting agency, where he or she was employed and in the position held by him or her when retired for disability, or in a position in the same classification, and for the duties of the position with regard to which he or she has applied for reinstatement from retirement.

(Gov. Code, § 21192.)

5. The minimum age for service retirement for a state safety member of CalPERS is 50 years old. (Gov. Code, § 21060, subd. (a).) Respondent was 44 years old as of the effective date of his disability retirement (June 5, 2006), and 53 years old as of the date of hearing (August 28, 2014).

6. If the member is determined to no longer be substantially incapacitated for performing his usual duties, he shall be reinstated to his former position.

If the determination pursuant to Section 21192 is that the recipient is not so incapacitated for duty in the position held when retired for disability or in a position in the same classification or in the position with regard to which he or she has applied for reinstatement and his or her employer offers to reinstate that employee, his or her disability retirement allowance shall be canceled immediately, and he or she shall become a member of this system.

If the recipient was an employee of the state or of the university and is so determined to be not incapacitated for duty in the position held when retired for disability or in a position in the same class, he or she shall be reinstated, at his or her option, to that position. However, in that case, acceptance of any other position shall immediately terminate any right to reinstatement. A recipient who is found to continue to be incapacitated for duty in his or her former position and class, but not incapacitated for duty in another position for which he or she has applied for reinstatement and who accepts employment in the other position, shall upon subsequent discontinuance of incapacity for service in his or her former position or a position in the same class, as determined by the board under Section 21192, be reinstated at his or her option to that position.

If the recipient was an employee of a contracting agency other than a local safety member, with the exception of a school safety member, the board shall notify it that his or her disability has terminated and that he or she is eligible for reinstatement to duty. The fact that he or she was retired for disability does not prejudice any right to reinstatement to duty which he or she may claim.

(Gov. Code, § 21193.)

7. As discussed in Factual Findings 25 through 27, complainant failed to establish that, upon the basis of medical examination, respondent is no longer permanently and substantially incapacitated for the performance of the usual job duties of a Correctional Officer with the California Correctional Center, California Department of Corrections and Rehabilitation, and should be reinstated to his former position. Therefore, his appeal from CalPERS's determination to the contrary should be granted.

///

ORDER

Respondent Eugene M. Henrich's appeal from CalPERS's determination that he is no longer permanently and substantially incapacitated for the performance of the usual duties of a Correctional Officer and should be reinstated to his former position is **GRANTED**. The Accusation is therefore **DISMISSED**.

DATED: November 10, 2014


COREN D. WONG
Administrative Law Judge
Office of Administrative Hearings