

**ATTACHMENT A**  
**THE PROPOSED DECISION**

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

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

PERRY C. LEFFLER,

Respondent,

and

FOLSOM STATE PRISON, CALIFORNIA  
DEPARTMENT OF CORRECTIONS AND  
REHABILITATION,

Respondent.

Case No. 2014-0373

OAH No. 2015021022

**PROPOSED DECISION**

Administrative Law Judge Ed Washington, Office of Administrative Hearings, State of California, heard this matter on August 25, 2015, in Sacramento, California.

Staff Counsel Preet Kaur represented the California Public Employees' Retirement System (CalPERS).

Richard E. Elder, Attorney at Law, represented Perry C. Leffler (respondent), who was present.

CalPERS properly served Folsom State Prison, California Department of Corrections and Rehabilitation (CDCR) with the Notice of Hearing. CDCR made no appearance. This matter proceeded as a default against CDCR pursuant to Government Code section 11520.

The parties stipulated to submit simultaneous written closing briefs after obtaining hearing transcripts. On October 30, 2015, CalPERS submitted its closing brief, which was marked as Exhibit 20, and respondent submitted his closing brief, which was marked as Exhibit D. On November 16, 2015, CalPERS submitted its Reply Brief, which was marked as Exhibit 21, and respondent submitted his Reply Brief, which was marked as Exhibit E. The record was closed and the matter submitted for decision on November 16, 2015.

## ISSUE

Is respondent no longer substantially incapacitated from performing the usual duties of a Correctional Officer for CDCR?

## FACTUAL FINDINGS

### *Procedural History*

1. Respondent is 47 years old. He worked for CDCR as a Correctional Officer. His last day of work was September 30, 2008.
2. On or about January 29, 2009, respondent applied for disability retirement. Respondent's application was granted, and he disability retired effective October 1, 2009, based on an orthopedic condition (left shoulder, left knee, and back).
3. In May 2013, CalPERS initiated a re-examination of respondent to assess his ability to perform his former job duties pursuant to Government Code section 21192, because respondent was under the minimum age for voluntary service retirement. The re-examination involved a review of information obtained from medical providers, and information obtained from respondent regarding the scope, nature, and earnings of any employment.
4. After reviewing respondent's medical and employment information, CalPERS determined that respondent was no longer substantially incapacitated from performing the duties of a Correctional Officer. Respondent appealed from CalPERS' determination.

### *Respondent's January 2009 Disability Retirement Application<sup>1</sup>*

5. Respondent submitted a disability retirement application dated January 29, 2009. In this application, respondent described his disability, as follows:

Do [*sic*] to reoccurring on the job injurys [*sic*] – I have a long history of left shoulder tears, surgerys [*sic*], misc lower back and knee injury \* See claim history work comp.

In response to the question asking what limitations or preclusions resulted from his injury or illness, respondent stated:

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<sup>1</sup> Respondent submitted prior Applications for Disability Retirement in January 2005 and June 2007. CalPERS denied the January 2005 application. Respondent withdrew the July 2007 application after returning to work in December 2007.

No inmate contact, no physical force.

In response to the question asking how his injury or illness affected his ability to perform his job, respondent stated:

I cannot protect myself in my job performance with physical force or action.

In response to the question asking whether he was currently working in any capacity, respondent stated:

I am working modified per my physician in my place of business. I am not working at any capacity at Folsom Prison do [sic] to my limitations.

#### *Duties of a Correctional Officer*

6. The essential functions of a Correctional Officer are set forth in the CDCR, Division of Adult Institutions Correctional Officer Essential Functions form. The form lists 37 essential job functions of a CDCR Correctional Officer, including the following:

- Must be able to perform the duties of all the various posts.
- Must be able to swing a baton with force to strike an inmate.
- Disarm, subdue and apply restraints to an inmate.
- Defend self against inmate armed with a weapon.
- Run occasionally; run in an all-out effort while responding to alarms or serious incidents distances varying from a few yard to 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 while 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.
- 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 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 an inmate, including wrestling

an inmate to the floor. Drag/carry an inmate out of the cell. Perform the lifting/carrying activities while working in very cramped space.

- Reaching occasionally to continuously reach overhead while performing cell or body searches, etc.
- 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 an inmate to cease an activity to firing a lethal weapon at an inmate when another life is threatened with great bodily harm or death

7. On October 6, 2012, a CDCR representative completed a Physical Requirements of Position/Occupational Title form for respondent's position. According to that form, a Correctional Officer must be able to engage in the following physical activities:

- Running: Occasionally (up to 3 hours) when responding to alarms.
- Crawling: Occasionally (up to 3 hours) up to 50 yards.
- Kneeling: Occasionally (up to 3 hours).
- Climbing: Frequently (up to 6 hours) up to 150 steps.
- Squatting: Occasionally (up to 3 hours).
- Reaching (above shoulders): Occasionally (up to 3 hours).
- Lifting 26 to 50 lbs.: Frequently (up to 6 hours) 200 yards.
- Lifting between 51 and 100 lbs.: Occasionally (up to 3 hours).
- Lifting in excess of 100 lbs.: Occasionally (up to 3 hours).

8. In the section for "comments or additional requirements not listed above" at the bottom of the Physical Requirements of Position/Occupational Title form, the document includes the following additional requirements for Correctional Officers:

- Must be able to perform all of the essential functions on the attached Correctional Officer –Essential Functions.
- Must meet Peace Officer Standards per Government Code, Section 1031, subdivision (f). Be found to be free from any physical, emotional, or mental condition that might adversely affect the exercise of the powers of a Peace Officer.
- Regardless of the frequency of activity, an inability to perform the essential functions may result in serious consequences to the safety and security of the employee, coworkers, inmates, or the institution.

### *Respondent's Testimony*

9. Respondent testified to a series of injuries he suffered over the years while employed with CDCR. Around April 2001, he developed increasing left shoulder pain after carrying an inmate on a gurney at work. In August 2003, he injured his right shoulder while breaking up a physical altercation between inmates. Respondent was off work for approximately two weeks and then returned. He also developed back pain in 2003 when he

slipped on the floor at work while carrying food trays. In spring 2007, respondent strained his back while lifting an inmate who had hung himself in an attempt to commit suicide. He engaged in a variety of strenuous activities during a prison riot in 2008 and injured his back, shoulder and left knee. Respondent went off work due to these injuries and has not returned. His current treatment plan involves pain management through daily use of hydrocodone or Vicodin. Respondent now resides in Kuna, Idaho, where he owns and manages a bar and nightclub.

10. Respondent testified that his duties at Folsom prison included going up and down five flights of stairs every 30 minutes as part of regularly scheduled mandatory security checks. He estimated that each check required negotiating 150 steps in total. He completed a minimum of 16 security checks each eight-hour work shift, and performed additional checks when working overtime. In addition to the scheduled security checks, respondent traveled up and down these stairs throughout his work shift to remove and return inmates for medical appointments.

11. Respondent estimated that during an average work week, he was required to run to respond to serious incidents at least three times a week. The running sometimes exceeded 400 yards and frequently included running up and down flights of stairs. He had to subdue combative inmates weekly, and had to drag or carry inmates out of cells due to emergencies about once or twice a week. Respondent stated that his duties also included periodically breaking up fights between cellmates. During a prison riot in 2008, he had to gurney unconscious or injured inmates to safe areas and also worked with his coworkers to form a "scrimmage line" to protect elderly or disabled inmates from harm.

12. According to respondent, his injuries preclude him from performing the duties of a Correctional Officer. He asserted he cannot swing a baton with force; climb a ladder; run in an all-out effort while responding to alarms or serious incidents; subdue inmates; or exert enough bodily force to defend himself, coworkers, or other inmates from harm.

#### *Medical Reports and Records*

13. The basis for CalPERS' approval of respondent's January 2009 Application for Disability Retirement was not established at hearing. However, the medical reports and records in evidence reflect the following chronology:

- In June 2001, respondent was evaluated by Steven Barad, M.D., for left shoulder pain. An MRI scan revealed a labral injury and paralabral cyst. Treatment was provided in the form of a subacromial injection and prescription pain medication. The injection provided temporary relief, but discomfort returned. The left shoulder presented clicking with range of motion.

- In August 2001, Rita Bermudez, M.D., performed an electromyography (EMG) and nerve conduction velocity (NCV) study. The EMG was normal. A prolonged latency to the innervated aspect of the ring finger was determined.
- In October 2001, Dr. Barad performed an arthroscopy on respondent's left shoulder to remove the inferior labral tear.
- Between January and March 2002, Dr. Barad performed several assessments. Mild carpal tunnel syndrome was determined. Respondent reported increased pain and discomfort.
- In April 2002, respondent was re-evaluated due to re-injury. Clicking and neurological symptoms were present in his left shoulder. A cervical spine MRI revealed a mild disc bulge on the right side at C5-C6, and central to the right at C6-C7.
- In July 2002, respondent was evaluated by Tim Mar, M.D. It was determined that the labral tear in respondent's left shoulder had not properly healed. There were symptoms related to overhead activities and throwing.
- In August 2002, Dr. Mar determined that respondent had nerve impingement from C6-C7.
- In October 2002, Richard Baker, M.D., evaluated respondent regarding a work-related injury. He noted that there had been a labral tear and that the shoulder presented instability. He also identified intermittent brachial plexus compression.
- In January 2003, another surgical procedure was performed on respondent's left shoulder to address shoulder instability, difficulty with gripping and lifting, and difficulty with overhead activity.
- In April 2003, respondent returned to work and continued physical therapy. Clunking and crepitus symptoms persisted.
- In October 2003, respondent was re-evaluated by Dr. Baker due to a reported workplace injury two months prior. Respondent reported a right arm injury due to being pulled into a cell by an inmate. Dr. Baker diagnosed respondent with left shoulder labral tear, impingement, anterior laxity, partial rotator cuff tear with previous surgery, cervicothoracic myofascial pain secondary to the left shoulder, right shoulder strain, low

back strain, and right knee strain, resolved. Respondent's symptoms persisted.

- In August 2004, respondent was evaluated by Mark Hambly, M.D., related to another injury he suffered at work. He reported back pain after he slipped on tiles at work. There was normal range of motion and strength. A central protrusion at L3-L4 was identified along with symptoms of nerve irritation in the lower extremities.
- Between November 2004 and April 2006, respondent was evaluated and treated by a series of medical providers for his recurring symptoms.
- In April 2006, Arthur Auerbach, M.D., met with respondent and completed an independent medical evaluation. Respondent complained of constant left shoulder pain and constant low back pain. He felt he could not perform his job duties because engaging in an altercation or any activity requiring a burst of speed would produce pain and cause him to miss work. Dr. Auerbach diagnosed respondent with right shoulder injury, resolved; left shoulder injury with impingement syndrome post left shoulder arthroscopy and debridement of inferior labral tear with development of some laxity, episodic brachioplexus compression, post 2003 arthroscopy with subacromial decompression with acromioplasty, debridement of partial cuff tear with almost complete resolution of left shoulder problem; low back injury with subsequent development of degenerative disc disease, mild disc bulging, and mild bilateral lumbar radiculopathy. Dr. Auerbach opined that respondent could perform all of his job duties and was not substantially incapacitated for the performance of those duties.
- In May 2007 respondent reported a flare-up of back and shoulder pain that occurred while responding to an emergency in March 2007. He reported continued left shoulder pain radiating into his extremities and intermittent lower back pain.
- In December 2008, Dr. Mar determined that the second of two MRI reports of respondent's left shoulder indicated a low-grade partial tear of the anterior supraspinatus and some bursitis. Dr. Mar felt the second MRI finding was consistent with respondent's symptoms.
- In January 2009, Dr. Baker re-evaluated respondent. He diagnosed respondent with left knee strain with patellar chondromalacia. Respondent's left shoulder had not improved and instability was present. In the same month, respondent was also examined by Dr. Mar. He complained of left shoulder pain with overhead activity and left knee pain. It was Dr. Mar's opinion that respondent condition prohibited him from

returning to work as a Correctional Officer. He stated that both a arthroscopy of the left knee and re-arthrosopy of the left shoulder were necessary.

- On March 10, 2009, Dr. Baker also reached the conclusion that respondent's condition precluded him from returning to work as a Correctional Officer.
- In March 2009, Dr. Mar performed an arthroscopy of respondent's left shoulder. A bursectomy was also completed. This was the third surgery performed on respondent's left shoulder.
- In April and May 2009, respondent was evaluated by Dr. Mar. Light activity was approved but heavy impact activities were prohibited. There was back pain, increased knee pain, and weight gain. Respondent's back pain, left knee pain, and left shoulder pain persisted.
- On January 27, 2014, Dr. Mar performed an arthroscopy on respondent's left knee. He discovered damaged cartilage and cracks in respondent's patella.

#### *Expert Opinions*

14. Respondent submitted three documents prepared by Dr. Mar. Dr. Mar is respondent's treating orthopedic surgeon and became his treating physician in 2002. He is a board-certified orthopedic surgeon in private practice with privileges at Mercy General Hospital, Methodist Hospital, and Sutter General Hospital. The three documents are summarized, as follows:

- A December 3, 2013, letter from Dr. Mar to the State Compensation Insurance Fund states he saw respondent regarding his left knee, left hand, and shoulder. The letter specifies that respondent's hand and shoulder still bother him, but that his knee had become more problematic. There was pain with bending, squatting, and going up and down stairs. There was 3+ crepitus and grinding in the patellofemoral joint, and pain with rotation and pivoting. Dr. Mar recommended arthroscopic chondroplasty and removal of any scar tissue or plica and prescribed Motrin and Norco, as needed, pending surgery.
- A January 27, 2014, Operative Report reflects the surgical procedure performed on respondent's left knee and the related diagnoses. Both the preoperative and postoperative diagnoses reflect "chondral defect, lateral riding patella, painful plica, left knee."

- A March 24, 2014, letter from Dr. Mar to the State Compensation Insurance Fund states he saw respondent regarding his left knee, left hand, and shoulder. The letter specifies that respondent's hand, shoulder, and lower back continue to bother him on a regular basis. The knee still presented 3+ crepitus, grinding, and pain about the patellofemoral region, despite the January 2014 arthroscopy. Respondent experienced pain with both standing and walking. The knee continued to bother him on a regular basis in the area of the kneecap and along the medial joint line with pivoting or rotation. Dr. Mar did not feel respondent could return to his duties as a Correctional Officer. He stated that any kind of impact, repetitive running, lifting or twisting would bother respondent significantly regarding his left knee condition.

15. Robert Henrichsen, M.D., testified at hearing. Dr. Henrichsen is a board-certified orthopedic surgeon and a certified Fellow of the American Academy of Orthopaedic Surgeons. On December 3, 2013, he evaluated respondent, reviewed his job functions and medical records, and prepared a 21-page report.

16. Respondent told Dr. Henrichsen that he was experiencing intermittent pain in his left arm and that his left shoulder was popping. He told Dr. Henrichsen that his left shoulder felt unstable and that he could not throw. Respondent also complained of grinding in his left knee, weakness in his left hand, and pain in his right hand. He attributed the pain in his hands to carpal tunnel syndrome. Respondent claimed that his lower back "goes out intermittently" and that he has pain in his thoracic spine.

17. After conducting a physical examination of respondent and reviewing his medical records, Dr. Henrichsen reached the following diagnostic impressions:

1. History of left shoulder labral tear, status post debridement.
2. History of left shoulder impingement syndrome, status post-surgical decompression.
3. Resolved right shoulder pain, with history of impingement syndrome.
4. Resolved thoracic spine.
5. Degenerative disc disease and degenerative facet arthritis, lumbar spine, with disc bulging at L3-L4 and L4-L5.
6. History of right elbow biceps tendon avulsion, status post repair.
7. Left knee patellofemoral chondromalacia.
8. Morbid obesity.
9. Degenerative disc disease, cervical spine.
10. Persistent left upper extremity subjective symptoms.

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18. Dr. Henrichsen's report included the following assessment:

Applicant has persistent left shoulder symptoms, where he has pain with overhead activities. ... I did not find any medical record examination of mechanical shoulder instability.

[¶] ... [¶]

His neck has some degenerative disease and has intermittent pain. His thoracic spine had a strain while holding up an inmate. His examination of the thoracic spine demonstrates some tenderness. His lumbar spine has degenerative disease, aggravated by his work, and there are a variety of residual symptoms in his lumbar spine, which sometimes are and sometimes are not radicular in nature, however, he does not have evidence of nerve impingement in his low back pursuant to his two MRI scans. He also has a chronic unfavorable power-to-weight ratio. His left knee has some crepitus of the patella femoral joint.

My review of this available information indicates that the left knee, the lumbar spine, the neck, the right shoulder, and both hands and wrists do not arise to the level of substantial incapacity to perform his occupation.

His left shoulder is the area of the majority of medical concern. He had difficulty with overhead activities on examination, has symmetrical range of motion of both shoulders. I was not able bring out any specific abnormality of either shoulder by examination today. None of the physician's [*sic*] opined that a second shoulder MRI scan would be beneficial to better identify pathology.

Considering that a Correctional Officer may, with assistance of other officers, respond up to three or four alarms per shift and they may run or jog to the alarms, I have the following opinion regarding the exact questions submitted to me.<sup>2</sup>

[Are there specific job duties that you feel the member is unable to perform because of a physical or mental

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<sup>2</sup> Dr. Henrichsen's conclusion that a "Correctional Officer may, with assistance of other officers, respond up to three or four alarms per shift and they may run or jog to the alarms" was not established by the evidence.

condition?]) The specific duties he would have difficulty with are repeated overhead lifting, hammering, or throwing with the left hand. These would produce increased pain in his left shoulder. He actually could accomplish them, but he would have more pain and symptoms. There are no specific job duties [respondent] is unable to perform, based on my evaluation and review of extensive records.

[In your professional opinion, is the member presently substantially incapacitated for the performance of his duties?] The information and my examination do not support that his left shoulder, back or knee produces substantial incapacity as described by CalPERS for the performance of his duties as a Correctional Officer.

19. Dr. Henrichsen's testimony at hearing echoed his December 2013 report. He explained his examination process and reiterated the diagnoses in his report, noting that respondent's left shoulder labral tear had been repaired. He felt that respondent's symptoms at the time of his examination were routine for someone with left knee patellofemoral chondromalacia, degenerative disc disease, and three shoulder surgeries. He testified that he reviewed the essential functions and physical requirements of respondent's job duties and believed respondent could perform each of those job functions. He added that it would be painful for respondent to perform some of the job functions, "but not prohibitively so."

20. It was Dr. Henrichsen's opinion that the previous CalPERS determination that respondent was substantially incapacitated from the performance of his usual job duties was premature. He testified that the information he reviewed regarding respondent's reported incapacity "showed a relative absence of objective standards." Dr. Henrichsen felt the determination was based on symptoms, rather than objective medical findings, and did not meet the standard for determining substantial incapacity.

21. Dr. Henrichsen testified that he reviewed the aforementioned documents prepared by Dr. Mar and they did not alter his opinion that respondent was not substantially incapacitated for the performance of his duties. He testified that the documents from Dr. Mar appeared to reach medical conclusions based on respondent's subjective symptoms, rather than objective findings stemming from an examination. He stated that "the best way [I know] to medically to determine incapacity is to establish a reasonable correlation of a person's symptoms with imaging or electrical studies." In his opinion, respondent's claims of incapacity were not supported by these types of objective data.

22. Dr. Mar also testified at hearing. He opined that respondent cannot perform a substantial portion of the job duties of a Correctional Officer due to structural damage in his left knee and left shoulder. He performed respondent's second rotator cuff surgery on his left shoulder in 2003 and what he described as a left shoulder debridement in 2009. In January

2014, he also performed a chondroplasty of respondent's left knee to address pain and grinding in the patellofemoral region by removing portion of scar tissue or plica present under respondent's left knee cap.

23. Dr. Mar identified and described structural damage in respondent's left shoulder utilizing intraoperative photographs taken during respondent's March 2009 shoulder surgery. He identified and described damage to respondent's labrum and a partial tear in respondent's supraspinatus tendon to demonstrate that respondent's rotator cuff was not completely repaired through surgery. He testified that despite multiple surgeries the supraspinatus tendon had not healed well. Because this tendon had not healed well post-surgery, Dr. Mar was reluctant to perform additional surgery in that area, as it may do more harm than good. Through the intraoperative photographs, Dr. Mar also identified and described bone fragments and scar tissue in the shoulder. He asserted that the condition of respondent's shoulder, as demonstrated in the photographs, limit respondent's ability to perform overhead work, and perform certain shoulder movements with any meaningful degree of force.

24. Dr. Mar also used intraoperative photographs to explain structural damage in respondent's left knee. He identified and described deteriorated portions of the cartilage in respondent's left knee cap. Dr. Mar also identified and described how impact injuries to the patella reflected "full cracks down to the bone." His opined that the condition of respondent's knee limits his ability to perform several of his job duties including bending, squatting, and running down stairs.

25. In Dr. Mar's opinion, the intraoperative photographs of respondent's left shoulder and left knee arthroscopies constitute objective findings that "correlate fairly well with respondent's subjective complaints." He testified that the condition of the fulcrum in respondent's left shoulder precludes him from completing most shoulder movements with force. Dr. Mar stated that respondent cannot swing a baton with force and cannot use bodily force to disarm and/or subdue an inmate of adult-size. It was Dr. Mar's opinion that respondent could not use bodily force to defend himself against an armed adult-size inmate, particularly because he is left-hand dominant and cannot generate significant force from his left shoulder and his knee would "give out" under pressure. He stated that respondent cannot perform any job functions that require squatting, regular climbing, extended running, or running at an incline—including climbing stairs, specifying that if he does "his knee will give way and he will fall out."

### *Discussion*

26. On May 18, 2010, CalPERS notified respondent that his January 2009 application for disability retirement had been approved. He had been found substantially incapacitated from the performance of his usual job duties as a Correctional Officer due to the condition of his left shoulder, left knee and back. Respondent's medical records reflect that CalPERS's determination was based, at least in part, on medical opinions from Dr. Mar

and Dr. Baker, asserting that the condition of respondent's left shoulder and left knee preventing him from returning to work as a Correctional Officer.

27. CalPERS now argues that respondent is no longer substantially incapacitated from the performance of his duties, based on the December 2013 medical evaluation and report of Dr. Henrichsen and his testimony at hearing. Dr. Henrichsen's report and testimony reflected his opinion that respondent's medical condition and complaints of pain were routine for someone of his age and size with multiple shoulder surgeries. His report and testimony also reflected his belief that there was a relative absence of objective medical findings to support respondent's claimed incapacity. Essentially, Dr. Henrichsen argued that respondent could perform his job duties with non-debilitating pain, and that respondent's claimed incapacity is not medically supported.

28. However, Dr. Mar testified persuasively to objective findings that supported respondent's claimed incapacity in the form of structural damage to respondent's left shoulder and left knee. He testified that he operated on respondent's left shoulder in 2003 and 2009 and observed damage to his rotator cuff. The supraspinatus tendon had a partial tear that had not properly healed after surgery in 2001. Dr. Mar provided intraoperative photographs of the 2009 shoulder surgery and identified and described the partial tendon tear and the areas of deficient post-operative healing. Similarly, Dr. Mar produced intraoperative photographs from the left knee arthroscopy he performed on respondent in January 2014. He identified and described worn cartilage and full cracks in the patella of respondent's left knee. He testified that these photographs correlated with his numerous examinations of respondent and respondent's complaints of pain and diminished range of motion. Dr. Mar opined that these photographs provided objective and reliable medical evidence of respondent's inability to perform a significant portion of his former job duties.

29. The testimony of Dr. Mar was compelling and largely unrefuted. He provided competent medical evidence that supported his opinion that respondent cannot perform a substantial portion of the usual duties of a Correctional Officer for CDCR. Dr. Henrichsen did not discuss the intraoperative images of respondent's left shoulder and left knee during his testimony and there was no evidence he had ever seen or considered them. CalPERS provided no evidence to rebut Dr. Mar's opinion that the intraoperative images objectively supported respondent's claimed incapacity.

30. Through Dr. Mar, respondent presented objective findings of current substantial incapacity. CalPERS has the burden of establishing that respondent is no longer substantially and permanently disabled from performing the usual duties of a Correctional Officer. CalPERS did not present sufficient evidence to meet its burden of proof. Consequently, its request that respondent be involuntarily reinstated from disability retirement must be denied at this time.

## LEGAL CONCLUSIONS

1. In accordance with Government Code section 21192, CalPERS re-evaluates members receiving disability retirement benefits who are under the minimum age for service retirement. That section, in relevant part, provides:

The board ... 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 .... The examination shall be made by a physician or surgeon, appointed by the board .... 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 ... 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.

2. Government Code section 21193 governs the reinstatement of a recipient of disability retirement who is determined to no longer be substantially incapacitated for duty and, in relevant part, provides:

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.

3. Government Code section 20026 defines “disability” and “incapacity for performance of duty,” and, in relevant part, 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 ... on the basis of competent medical opinion.

4. In *Mansperger v. Public Employees' Retirement System* (1970) 6 Cal.App.3d 873, 876, the court interpreted the term “incapacity for performance of duty” as used in Government Code section 20026 (formerly section 21022) to mean “the *substantial* inability of the applicant to perform his usual duties.” (Italics in original.) In *Hosford v. Board of Administration of the Public Employees' Retirement System* (1978) 77 Cal.App.3d 854, 862

the court held that a disability or incapacity must currently exist and that a mere fear of possible future injury which might then cause disability or incapacity was insufficient. Respondent presented competent evidence that the structural condition of his left shoulder and left knee are currently incapacitating and preclude him from substantially performing his usual and customary duties.

5. To involuntarily reinstate respondent from industrial disability retirement, CalPERS had the burden of establishing respondent is no longer substantially incapacitated from performing the usual duties of a Correctional Officer. As set forth in Factual Findings, CalPERS did not submit sufficient evidence at the hearing to meet its burden of proof. Dr. Henrichsen did not address or explain how intraoperative images of respondent's left shoulder and left knee failed to constitute objective medical evidence of his claimed incapacity. Conversely, Dr. Mar persuasively testified that his opinion that respondent was substantially incapacitated from the performance of his usual job duties was based not only on respondent's subjective complaints of pain, but also on his examination of respondent and the structural damage he observed in respondent's left knee and left shoulder—as reflected in the intraoperative images. He established that the structural damage to respondent's left shoulder and left knee constituted a present disability that precluded him from performing a significant portion of his former job duties, or that would be aggravated by performing many of those duties. Consequently, CalPERS' request that respondent be involuntarily reinstated from disability retirement must be denied at this time.

#### ORDER

Respondent's appeal is GRANTED. The request of California Public Employees' Retirement System to involuntarily reinstate respondent Perry C. Leffler from disability retirement is DENIED.

DATED: December 18, 2015

DocuSigned by:  
*Ed Washington*  
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ED WASHINGTON  
Administrative Law Judge  
Office of Administrative Hearings