ATTACHMENT A

THE PROPOSED DECISION

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

In the Matter of the Application for Industrial Disability Retirement of: DESCHELLE R. WALKER, Respondent, AND CALIFORNIA STATE PRISON—LOS ANGELES COUNTY, CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION, Respondent.	CASE NO. 2014-0354 OAH No. 2014070378

PROPOSED DECISION

Carla L. Garrett, Administrative Law Judge (ALJ), Office of Administrative Hearings, State of California, heard this matter on August 23, 2016 and October 21, 2016, in Los Angeles, California.

Rory Coffey, Senior Staff Attorney, represented the Petitioner, California Public Employees' Retirement System (CalPERS). Danny T. Polhamus, Attorney at Law, represented Respondent Deschelle R. Walker (Respondent) who appeared at hearing. No one appeared on behalf of Respondent California State Prison—Los Angeles County Department of Corrections and Rehabilitation.[1]

Oral and documentary evidence was received, the record was closed, and the matter was submitted for decision on October 21, 2016.

[1] Respondent California State Prison—Los Angeles County Department of Corrections and Rehabilitation was properly served with the Statement of Issues and the Notice of Hearing, but failed to appear at hearing. The matter therefore proceeded as a default against Respondent California State Prison—Los Angeles County Department of Corrections and Rehabilitation.

CALIFORNIA PUBLIC EMPLOYEES'
RETIREMENT SYSTEM
FILED Nov. 22, 20 16
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FINDINGS OF FACT

1. On June 30, 2014, Anthony Suine, in his official capacity as Benefit Services Division Chief, Board of Administration, CalPERS, executed a Statement of Issues, Case No. 2014-0354, against Respondent. Respondent filed a timely appeal on September 6, 2013 and requested an administrative hearing to dispute CalPERS' August 26, 2013 determination that Respondent was not substantially incapacitated from the performance of her duties as a correctional officer with the California State Prison—Los Angeles County Department of Corrections and Rehabilitation (the prison).

2. On January 1, 1994, Respondent began working as a correctional officer at the prison, which required six weeks of physical and verbal training, and included "take-downs," weapons training, baton training, aerobic training, physical restraints and holds, and other training. Respondent's job duties as a correctional officer entailed, among other things, supervising inmates, responding to alarms, transporting weapons to different areas in the prison, and, at times, restraining inmates. Respondent's job required constant walking, standing, bending, ascending and descending stairs, eight to ten hours per day, 40 to 50 hours per week.

3. On May 11, 2010, Respondent was assigned as an administrative segregation property officer at the prison, which required her to distribute property to the inmates in the segregation unit. Toward the end of her shift, Respondent placed approximately 10 bags of property, weighing 15 to 20 each, into the prison's pick-up truck, so she could take the property to a different area of the prison. She traveled through an open gate of a chain-linked fence located behind the vocational area on the yard, and exited the vehicle to close the gate. As Respondent stood at the gate securing it, she was suddenly struck from behind by the bumper of a "UPS size" unmanned truck. The bumper impacted the back of her knees and pinned her against the fence. She felt a pop in her right knee, as well as pain in her lower back, and her right shoulder hurt. She struggled to get free for approximately five minutes. An inmate and a maintenance worker saw Respondent pinned against the fence, and tried to free her by pulling her while attempting to push the truck back, but they were unsuccessful. The maintenance worker then entered the truck's cabin and backed the truck away from the fence, freeing Respondent in the process. Because the accident occurred at the end of her shift, Respondent went home without reporting the accident.

4. Later that night, Respondent's knee, back, shoulder, and neck began hurting quite significantly. The following day, Respondent reported the accident and injuries to her supervisor. Her supervisor sent her to High Desert Medical Center (medical center). The physician at the medical center x-rayed her knee, but not her shoulder, back, or neck. The physician opined that Respondent had a bone contusion in her knee, but referred her to an orthopedic specialist to be sure. The physician took Respondent off work for several days.

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Dr. Gregg Sobeck

5. The specialist, orthopedic surgeon, Gregg Sobeck, M.D., began treating Respondent shortly thereafter.[2] Dr. Sobeck examined Respondent's right knee, and ordered an MRI. Dr. Sobeck focused on Respondent's right knee as opposed to her other areas of complaint, because her knee caused her more problems than her neck, shoulder, or back, and the prison had only accepted Respondent's knee injury, as opposed to her other reported injuries. On June 21, 2010, the results of the MRI revealed "a grade two chondromalacia of the trochlear groove and right two to three chondromalacia[3] of the medial femoral condyle." (Exhibit A, page 4.) The MRI revealed no tear of the menisci or the ACL. Dr. Sobeck kept Respondent off work and treated her with physical therapy and oral medications; however, Respondent's condition did not improve.

6. Thereafter, prior to January 28, 2011, Dr. Sobeck released Respondent to return to work, but with restrictions. The prison's administrators advised Respondent that it could not accommodate the restrictions, because it expected its correctional officers to be able to perform all of their job duties. Consequently, Respondent did not return to work. Respondent remained on temporary disabled status.

7. On February 28, 2011, Dr. Sobeck performed arthroscopic surgery on Respondent's right knee, and removed "loose bodies," addressed "patellofemoral and medial compartment chondroplasties," and performed an "intraarticular injection." (Exhibit A, page 4.) Thereafter, Respondent received about two months of post-operative physical therapy.

8. Dr. Sobeck again released Respondent to return to work with restrictions. Again, the prison administration advised it was unable to accommodate the work restrictions. Consequently, Respondent remained on disability.

9. After surgery, Respondent developed an antalgic gait stemming from her right knee issues, which resulted in Respondent experiencing more pain in her right knee, and increased lower back symptoms. Because she felt she was not improving, and Dr. Sobeck had not addressed the other parts of her body that were causing her problems (i.e., lower back, shoulder, and neck), Respondent elected to seek legal representation in July 2011. Respondent ultimately filed a workers' compensation claim.[4]

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[2] It is unclear the date Dr. Sobeck began treating Respondent, but a review of the evidence indicates that he began treating Respondent several weeks after the date of injury.

[3] Chondromalacia is the inflammation of the underside of the patella and the softening of the cartilage.

[4] It is unclear when Respondent filed her workers' compensation claim.

Treatment by Dr. Mark Greenspan

10. Respondent began treating with orthopedic surgeon, Mark Greenspan, M.D., on September 22, 2011 and still continues to see Dr. Greenspan. Dr. Greenspan, who testified at hearing, has been a licensed physician for 36 years, and spends approximately 80 percent of his practice treating patients and the remaining 20 percent in the area of medical-legal reporting (i.e., performing independent medical evaluations).

11. Dr. Greenspan prepared a comprehensive report dated August 7, 2014, highlighting his years of treatment of Respondent between September 2011 and June 2014. Respondent initially presented with complaints of pain and discomfort in her right knee and her lower back radiating to her leg with numbness. Dr. Greenspan reviewed Respondent's medical records, including her MRI results. Dr. Greenspan diagnosed Respondent with chronic contusion/sprain of the right knee, chronic sprain of the lumbar spine, and chondromalacia patella of the right knee. In September 2011, Dr. Greenspan was of the opinion that Respondent could return to work with restrictions, such as no prolonged standing, no prolonged ambulation, and a requirement that she sit 10 to 15 minutes of each hour worked. Dr. Greenspan prescribed naproxen and Norco, and recommended a course of acupuncture.

12. Dr. Greenspan saw Respondent nearly every month to monitor Respondent's progress and documented continued complaints of Respondent's right knee pain and numbness, as well as documented complaints concerning her back. Dr. Greenspan refilled Respondent's prescriptions, recommended she continue acupuncture treatments, and required her to engage in a home exercise program, and use ice and heat.

13. On April 25, 2012, Respondent returned to Dr. Greenspan with complaints of pain and discomfort in the right knee, with numbness and tightness radiating to her lower leg. Upon examination, Dr. Greenspan noted a limited and painful range of motion. Dr. Greenspan opined the potential for increasing knee pain, swelling, giving way, and buckling was more than likely, given that further degeneration would occur in her knee, and more of the articular cartilage would wear out. Dr. Greenspan recommended a Synvisc injection, aquatic therapy, and continued acupuncture.

14. In approximately June 2012, Dr. Greenspan felt Respondent could return to work, but be restricted to sitting work or sedentary work only. Dr. Greenspan believed Respondent would experience great difficulty performing her normal work duties, because Respondent's right knee would greatly impact Respondent's ability to squat, stoop, kneel, bend, and run. The prison's administration could not accommodate Respondent's return to work with restrictions, because it expected its correctional officers to be able to perform all of their job duties.

15. When Respondent returned to Dr. Greenspan for her July 12, 2012 appointment, she reported that she had fallen due to knee instability, resulting in a minor injury to her right thumb. During her August 16, 2012 visit, Respondent reported to Dr.

Greenspan that her right knee kept giving out, which resulted in her falling down the stairs at her home. During her November 15, 2012 visit, Respondent reported that on November 10, 2012, while walking down the steps at her home, her right knee buckled and she fell down, landing on her buttocks and injuring her tailbone and lower back.

16. On December 7, 2012, Respondent underwent a MRI of her lower back, which revealed a disc protrusion at L4-L5 which narrowed the lateral recess, a tiny annular fissure, mild canal stenosis, moderate left neutral stenosis, and mild-to-moderate right neutral foraminal stenosis. At L5-S1, the MRI showed broad-based disc protrusion, narrowing of the left recess, mild-to-moderate right neutral foraminal stenosis, which abutted the S1 nerve roots bilaterally.

17. On February 25, 2013, Respondent submitted to CalPERS a Disability Retirement Election Application seeking industrial disability retirement, claiming she suffered a disability. Specifically, she claimed to have suffered an injury to her knee and back on May 11, 2010 when she was struck by a truck, which resulted in an inability to perform necessary duties of her job, such as running, kneeling, prolonged standing or walking, subduing, disarming, or restraining inmates, frequent extensions of her back, repetitive bending or stooping, and walking on uneven terrain or stairs. Respondent contended that such limitations impacted her ability to perform heavy lifting duties, work in combative situations, subdue or restrain inmates, remain on her feet throughout a shift, and perform repetitive bending needed for the job.

Agreed Medical Evaluation by Dr. Steven Weiss

18. On April 5, 2013, Dr. Steven Weiss performed an agreed medical evaluation of Respondent in relation to her workers' compensation matter. Dr. Weiss diagnosed, among other things, contusion of the right knee, chondromalacia to the right patella and medial femoral condyle, post arthroscopic chondroplasty of the right patella and medial femoral condyle, lumbar contusion, left L5-S1 lumbar radiculopathy,[5] cervical sprain/strain, and pelvis contusion. Dr. Weiss recommended, among other things, pain relievers, muscle relaxants, therapeutic stretching and strengthening exercises, lumbar epidural injections, a neoprene brace, a lumbar corset, and repeat arthroscopic surgery of the right knee, as well as lower back surgery, if Respondent's condition did not improve with physical therapy and epidural injections.

CalPERS Medical Evaluation by Dr. Pierre Hendricks

19. On June 27, 2013, Dr. Pierre Hendricks, a fellow with the American Board of Orthopedic Surgeons, performed an orthopedic independent medical evaluation on Respondent at the behest of CalPERS. Dr. Hendricks, who testified at hearing, earned a Bachelor of Science degree in biology from the University of California at San Diego in

[5] Radiculopathy is pain that radiates to other body parts as a result of a compressed or irritated spinal nerve.

1977 and his medical degree from the University of Southern California's School of Medicine in 1982. Dr. Hendricks completed his general surgery internship in 1983, and his general surgery and orthopedic surgery residencies in 1984 and 1988, respectively, and was in private practice from 1988 to November 2015. Dr. Hendricks has performed medical examinations for CalPERS since 2005.

20. When evaluating members for disability retirement, Dr. Hendricks made it his custom and practice to interview the member, obtain a medical history, talk to the member about the areas causing complaint, review prior records, review the member's job description provided by CalPERS, and then examine the member. He followed this custom and practice with respect to Respondent.

21. CalPERS provided Dr. Hendricks with a list of essential functions of a correctional officer, which included swinging a baton with force to strike an inmate; disarm, subdue, and apply restraints to an inmate; defend self against an inmate armed with a weapon; walk occasionally to continuously; run occasionally to run in an all-out effort to respond to alarms or serious incidents for distances ranging from a few yards to 400 yards—such running may take place over varying surfaces including uneven grass, dirt areas, pavement, and cement, and could include running up and/or down flights of stairs; climb occasionally to frequently, ascend or descend or climb a series of steps/stairs, several tiers of stairs or ladders, as well as climb onto bunk/beds, and 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; stand occasionally to continuously, depending on the assignment; sit occasionally to continuously; stoop or bend occasionally to frequently; lift and carry continuously to frequently 20 to 100 pounds, lift and carry an inmate and physically restrain the inmate, including wrestling an inmate to the floor and dragging/carrying an inmate out of a cell; continuously wearing a 15-pound equipment belt; pushing and pulling occasionally to frequently with respect to opening and closing locked gates and cell doors or during altercations between inmates; reaching occasionally to continuously; head and neck movement frequently to continuously throughout the workday; arm movements occasionally and continuously; bracing while restraining an inmate; twisting of the body in all directions; perform regular duties on a wide range of working surfaces, which may become slippery; and defend self, staff, and inmates.

22. In addition to the essential functions of a correctional officer, Dr. Hendricks reviewed Respondent's medical records from the medical center, Dr. Sobeck, Dr. Greenspan, Dr. Weiss, and from Respondent's December 7, 2012 MRI.

23. Dr. Hendricks conducted an evaluation of Respondent and prepared a written report dated June 27, 2013. Specifically, Dr. Hendricks examined Respondent's cervical spine and noted there was no visible soft tissue swelling, torticollis, muscle spasm, or localized muscle atrophy. He also found no evidence of lymphadenopathy, muscle spasm, increased heat mass localized swelling, soft tissue defect, or bony deformity. Dr. Hendricks' examination of Respondent's lumbar spine revealed no spinal deformity or bony prominence.

When he examined Respondent's knee, he noted no evidence of muscle atrophy and that Respondent's muscle showed normal strength.

24. Dr. Hendricks' diagnosed Respondent with contusion of the right knee, right thigh, and right calf, right knee grade two chondromalacia patella and grade two to three medial compartment chondromalacia, lumbosacral contusion/sprain/strain, lumbar spondylosis with a three millimeter disc bulge at L4-5 and L5-S1, bilateral L5-S1 facet arthrosis, mild-to-moderate right L5-S1 neuroforaminal stenosis, and moderate left L5-S1 neuroforaminal stenosis without lumbar radiculopathy.

25. Dr. Hendricks determined that there were no specific job duties that Respondent was unable to perform because of any medical or physical condition. Dr. Hendricks concluded that in regard to the right knee, Respondent's grade two chondromalacia of the patella femoral joint and grade two to three chondromalacia of the medial compartment were age-related degenerative changes of the articular surface that did not necessitate work restrictions. He found that Respondent's right knee examination was essentially normal with no tenderness, and yielded a negative patella grind test, a negative patella apprehension test, a full range of motion, no joint line tenderness, and no ligamentous laxity. He also found no evidence of thigh or calf atrophy and he determined there was normal lower extremity muscle strength.

26. Dr. Hendricks also found the problems with Respondent's lower back to be age-related degenerative changes that did not, in and of themselves, necessitate work restriction. Dr. Hendricks stated the MRI report did not reveal clear-cut evidence of nerve root impingement or lumbar spinal stenosis, and also concluded there was no neuro-diagnostic testing evidence of lumbar radiculopathy. Dr. Hendricks concluded his lumbar examination of Respondent revealed no guarding of the motion of the lumbar spine, a full lumbar range of motion, a negative straight leg raise test, normal lower extremity muscle strength, and normal extremity sensation. Although Respondent reported sensory abnormalities of tingling, Dr. Hendricks determined it was in a non-dermatomal pattern.

27. Dr. Hendricks determined that Respondent had no work restrictions due to the condition of the lumbar spine and right knee, and, therefore, was not substantially incapacitated for the performance of her usual duties as a correctional officer. He also stated that Respondent had no permanent disability due to the condition of her lumbar spine or right knee.

28. Dr. Hendricks felt that Respondent exaggerated her complaints, because during his examination when he measured Respondent's cervical forward flexion, she demonstrated substantially less motion than when he observed Respondent engage in spontaneous cervical forward flexion. Additionally, he concluded that provocative testing of upper extremity peripheral nerves produced results that were inconsistent with peripheral nerve anatomy. Finally, Dr. Hendricks noted from his review of Respondent's medical records that Respondent complained of right lower extremity numbness prior to the

December 7, 2012 lumbar spine MRI, but complained of left lower extremity numbness subsequent to this testing.

29. Dr. Hendricks concluded that while the contusion of Respondent's right knee, right thigh, and right calf was caused by the specific industrial injury that occurred on May 11, 2010, Respondent's neck and back were not injured in the May 11, 2010 accident, and such symptoms likely would have been present absent her employment. Dr. Hendricks also stated at hearing that surgery on Respondent's knee was unnecessary, as the MRI results did not support the performance of such a procedure.

30. At hearing, Dr. Hendricks demonstrated great defensiveness of his findings concerning his examination of Respondent, and appeared very resistant to accept certain factors, no matter how unbiased. Specifically, Dr. Hendricks was resistant to accepting that Respondent's chondromalacia patella diagnosis could have stemmed from the injury Respondent suffered at work, despite the lack of evidence showing that Respondent had suffered a pre-existing knee condition or the lack of evidence showing that she had been suffering age-related degenerative changes of the articular surface at the time of the injury. Dr. Hendricks also seemed to disregard evidence that prior to the accident, Respondent had been performing all of her job duties without inhibition.

31. At hearing, Dr. Greenspan disagreed with Dr. Hendrick's conclusion that Respondent could perform all job duties and could return to work without any restrictions. Dr. Greenspan opined that Dr. Hendricks gave no credence to any of the objective findings concerning Respondent, and believed Dr. Hendricks had been unfair to Respondent. Specifically, Dr. Greenspan appeared to disregard the fact that while Respondent's diagnosis started off as a knee contusion, it had evolved into something else to the point of a MRI discovering the presence of chondromalacia, which was confirmed by the surgeon (Dr. Sobeck) during the surgery of Respondent's knee. Additionally, Dr. Hendricks seemed to disregard that Respondent had complained more than once about pain radiating down her leg, or that Respondent's knee had buckled repeatedly, which resulted in Respondent falling. Dr. Greenspan testified that such buckling was evidence of knee weakness, and opined Respondent would be subjected to future falls as a result. Additionally, at hearing, Dr. Greenspan reiterated Respondent would be incapable of performing many of her work duties, including heavy lifting, standing and walking more than six hours per day, especially on uneven ground, and agreed with Dr. Weiss' report that Respondent's chondromalacia caused significant symptomology rendering Respondent incapable of performing her work duties.

32. On August 26, 2013, CalPERS sent Respondent a letter denying her application for industrial disability retirement. CalPERS determined Respondent's orthopedic conditions of her right knee and back were not disabling. As a result, CalPERS concluded that Respondent was not substantially incapacitated from the performance of her job duties as a correctional officer. On September 6, 2013, Respondent filed an appeal of CalPERS' decision denying her application for industrial disability retirement.

Continued Treatment with Dr. Greenspan

33. Dr. Greenspan noted in his report that during her August 22, 2013 visit, Respondent complained of pain and discomfort in her right knee, neck, and lower back, and on October 3, 2013 and November 22, 2013, Respondent complained of pain and discomfort in her right knee, cervical spine, and lumbar spine. On January 9, 2014 and February 6, 2014, Respondent complained of constant neck pain with radiating pain to the left arm, and electrical sensations. She also complained of lower back and right knee pain, with radiating pain to the bilateral legs and feet, with numbness present.

34. On February 12, 2014, Respondent underwent a MRI of the cervical spine which revealed a straightening to a mild reversal of the normal cervical lordosis; mild-to-moderate degenerate disc disease at C4-C5 and C5-C6; at C5-C6, a four millimeter broad-based disc-osteophyte complex asymmetric to the right effacing the ventral cerebrospinal fluid and contributing to overall mild-to-moderate central canal stenosis, more pronounced on the right; and moderate left neural foraminal stenosis.

35. On February 12, 2014, Respondent underwent a MRI of the lumbar spine which revealed mild degenerative disc disease at the lower lumbar spine with mild interval progression; infiltration of the normal T1 bone marrow signal; at L4-L5, a small disc budge asymmetric to the left.

36. On March 13, 2014, Respondent underwent electromyography/nerve conduction studies (EMG/NCS), which showed evidence of S1 radiculopathy on the left and peripheral neuropathy of bilateral lower extremities affecting the sural sensory serve.

37. On March 20, 2014, Respondent returned to Dr. Greenspan's office with complaints of pain and discomfort in the cervical spine, lumbar spine, and right knee. Additionally, Respondent suffered radiating pain from the cervical spine to the fingertips and from the lumbar spine to the bilateral legs to the feet, with numbness.

Agreed Medical Re-Evaluation by Dr. Steven Weiss

38. On April 7, 2014, Dr. Weiss performed an agreed medical re-evaluation of Respondent in relation to Respondent's workers' compensation claim. Respondent advised Dr. Weiss of complaints of pain and discomfort in her neck, low back, and right knee. Dr. Weiss diagnosed Respondent with contusion to the right knee; chondromalacia patella and medial femoral condyle of the right knee; status post arthroscopic chondroplasty of the medial femoral condyle and patella, removal of loose bodies of the right knee; lumbar contusion and sprain/strain; multilevel lumbar spondylosis and degenerative disc disease, left S1 radiculopathy due to herniated nucleus pulposus, L5-S1; cervical sprain/strain; C4-C5 and C5-C6 degenerative disc disease; acquired central canal stenosis, C5-C6; and contusion to the pelvis. Dr. Weiss noted that Respondent's orthopedic condition had not reached maximum medical improvement. He recommended lumbar epidural injections, and if not effective, a referral to a spine surgeon. For the knee, he recommended three visco-

supplementation injections and then a MR arthrogram. If the MR arthrogram revealed surgical pathology and there was no improvement in her knee symptoms with the visco-supplementation injections, she might require repeat arthroscopic surgery of the right knee. Dr. Weiss recommended that there was no further treatment or further evaluation required for her cervical spine. He stated there was basis for non-industrial apportionment relative to the spine due to pre-existent, multilevel spondylosis and degenerative disc disease and that there was no basis for non-industrial apportionment relative to the right knee.

39. On April 22, 2014, Respondent underwent a MR arthrogram of the right knee which revealed a six millimeter focal full thickness cartilage defect weight-bearing medial femoral condyle, a small communicating popliteal cyst, and a high positioned patella with lateral overriding.

40. Dr. Greenspan's August 7, 2014 report noted visits up to June 5, 2014 with continued complaints of pain and discomfort in the cervical spine, right knee, and lumbar spine, with pain radiating from the neck into the left arm, and from the lower back into both feet and toes. Dr. Greenspan opined, based on the findings of his physical examinations and a review of diagnostic studies and specialty evaluations, that Respondent's orthopedic condition had reached a point of maximum medical improvement and considered Respondent's condition permanent and stationary. Dr. Greenspan concluded Respondent was not able to return to her prior occupation as a correctional officer, in that, in relation to her back injury, she had lost approximately half of her pre-injury capacity for lifting, bending, and stooping, and that, in relation to her knee injury, she was precluded from bending, stooping, squatting, kneeling, crawling, climbing, running, jumping, using ladders and stairs repetitively, and from walking or running unsafe heights and uneven terrain. It was Dr. Greenspan's impression that Respondent's physical condition had stabilized and was unlikely to change substantially with or without additional medical care or treatment. Dr. Greenspan still maintained those views at the time of hearing.

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Credibility Findings[6]

41. Dr. Greenspan was a very credible witness, as he testified in a clear, concise, and forthright way, buttressed by his wealth of knowledge and his years of experience as an orthopedic surgeon. Dr. Hendricks, though very experienced in the area of orthopedics, was not as credible as Dr. Greenspan. Dr. Hendricks demonstrated great defensiveness of his findings concerning his examination of Respondent, and appeared very resistant to accept certain factors, no matter how unbiased. Specifically, he appeared reluctant to accept that Respondent's chondromalacia patella diagnosis could have stemmed from the injury Respondent suffered at work, despite the lack of evidence showing that Respondent had been suffering from any pre-existing knee condition, and that such a condition served as a contributing factor to the debilitating nature of the injury described by Respondent. Moreover, Dr. Greenspan convincingly rebutted Dr. Hendrick's conclusion that Respondent could perform all job duties and could return to work without any restrictions. Specifically, Dr. Greenspan persuasively testified that Dr. Hendricks gave no credence to any of the

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[6] The manner and demeanor of a witness while testifying are the two most important factors a trier of fact considers when judging credibility. (See Evid. Code § 780.) The mannerisms, tone of voice, eye contact, facial expressions and body language are all considered, but are difficult to describe in such a way that the reader truly understands what causes the trier of fact to believe or disbelieve a witness.

Evidence Code section 780 relates to credibility of a witness and states, in pertinent part, that a court "may consider in determining the credibility of a witness any matter that has any tendency in reason to prove or disprove the truthfulness of his testimony at the hearing, including but not limited to any of the following: . . . (b) The character of his testimony; . . . (f) The existence or nonexistence of a bias, interest, or other motive; . . . (h) A statement made by him that is inconsistent with any part of his testimony at the hearing; (i) The existence or nonexistence of any fact testified to by him. . . ."

The trier of fact may "accept part of the testimony of a witness and reject another part even though the latter contradicts the part accepted." (*Stevens v. Parke Davis & Co.* (1973) 9 Cal.3d 51, 67.) The trier of fact may also "reject part of the testimony of a witness, though not directly contradicted, and combine the accepted portions with bits of testimony or inferences from the testimony of other witnesses thus weaving a cloth of truth out of selected material." (*Id.*, at 67-68, quoting from *Neverov v. Caldwell* (1958) 161 Cal.App.2d 762, 767.) Further, the fact finder may reject the testimony of a witness, even an expert, although not contradicted. (*Foreman & Clark Corp. v. Fallon* (1971) 3 Cal.3d 875, 890.) And the testimony of "one credible witness may constitute substantial evidence," including a single expert witness. (*Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040, 1052.) A fact finder may disbelieve any or all testimony of an impeached witness. (*Wallace v. Pacific Electric Ry. Co.* (1930) 105 Cal.App. 664, 671.)

objective findings concerning Respondent, in that Dr. Greenspan appeared to disregard the fact that while Respondent's diagnosis started off as a knee contusion, it had evolved into something else to the point of a MRI discovering the presence of chondromalacia, which was confirmed by the surgeon (Dr. Sobeck) during his surgery of Respondent's knee. Additionally, Dr. Hendricks seemed to disregard that Respondent had complained more than once about pain radiating down her leg, or that Respondent's knee had buckled repeatedly, which resulted in Respondent falling.

42. Moreover, Dr. Hendrick's opined that Respondent never required knee surgery, which he based on a review of medical records and a one-day examination. This opinion did not match Dr. Greenspan's, who had treated Respondent on a monthly basis for four years. Additionally, Dr. Hendrick's opinion appeared to disregard the fact that Dr. Sobeck had attempted to resolve Respondent's knee issues with less intrusive forms of treatment (i.e., physical therapy and oral medication) long before deciding to perform the surgery (i.e., approximately nine months).

43. Given these factors, Dr. Greenspan's testimony is deemed more credible than that of Dr. Hendrick, and, as such, afforded more weight than Dr. Hendrick's.

LEGAL CONCLUSIONS

1. Respondent has the burden of proof regarding her entitlement to the retirement benefits for which she has applied. (*McCoy v. Board of Retirement* (1986) 183 Cal.App.3d 1044, 1051.) As set forth in more detail below, Respondent has met this burden.

2. Government Code section 20016 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."

3. Government Code section 21152 provides, in pertinent part:

> "Application to the board for retirement of a member for disability may be made by:
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> "(a) The head of the office or department in which the member is or was last employed, if the member is a state member other than a university member. [¶] . . . [¶]

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"(c) The governing body, or an official designated by the governing body, of the contracting agency, if the member is an employee of a contracting agency.

"(d) The member or any person in his or her behalf."

4. Government Code section 21153 provides:

"Notwithstanding any other provision of law, an employer may not separate because of disability a member otherwise eligible to retire for disability but shall apply for disability retirement of any member believed to be disabled, unless the member waives the right to retire for disability and elects to withdraw contributions or to permit contributions to remain in the fund with rights to service retirement as provided in Section 20731."

5. Government Code section 21154 provides, in pertinent part:

"The application shall be made only (a) while the member is in state service . . . . On receipt of an application for disability retirement of a member, . . . the board shall, or of its own motion it may, order a medical examination of a member who is otherwise eligible to retire for disability to determine whether the member is incapacitated for the performance of duty. . . ."

6. "Incapacitated for the performance of duty," means the "substantial inability of the applicant to perform her usual duties," as opposed to mere discomfort or difficulty. (*Mansperger v. Public Employees' Retirement System* (1970) 6 Cal.App.3d 873, 877; *Hosford v. Board of Administration* (1978) 77 Cal.App.3d 854.) The increased risk of further injury is not sufficient to establish current incapacity; the disability must exist presently. Restrictions which are imposed only because of a risk of future or further injury are insufficient to support a finding of disability. (*Hosford, supra*, 77 Cal.App.3d 854, 862 - 863.)

7. Government Code section 21156, subdivision (a)(1), provides, in pertinent part:

"If the medical examination and other available information show to the satisfaction of the board, . . . that the member in the state service is incapacitated physically or mentally for the performance of his or her duties and is eligible to retire for disability, the board shall immediately retire him or her for disability . . . ."

8. Here, Respondent met her burden of demonstrating that CalPERS erred in denying her application for disability. Specifically, the totality of the evidence established

that Respondent's medical condition in her right knee and back rendered her substantially unable to perform her usual duties as a correctional officer for the California State Prison—Los Angeles County Department of Corrections and Rehabilitation. Dr. Greenspan opined Respondent could not perform her normal work duties, because Respondent's right knee rendered her incapable of squatting, stooping, kneeling, bending, running, lifting heavy weight, and standing and walking more than six hours a day, especially on uneven ground. Dr. Greenspan also credibly reported that Respondent's orthopedic condition reached a point of maximum medical improvement, contributing to his conclusion that Respondent's condition was permanent and stationary.

9. While Respondent was released to return to work twice by Dr. Sobeck, as well as initially by Dr. Greenspan in September 2011, with a number of physical restrictions, it is clear from the credible testimony of Dr. Greenspan that during the four years in which he treated Respondent, and given the evolution of the debilitating nature of Respondent's right knee and back that caused him to conclude that Respondent's orthopedic condition was permanent and stationary, it is reasonable to conclude that the restrictions initially proposed by Dr. Greenspan and Dr. Sobeck were more than for prophylactic reasons, but rather because Respondent was incapable of performing all of her job duties, particularly the physical ones.

10. In light of the above, it is clear that Respondent is incapacitated for the performance of duty or substantially unable to perform her usual duties. As such, Respondent's appeal shall be granted.

ORDER

Respondent's appeal is granted. Respondent's Disability Retirement Election Application seeking industrial disability retirement is approved.

Date: November 21, 2016

DocuSigned by:
Carla L. Garrett
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CARLA L. GARRETT
Administrative Law Judge
Office of Administrative Hearings