ATTACHMENT A

THE PROPOSED DECISION

BEFORE THE
CALIFORNIA PUBLIC EMPLOYEES' RETIREMENT SYSTEM
STATE OF CALIFORNIA

In the Matter of the Reinstatement from Industrial Disability Retirement of:	Case No. 2013-0092
CAREY E. KELLY,	OAH No. 2015080601
Respondent,	
and	
DEPARTMENT OF CALIFORNIA HIGHWAY PATROL,	
Respondent.	

PROPOSED DECISION

This matter was heard before Timothy J. Aspinwall, Administrative Law Judge, Office of Administrative Hearings, State of California, on November 17, 2016, in Sacramento, California.

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

Richard E. Elder, Jr., Attorney at Law, represented Carey E. Kelly (respondent) who was present at the hearing.

Judith A. Recchio, Supervising Deputy Attorney General, represented the Department of the California Highway Patrol (CHP).

Evidence was received, the record was closed, and the matter submitted for decision on November 17, 2016.

ISSUE

The issue for Board determination is whether CalPERS established that respondent is no longer substantially incapacitated from performing the usual duties of a CHP Officer?

FACTUAL FINDINGS

1. Respondent was born in 1968.[1] She was employed as a CHP Officer for approximately five years. She last worked in that position in 1998. On or about November 13, 1998, respondent applied for industrial disability retirement. Respondent's application was granted, and she retired for disability effective October 5, 1999, on the basis of orthopedic (neck, back, and left shoulder) conditions. Because respondent was under the minimum age for voluntary service retirement, pursuant to Government Code section 21192, in 2012 CalPERS sent respondent for an independent medical examination. After reviewing the reports of the independent medical examiner, CalPERS determined that respondent was no longer substantially incapacitated from performing the duties of a California Highway Patrol (CHP) Officer. Respondent appealed from CalPERS' determination.

Duties of a CHP Officer

2. The CHP lists a set of Critical Physical Activities required of a CHP Officer. They are, in relevant part, as follows:

> Lift/Carry
>
> (a) Lift and carry objects weighing 10 to 25 pounds (e.g., gear bag); 1 to 3 times per day.
>
> (b) Without assistance, lift and carry objects weighing 30 to 50 pounds (e.g., car tire, road debris); 1 to 3 times per month.
>
> (c) With assistance, lift and carry an individual resisting arrest (20-35 feet); 1 to 2 times per year.
>
> Push/Pull
>
> (a) Pull/drag a non-resistive/incapacitated person (160-200 pounds) 5-20 feet at an emergency situation or protest; 1 to 2 times per year.
>
> (b) Pull/drag an individual (160-200 pounds) resisting arrest 5-20 feet; 1 to 2 times per year.
>
> (c) Separate uncooperative persons (160-200 pounds) by pushing, pulling, using locks, grips, or holds, and physically

[1] The Accusation states that respondent was born on December 28, 1969. The medical records in evidence give respondent's date of birth as December 28, 1968.

restrain or subdue a resistive individual using reasonable force; 1 to 3 times per month.

(d) Handcuff a suspect; 1 to 3 times per month.

(e) Pull/drag heavy objects (e.g., logs) off the roadway (5-35 feet); 4 to 6 times per year.

Sit

(a) Sit in patrol car for an extended period of time during patrol or surveillance; 1 to 3 times per day.

Stand

(a) Stand and direct traffic; 1 to 3 times per month.

(b) Stand for extended periods at an accident/crime scene, during stakeout, surveillance, and crowd control, to provide security for various events, or to secure the perimeter; 1 to 3 times per month.

Squat/Bend/Kneel

(a) Stoop/squat/kneel to look for physical evidence under the seats or dash of a vehicle, in the trunk, and under the hood of a vehicle; to look under a vehicle for evidence, suspects, defects, or violations; or to look under furniture for physical evidence at an crime/accident scene; 1 to 3 times per week.

(b) Stoop/squat/bend to set a flare pattern or ignite flares, to set cones at accident/crime scene, to use a tape measure to measure skid marks, or take measurements at an accident/crime scene; 1 to 3 times per month.

(c) Frisk/pat down individuals for weapons; 1 to 3 times per month.

Walk

(a) Walk continuously while on foot patrol for special assignments and to conduct searches; 1 to 2 times per year.

(b) Walk around obstacles; over uneven ground; up hills/embankments, in loose dirt, gravel, mud, ice, or snow; 1 to 3 times per month.

(c) Walk to and from a violator's vehicle, to place flares or cones in traffic, or keep an eye on a suspect. Distance walked in a day is 1/4 to 1 mile; 1 to 3 times per day.

Run

(a) Run (5-100 yards) to get to an emergency or crime scene, to assist other officers, or to pursue a fleeing suspect; 1 to 2 times per year.

Climb

(a) Climb over a guardrail or median barrier (2-3 feet); 1 to 3 times per month.

(b) Climb over chain link or wooden fences (5-7 feet) and over walls (4-7 feet); 4 to 6 times per year.

(c) Climb steep embankments, hills, or gullies; 4 to 6 times per year.

Jump

(a) Jump across and/or over obstacles (e.g., guard rail) 2-4 feet, and down from elevated (4 feet) surfaces (e.g., fence); 4 to 6 times per year.

Manual Dexterity/Firearms

(a) Fire 50-100 rounds with a handgun at a target during practice, firearms qualification, or at a combat style shooting course; 4 to 6 times per year.

(b) Fire a shotgun and rifle during practice, firearms qualifications, or on the job; 4 to 6 times per year.

(c) Draw and hold a handgun, shotgun, or rifle on a felony suspect until back-up arrives, or to cover an area of responsibility for extended time periods; 4 to 6 times per year.

2012 Independent Medical Examination by Brendan V. McAdams, M.D.

3. In 2012, in accordance with Government Code section 21192, CalPERS began re-evaluating respondent for continued qualification for disability retirement. CalPERS sent respondent to Brendan V. McAdams, M.D., a board-certified orthopedic surgeon. Dr. McAdams testified at hearing. Dr. McAdams graduated from medical school in 1962. He completed a residency in orthopedics at the Integrated Orthopedic Residency Program in Milwaukee, Wisconsin. He has been licensed as a physician in California since 1969. He retired from an active patient practice in the early 1990s. He has been an independent medical examiner since 1980.

4. Dr. McAdams examined respondent on or about May 20, 2012, reviewed respondent's medical records, and issued an Independent Medical Examination report on May 21, 2012. Respondent was 43 years old at the time of the examination.

5. During the examination, respondent gave the following history. She stated she was involved in two separate automobile accidents while working as a CHP officer, one in 1997, and one in 1998. These accidents resulted in constant pain between her shoulder blades, and she also developed low back pain with pain radiating down her left leg. She stated she was retired in 1999 or 2000. She stated that she remained active raising two small children, and that she lies down when she has pain from too much activity. Dr. McAdams noted that during examination respondent did not display any sign of pain or discomfort. She ambulated in the examination room without any sign of discomfort. She appeared comfortable as she sat throughout the interview.

6. During his testimony, Dr. McAdams summarized his examination of respondent. On examination of the cervical spine, he found respondent to have good strength in her upper extremities, with no neurological deficits or muscle atrophy. On examination of respondent's lower back, he found good strength and flexibility. Respondent's lower extremities were evaluated in a sitting position, and reflexes were normal with no atrophy of the calves. Dr. McAdams found respondent to have good strength, flexibility, and no areas of discomfort even with palpation. He found no objective signs of disability. Dr. McAdams recorded his examination findings in his report, as follows:

> The claimant stood erect. There was no list. She was able to forward flex to a point where her fingertips easily touched the floor. She fully reversed her lumbar lordotic curve. She extends 10 degrees and lateral bends is 30 degrees in both directions and has a full 90 degrees of rotation in both directions. She is able to squat down and come back up without any hesitation. She walks on her heels and toes without any evidence of weakness.

> Sitting position, deep tendon reflexes, knee jerks and ankle jerks are equal and active. She has full extension of the knees without any evidence of lumbar lurch.
>
> Cervical spine, she maintains her head erect. She has full flexion, extension lateral bending and lateral rotation.
>
> There was full elevation of the upper extremities to 180 degrees and excellent strength of the arms at 90 degrees of abduction. She has excellent strength of the biceps triceps, dorsiflexion, volar flexion of the wrist and the interosseous muscle. Sensation is intact to pinwheel throughout both upper extremities. The forearm maximum girth was measured bilaterally. They both measured 23 cm. She has negative Tinel's signed bilaterally and she has no evidence of any atrophy of the thenar musculature.
>
> [In supine position, lying on her back] Straight leg raising was 90/90 degrees. Negative Lasegue's signed bilaterally. She has negative Faber's signed bilaterally. She has excellent strength of the dorsiflexors of the feet .... She has excellent strength of the peroneal muscles as well. On measuring the calve's maximum girth they both measure 36 cm.
>
> [In prone position, lying on her front] She has no particular point of tenderness in the entire axial spine. No pain with compression of the iliac crest or trochanter's. No pain in the sciatic notches. Negative knee flexion provocative testing.

7. Dr. McAdams also reviewed medical records that were supplied to him, which date back to 1997, when respondent was involved in an automobile accident. Dr. McAdams recorded his review of the medical records in his report, as follows:

> She had multiple complaints of both upper back neck and shoulder as well as low back and the patient was treated by several physicians including Dr. Albert an orthopedist, who ultimately treated her in 1998. I do not have records that pertain particularly to the immediate treatment after the accident however, Dr. Albert did order an MRI that was performed on 06/23/2009 and he stated that the lady does have findings in the low back of herniation. She also had an MRI of the cervical spine and this was read as having broad-based disc bulges at C4-C-5, C5-C6 and C6-C7. Dr. Albert on 09/15/1998 allowed the member to return to work with restrictions however he felt that she was unable to do the usual and customary work because of

> excessive demands even on a one-time basis that is in the job description. The job description does document multiple activities requiring lifting, pulling heavy weights up to 200 pounds, running up steep inclines, subduing individuals as well as clearing roads of debris and heavy materials. Dr. Albert felt that she would be unable to do that.
>
> There are records of an MRI of the left shoulder on 04/28/1999 and this was described as having a prior partial separation of the anterior glenoid labrum as well as some generalized tendonitis. On the same date there was an MRI of the lumbar spine ordered by Dr. Matos that was read as a normal lumbosacral spine.

8. Dr. McAdams opined that there were "[n]o objective findings of any orthopedic restriction or limitation." With respect to the question of whether there are specific job duties that respondent is unable to perform because of a physical condition, Dr. McAdams opined that respondent can perform each of the critical physical activities required of a CHP Officer, though she would have some difficulty with the first two items (Lift/Carry and Push/Pull). Dr. McAdams found that respondent is not substantially incapacitated for the performance of the duties of a CHP Officer. Dr. McAdams further opined that:

> Regarding the physical condition based on the examination today, I can find no reason physically that this claimant cannot perform the usual and required activities of a California Highway Patrol Officer, however, she does have subjective complaints on a frequent basis based on historically describing back and shoulder pain. This I cannot determine at this time, that she is absolutely asymptomatic at this time. Objectively, there were no orthopedic findings during today's evaluation.

9. On October 31, 2012, Dr. McAdams issued a Clarification Report responding to CalPERS's request for clarification as to whether he reviewed the position description and the physical requirements of a CHP Officer, which were not specifically noted in his original report dated May 21, 2012. Dr. McAdams confirmed that he had reviewed the position description and physical requirements of a CHP Officer, and that his opinion remained unchanged from his original opinion stated in his report dated May 21, 2012.

10. On October 4, 2016, Dr. McAdams submitted a follow-up report to CalPERS addressing a 20-page report authored by Dr. Snook, dated June 21, 2016. Dr. McAdams' follow-up report did not address Dr. Snook's 20-page amended report dated July 14, 2016. Dr. McAdams reviewed Dr. Snook's June 21, 2016 report, his own report dated May 21, 2012, and the physical requirements of a CHP Officer. Dr. McAdams opined as follows:

> After reviewing this report as well as my own report, I must again conclude that this lady, in my opinion, at the time that I saw her had reached her pre-injury status. She had no evidence at all of any restriction, weakness, reflex changes, or sensory changes in her axial spine or extremities.

11. Dr. McAdams opined that the MRI of respondent's shoulder does not show any condition that would likely cause substantial physical impairment. The MRIs of respondent's lumbar spine and neck show some disc abnormality. Dr. McAdams opined that the abnormalities seen in the MRIs do not necessarily indicate a physical limitation. There would need to be positive clinical findings accompanying the diagnostic findings for Dr. McAdams to conclude that respondent suffers from any incapacity related to the conditions observed in the MRIs. Dr. McAdams opinion as articulated in his original report is not changed by his review of the more recent MRIs. Dr. McAdams opinion remains that respondent is not substantially incapacitated from performing the duties of a CHP Officer.

Medical Examination by Respondent's Expert Witness, Lee T. Snook, Jr., M.D.

12. Respondent called Dr. Snook as her expert witness. Dr. Snook graduated from medical school in 1980. He completed separate residencies in internal medicine and anesthesiology at the University of Wisconsin Hospital and Clinics, in Madison, Wisconsin. He is board-certified in anesthesiology, internal medicine, and pain medicine. He is the President and Medical Director of Metropolitan Pain Management Consultants, Inc. His current medical practice is comprised of 90-95 percent direct patient care and 5-10 percent workers' compensation evaluations as a Qualified Medical Examiner. He has evaluated a significant number of CHP officers and other law enforcement officers.

13. On or about July 14, 2016, Dr. Snook examined respondent and prepared a Medical Legal Consultative Report in connection with the status of respondent's continued disability. Dr. Snook first had respondent complete a 15-18 page pain questionnaire. He then interviewed respondent and performed a physical examination. Finally, he reviewed approximately 234 pages of medical records, including the digital images of MRIs. Dr. Snook's practice is to look at the actual MRI images, rather than relying solely on the reports prepared by the radiologist's, or another physician's note regarding the radiologist's report.

14. Respondent informed Dr. Snook during the examination that her pain had been "9/10" on average during the last month, with 10 being the worst pain she had ever experienced and zero being no pain. She reported her level of pain during the examination as "6/10". Using a diagram, she reported pain at the base of her neck, upper thoracic spine, interscapular area, left shoulder, lumbosacral spine, bilateral buttocks and right posterior thigh. Dr. Snook testified that pain is dynamic, and patient's level of pain can vary substantially. He also stated that he would not be surprised if respondent had less pain when she was examined by Dr. McAdams in 2012. Dr. Snook conducted a physical examination, and reported his findings, as follows:

Musculoskeletal: The patient has tenderness to the cervical spine with mild pain with motion. Range of motion is flexion to 30°, extension to 30°, left lateral flexion to 30°, right lateral flexion to 30°, left rotation 45°, right rotation 45°.

Axial compression and distraction are negative.

There is paraspinous muscle tension in the cervical and upper thoracic spine.

Thoracic spine reveals paraspinous muscle tenderness.

Range of motion of the left shoulder: Flexion is 160°, extension is 20°, abduction is 160°, adduction is 20°, and external rotation is 60°, internal rotation is 40°.

There is tenderness over the Acromioclavicular joint and bicipital groove.

Range of motion of the right shoulder is normal.

Examination of the lumbosacral spine reveals paraspinous muscle tenderness.

Range of motion of the lumbar spine: Flexion is 55°, extension is 20°, left lateral flexion is 25°, right lateral flexion is 25°, left rotation 60°, right rotation 60°.

[¶]...[¶]

Neurologic:

[¶]...[¶]

Sensory and gross motor examination are normal.

The balance and gait are normal.

Coordination, fine motor skills are normal.

Deep tendon reflexes are normal.

The patient does have a light touch sensory distribution of radiculitis down to the left calf and anterior shin, not down to the foot, consistent with a L3-L4 radiculitis pattern.

15. Dr. Snook found what he considers to be objective evidence of disability in his physical examination of respondent's back, the MRI imaging reports, and his own review of the MRI images. An MRI image of the lumbar spine taken on November 6, 2015, shows disc degeneration at three levels, from L3-L4 to the L5-S-1 levels. The MRI report states that at the L3-L4 level there is a "minimal diffuse disc bulge ... with a 3 mm right foraminal protrusion ... mild bilateral facet arthropathy ... [and] mild right foraminal narrowing." At the L4-L5 level there is "moderate to severe loss of disc height ... with a mild, diffuse disc osteophyte complex and ventral thecal sac deformity. There is a 3 mm right paracentral disc protrusion, which contacts the traversing right L5 nerve root." At the L5-S1 level, "minimal, posterior disc osteophyte complex is seen, slightly asymmetric in the left paracentral region. The disc osteophyte complex contacts both traversing S1 nerve roots."

16. Dr. Snook opined that respondent had a restricted range of motion in her shoulders, and that an MRI imaging report dated May 17, 2016, showed some abnormality in the respondent's left shoulder. Dr. Snook testified that he cannot say whether this is clinically significant, and would refer her to an orthopedist for a determination whether work restrictions are recommended.

17. Dr. Snook also examined respondent's neck and reviewed an MRI imaging report dated May 17, 2016, and also viewed the MRI images. Dr. Snook saw objective evidence of degenerative disc disease in the C5-6 and C6-7 levels. At both levels the MRI imaging report states "there is broad-based posterior disco osteophytic ridging with bilateral unconvertebral joint hypertrophy ...." At the C5-6 level there is "mild to moderate bilateral neural foraminal stenosis." At the C6-7 level there is "moderate central canal and moderate bilateral neural foraminal stenosis."

18. Based on his examination of respondent, and his review of the medical records including MRI images, Dr. Snook reported his impressions, as follows:

1. Cervical disc degeneration, M50.30.

2. Spinal stenosis, cervical region, M48.02.

3. Cervicalgia, M54.2.

4. Spondylosis without myelopathy or radiculopathy, lumbosacral region, M47.817.

5. Intervertebral disc displacement, lumbar region, M51.26.

6. Low back pain, M54.5.

7. Radiculopathy, lumbosacral region, M54.17.

8. Radiculitis of regions of the neck, back, sacral coccygeal region, M54.08.

9. Other shoulder lesions, left shoulder, M75.82.

10. Pain in left arm, M79.602.

11. Chronic pain due to trauma, G89.21.

12. Injury, muscle tendon of the rotator cuff of the left shoulder, S46.092A.

13. Impingement syndrome of the left shoulder, M75.42.

14. Dysthymia, F34.1.

19. Dr. Snook opined that respondent is unable to return to work in the capacity of a CHP Officer. Specifically he stated that:

> Based upon the medical record provided to me, report from the patient, physical examination and review of the medical records including imaging studies, the injured worker, Carey Kelly, has work-related cervical, lumbar and left shoulder pathology which most certainly precludes her from returning to the duties as a California Highway Patrol Officer. The specific activities were described in the body of the record above. It is clear the injured worker would be unable to engage in these rather vigorous activities, which require physical effort that she is unable to provide in the capacity of a California Highway Patrol Person. The general requirements are that the peace officer be at 100% capacity when engaged in potential dangerous confrontational activities, which are the requisite duties of the California Highway Patrolman.

20. Dr. Snook testified that a peace officer must be able to perform at 100 percent to return from disability. When Dr. Snook was asked on cross-examination where he obtained the standard that a peace officer must be 100 percent, Dr. Snook replied that he obtained the standard from injured peace officers he has been seeing.

21. Regarding the Lift/Carry category of the Critical Physical Activities, Dr. Snook testified that respondent probably could perform items (a) and (b) (lift and carry objects weighing up to 50 pounds without assistance). As to item (c) (with assistance, lift and carry an individual resisting arrest), Dr. Snook testified "[a]s we have established she is already injured, there is a fair degree of certainty that this would result in a significant enhancement of her pain and potentially a serious further injury."

22. Regarding the Push/Pull category of the Critical Physical Activities, Dr. Snook testified that respondent could pull/drag a non-resistive/incapacitated person, but she would likely incur injury at some point. As to separating uncooperative persons weighing 160-200 pounds by "pushing, pulling, using locks, grips or holds, [to] physically restrain or subdue a resistive individual" Dr. Snook testified as follows:

> She has pathology in her shoulder both on MRI and on physical examination that existed at the time I saw her. To engage in combat, which is with two unruly people, would require full requisite strength of her upper extremities that she currently doesn't have. That would preclude her from doing it. It's dangerous because she is entering into a combat situation and she is not 100 percent.
>
> [¶]...[¶]
>
> I think it's predictable that she will suffer an injury that would take her off the work force immediately by engaging in activity like this.

Respondent's Testimony

23. Respondent was employed with the CHP for approximately five years. She has not been employed since she last worked for the CHP in late 1998. Her back pain is variable, and becomes severe approximately twice per year. When she was examined by Dr. McAdams in 2012, she was having a good day. When she was examined by Dr. Snook she was experiencing moderate pain at a level of 6/10. In the month prior to her examination by Dr. Snook, she had a very bad episode where her pain level was 9/10.

24. Respondent believes she is disabled from performing most of the Critical Physical Activities required of a CHP Officer. With respect to the Push/Pull job tasks, she contends that she would not have the strength in her back, shoulder, and neck to perform these tasks, and it would hurt her back if she attempted to do so. The requirement that she be able to sit for up to two hours would also cause pain, as her utility belt pushes into her back when she sits in a patrol car. The requirement that she be able to stand for up to 45 minutes would also cause severe back pain, as respondent often needs to sit or lie down after standing for 10 to 15 minutes. Respondent testified that she would not be able to perform the Squat/Bend/Kneel job tasks. The tasks involving walking on uneven terrain would also cause pain in respondent's back. Respondent is also unable to sprint, climb, or jump as the representative job tasks require. With respect to the Manual Dexterity/Firearms job tasks, respondent cannot fire a shotgun because of the recoil, and could not hold a handgun steady in her left hand.

Discussion

25. Because respondent is already receiving disability retirement, the burden is on CalPERS to establish that respondent is no longer substantially and permanently disabled from performing the usual duties of a CHP Officer. CalPERS presented sufficient evidence through its expert, Dr. McAdams, to meet its burden of proof. Dr. McAdams applied the correct standard in reaching his opinion. Specifically, he found that respondent is no longer substantially incapacitated from performing the duties of a CHP Officer. Dr. McAdams opined that respondent could perform each of the Critical Physical Activities of a CHP Officer, though some of the tasks may be difficult. Dr. McAdams' written report and testimony were well reasoned and persuasive.

26. Respondent's expert, Dr. Snook, did not apply the correct standard in reaching his opinion that respondent remains disabled. Specifically, Dr. Snook's opinion is based on the premise that a peace officer must be able to function at 100 percent capacity, not 98 and not 99 percent. In Dr. Snook's own words, this is a very low threshold for determining disability. Given that Dr. Snook applied an incorrect standard for determining disability, his conclusion that respondent would not be able to perform certain of the Critical Physical Activities of a CHP Officer is unpersuasive.

27. Dr. Snook opined that respondent would suffer injury because of her existing pathologies if she attempted to perform some of the more difficult tasks, such as subduing resistive subjects. Dr. McAdams opined that respondent could perform such tasks, but with difficulty. Dr. McAdams' opinion was well reasoned, and is persuasive, especially given his expertise in orthopedics.

28. When all the evidence is considered, CalPERS submitted sufficient evidence to meet its burden. Respondent did not effectively rebut CalPERS's evidence. As a result, CalPERS's request that respondent be involuntarily reinstated from industrial disability retirement is granted.

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.

5. To involuntarily reinstate respondent from industrial disability retirement, CalPERS had to establish that respondent is no longer substantially incapacitated from performing the usual duties of a CHP Officer. Taking into account the evidence as a whole, CalPERS introduced sufficient evidence at the hearing to meet its burden of proof. Respondent did not offer sufficient evidence to rebut the evidence introduced by CalPERS. Consequently, CalPERS' request that respondent be involuntarily reinstated from disability retirement must be granted at this time.

ORDER

Respondent's appeal is DENIED. The request of California Public Employees' Retirement System to involuntarily reinstate respondent Carey E. Kelly from disability retirement is GRANTED.[2]

DATED: December 19, 2016

DocuSigned by:

26BAECCBE5EF478

TIMOTHY J. ASPINWALL
Administrative Law Judge
Office of Administrative Hearings

[2] The parties at hearing agreed based on a settlement between respondent and the CHP that if respondent's appeal is denied and CalPERS's request to involuntarily reinstate respondent from disability retirement is granted, the Order should not include that respondent be reinstated to her former usual job duties with the CHP.