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: ANTHONY D. BURTON, Respondent, and CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION, AVENAL STATE PRISON, KINGS COUNTY, Respondent.	Case No. 2014-0907 OAH No. 2016080698

PROPOSED DECISION

This matter was heard before John E. DeCure, Administrative Law Judge (ALJ), Office of Administrative Hearings, State of California, on March 7, and April 26, 2017, in Fresno, California.

Kevin Kreutz, Senior Staff Counsel, represented the California Public Employees' Retirement System (CalPERS and Complainant).

Anthony D. Burton (respondent), appeared and was represented by Michael T. Bannon, Attorney at Law.

There was no appearance by or on behalf of the Department of Corrections and Rehabilitation (CDCR or Department), Avenal State Prison, Kings County (Correctional Facility). CalPERS established that CDCR was properly served with the Notice of Hearing. Consequently, this matter proceeded as a default hearing against CDCR under Government Code section 11520.

Evidence was received and the record closed on April 26, 2017.

ISSUE

Is respondent permanently disabled or substantially incapacitated from performance of his duties as a Correctional Officer (CO) at a Correctional Facility, on the basis of an internal (gastroesophageal reflux disease (GERD),[1] irritable bowel syndrome (IBS)[2], and colitis[3]) condition?

FACTUAL FINDINGS

Respondent's Employment History

1. Respondent is currently 45 years of age. He began working for CDCR in 2003. His last position with CDCR was as a CO in 2009. He described his work history as mostly unpleasant, beginning with his sustaining a burst appendix when he was going through the CDCR's training academy. On the job, respondent experienced work-related stress which, in January 2011, induced stomach pains and anxiety. These symptoms led to a diagnosis of irritable bowel syndrome (IBS) and gastroesophageal reflux disease (GERD). Respondent filed his Application for Industrial Disability Retirement Benefits (Application) on January 6, 2011. CalPERS approved his application on May 17, 2011. He worked until the end of 2010, until he was medically retired on the basis of industrial disability effective December 28, 2010.

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[1] GERD is the return of the stomach's contents back up into the esophagus. In normal digestion, the lower esophageal sphincter (LES) opens to allow food to pass into the stomach and closes to prevent food and acidic stomach juices from flowing back into the esophagus. Gastroesophageal reflux occurs when the LES is weak or relaxes inappropriately, allowing the stomach's contents to flow up into the esophagus. (Mayo Clinic, Diseases and Conditions, at http://www.mayoclinic.org/diseases-conditions/gerd/basics/definition/con-20025201 [as of May 11, 2017].)

[2] IBS is a disorder of the large intestine (colon) and commonly causes cramping, abdominal pain, bloating, gas, diarrhea and constipation. IBS is a chronic condition that requires long-term treatment and management. (Mayo Clinic, Diseases and Conditions, at http://www.mayoclinic.org/diseases-conditions/irritable-bowel-syndrome/basics/definition/con-20024578 [as of May 11, 2017].)

[3] Ulcerative colitis is an incurable disease that causes inflammation and sores (ulcers) in the lining of the large intestine (colon). It usually affects the lower section (sigmoid colon) and the rectum, but it can affect the entire colon. In general, the more of the colon that is affected, the worse the symptoms will be. Common symptoms are abdominal pain and cramps, diarrhea, and rectal bleeding. Some patients experience fever, loss of appetite, weight loss, and recurrent episodes of diarrhea up to 20 times per day. (Mayo Clinic, Diseases and Conditions, at http://www.mayoclinic.org/diseases-conditions/ulcerative-colitis/basics/definition/con-20043763 [as of May 11, 2017].)

Duties of a Correctional Officer

2. As set forth in the CDCR CO Job Analysis, the CO at the Correctional Facility is a sworn Public Safety Officer, must be qualified in the use of firearms and other areas relating to a sworn position, and must provide security to inmates in accordance with prison policies, regulations, and procedures, observing inmates' conduct and behavior to prevent disturbances and escapes. The CO directs inmates during work assignments, and patrols assigned areas for evidence of forbidden activities, rules infractions, and unsatisfactory prisoner attitudes or adjustment. The CO employs weapons or force to maintain discipline when necessary, provides security to prison entrances, screens visitors, and supervises visiting locations. The CO may escort inmates to and from visiting rooms, medical offices, and religious services, and may transport inmates between the correctional institution and outside medical care, courtrooms, and so on. The CO inspects locks, windows, bars, grills, doors and gates for tampering, and conducts routine searches of inmates and their inmate cells for contraband. The CO creates written reports regarding inmate disturbances, injuries, or other activities requiring reportage pursuant to CDCR policy.

3. The CO may be assigned to different correctional institutions ranging from minimum to maximum security, and must be able to work in both, including male and female facilities. Various work assignments are described in the Job Analysis as follows:

> There are many different posts which [CO's] may be assigned to work in a correctional institution, such as guard tower, control room/booth, dining room, housing unit/dorm, kitchen, bakery, hospital, gymnasium, classroom, visiting room, entrance gate, plaza area, library, community service crew, administrative segregation, transportation, outside patrol, range/arsenal, truck sally port, receiving and release, etc. [The CO] must be able to perform the duties of all the various posts.

4. According to the CO Job Analysis and a CalPERS "Physical Requirements Information" form completed by respondent's employer, the physical requirements of the CO position[4] are each set forth in terms of frequency, which is categorized as "never," "occasionally" (up to three hours), "frequently" (three to six hours), and "constantly" (over six hours).

5. The CO primary physical activities and their corresponding frequencies were reported as follows: sitting, standing, and walking (occasionally/frequently/constantly); running ((up to 400 yards, all-out effort) occasionally); crawling, kneeling, and squatting (occasionally); climbing ((up to 150 steps) occasionally/frequently); bending and twisting neck (frequently/constantly); bending waist (occasionally/frequently); twisting waist

[4] Physical requirements of the job outline the frequency with which an incumbent is required to lift, carry, push, pull, move, or tolerate exposure to noise, light, or other bio-hazards.

(frequently/constantly); reaching above or below shoulder (occasionally); pushing and pulling (occasionally/frequently); fine manipulation (frequently/constantly); power grasping, simple grasping, and repetitive use of hands (frequently/ constantly); keyboard and mouse use (occasionally); lifting and carrying 0-10 pounds (constantly), 11-25 pounds (constantly), 26-50 pounds (frequently), 51-75 pounds (occasionally), 76-100 pounds (occasionally), or 100-plus pounds (occasionally); walking on uneven ground ((up to 1-5 miles) occasionally/frequently/constantly); and driving ((up to 8 hours) occasionally/frequently/constantly).

6. Various other CO activities were reported as follows: working with heavy equipment (never); exposure to excessive noise (occasionally); exposure to extreme temperature, humidity, wetness (occasionally/frequently/constantly); exposure to dust, gas, fumes, or chemicals (occasionally/frequently); working at heights (occasionally/frequently); operation of foot controls or repetitive movement (occasionally); use of special visual or auditory protective equipment (occasionally); and working with bio-hazards (occasionally).

Respondent's Medical Evaluation and Application

7. On January 6, 2011, respondent filed his Application with CalPERS. In his Application, respondent reported an injury date of January 5, 2009. He identified "ulcerative colitis, IBS, [and] acid reflux" as his specific disability. This injury did not occur on a specific date but was "cumulative." Respondent was treated by William Holvik, M.D., and John Booker, M.D., both in Visalia. He filed a worker's compensation claim (no. 05420380). Respondent attached a supplemental statement to his Application, which states:

> What are your limitations/preclusions due to your injury or illness?
>
> If at home, I am unable to leave the house because I need to be within a few feet of a bathroom during an "episode[.]" I am unable to perform common duties at home during an "episode," because I will spend long periods of time in pain, and in the bathroom[.] At times the pain can be so bad that standing [and] sitting are not an option[.] Beyond the pain and discomfort caused by Acid Reflux, it causes me to sit up to relieve the pain while in bed and I am unable to sleep[.]
>
> How has your injury or illness affected your ability to perform your job?
>
> I could spend anywhere between 30 minutes and an hour in the bathroom, multiple times during an 8 hour shift[.] This causes my partners to be left alone and the inmates to go un-supervised[.] There are many posts at work that I am unable to perform because [of] a lack of a close proximity bathroom, and

the fast pace of the position[.] Many times during an "episode" I am unable to get any rest between shifts, which causes me to be less than alert if I am even able to make [it] into work. "Episodes" can last 4-5 days at a time, which forces me to call in sick and not make [it] into work for many days at a time.

If there is a Code Alarm (emergency) at work, all employees of the State are considered responders, and depending on the post I am working, I may be a Code 1-4 responder[.] If I am suffering an "episode," and am in the bathroom, I am unable to respond[.] These emergencies can be anything from a medical emergency for an inmate to full scale riots[.] Even if I am not in the bathroom, but just suffering pain from an "episode" running [and] walking to an alarm becomes impossible.

Some positions require me to drive in a vehicle[.] This is impossible now because of the frequency, and unpredictability of my need to rush without notice to a bathroom[.]

Some of the medications that I take affect my ability to stay hydrated[.] At my place of employment, during the spring and summer months, I am frequently exposed to temperatures above 100 degrees outside, and over 90 degrees inside[.] Staying hydrated is already a difficult thing to do without the need for my medication[.]

The acid reflux just adds to the instability to obtain a sufficient amount of rest between shifts, whether 8 hour shifts or 16 hour shifts[.]

<u>Other Information you would like to provide.</u>

Because of the stress [and] anxiety that accompanies the career of a Correctional Officer, I am in a constant state of an "episode" while at work, because stress [and] anxiety aggr[a]vate my conditions[.] Simply driving to work to pick up a paycheck has and does cause a flare-up and an episode will begin. It has reached the point that even being on the property causes me to suffer through an "episode." Staying away from work reduces the "episodes," but whenever I return to work the "episodes" begin immediately. The Return to Work Coordinator sent a letter to my Doctor requesting he describe my limitations in relation to the "Essential Duties" of a Correctional Officer. I have attached a copy of his response.

8. On May 17, 2011, CalPERS wrote a letter to respondent, informing him that his Application had been approved.

2014 Reexamination

9. By letter dated February 14, 2014, respondent was notified that his case was being reexamined by CalPERS. He was instructed to provide a signed Authorization to Disclose Protected Health Information (form BSD-35), names and addresses of all physicians treating him within the last year for the disabling conditions, and the name of his current employer. He was also informed that a second Independent Medical Examination (IME) might be arranged.

10. Respondent attended an IME with Samuel Rush, M.D., on May 30, 2014. Dr. Rush has been licensed in California since 1969 and specializes in internal medicine. He practices in Fresno. Dr. Rush prepared an IME report dated May 30, 2014, which was submitted into evidence. He reviewed the CDCR CO job analysis and available medical records. Dr. Rush obtained a medical history from respondent and administered a physical examination. He testified about his findings and IME report.

11. Respondent reported to Dr. Rush a history of irritable bowel syndrome with alternating constipation and cramping diarrhea, which worsened with stress. Respondent's condition worsened after he began training as a CO. He reported having occasional symptoms before 2003 with occasional bright red stool and a colonoscopy that revealed some polyps and inflammation. Dr. Rush's review of the records revealed no definitive diagnosis, and he did not see a pathology report that showed evidence of ulcerative colitis. Respondent has suffered from GERD since 2007, and it has improved with decreased stress. Respondent believed all his intestinal and stomach problems are stress-related, and he was diagnosed with anxiety disorder[5] in 2007. Respondent reported his anxiety disorder has improved from his not working as a prison CO. He takes Xanax on occasion for anxiety. He takes Bentyl (dicyclomine) to reduce cramping and Dexilant to relieve acid reflux symptoms. An endoscopy was performed in relation to respondent's GERD, but Dr. Rush did not locate a related pathology report in his review of medical records. Respondent has not reported vomiting, anemia, or weight loss.

12. Respondent's physical examination was unremarkable. His mental status was normal, although he admitted to being "a little bit anxious."

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[5] Anxiety disorders are a group of related conditions, and each with unique symptoms. However, all anxiety disorders have one thing in common: persistent, excessive fear or worry in situations that are not threatening. (National Alliance on Mental Illness, Anxiety Disorders, at https://www.nami.org/Learn-More/Mental-Health-Conditions/Anxiety-Disorders [as of May 11, 2017].)

13. In the IME report, Dr. Rush's primary impressions and opinions came from his review of the medical records, which in his opinion, failed to provide a comprehensive impression of respondent's condition:

> I feel the records received were lacking in certain important areas. More specifically detailed reports of colonoscopies and upper gastroesophageal endoscopies. These reports would be helpful enough and I would be glad to review them at a future time and would generate a supplemental report. I hope this information is helpful to you.

14. Dr. Rush reviewed several notable medical records, which he summarized in his IME report in non-chronological order as he received them, as follows.

a. A report of disability, dated January 13, 2011, showed respondent had a work-related job-stress-induced incident of IBS and GERD. The treating physician, Dr. Booker, noted stomach pains, anxiety, and left lower quadrant tenderness, and his impressions were: IBS and anxiety disorder.

b. On February 19, 2014, respondent was seen at the Holvik Family Health Center for anxiety and gastric issues. The impressions were: anxiety state, neurotic depression, and irritable colon. Laboratory reports from July 2013 resulted in findings of normal sedimentation rate, normal uric acid, rheumatoid factor not elevated, normal white blood cell count, no anemia, glucose level 106 (borderline high), no diabetes, testosterone normal, PSA not elevated, and urinalysis clear.

c. A May 10, 2013 progress note from Exam Health Center stated respondent, who had a soft abdomen on examination, was taking Bentyl for stomach issues and IBS with good results.

d. William Holvik, M.D., signed a November 1, 2012 progress note stating respondent needed to take his blood-pressure medication. Dr. Holvik's assessment was anxiety and depression, and he advised respondent to continue with a therapist. A stool culture was taken in April 2012 with results pending, although no such results are mentioned later in the IME.

e. Dr. Holvik made a progress note on March 29, 2012, after respondent was seen for stomach gas pain. Respondent reported that a worker's compensation physician found he had ulcerative colitis. Blood was noticed in the stool and rectal bleeding was noted. Respondent was taking Xanax and Lexapro for anxiety. The diagnosis was non-specific colitis, stress related. Dr. Holvik referred respondent to a gastrointestinal physician.

f. An undated chemical panel Dr. Rush reviewed was normal, and a urinalysis was clear.

g. Dr. Holvik wrote a progress note in December 2010 diagnosing GERD, IBS, ulcerative colitis, hypertension, and anxiety disorder.

h. Robert F. Meth, M.D. in a December 2010 worker's compensation evaluation, reported that in February 2010, respondent noticed that about every 10 days he would experience cramping and constipation, followed by 12-hour episodes of diarrhea. Respondent could function normally except for the days he experienced diarrhea. Dr. Meth's impression was: complaint of perceived anxiety and depression; ulcerative colitis; and GERD. Respondent's ulcerative colitis was considered 85 percent industrially related secondary to work-related stress, and 15 percent pre-existing. Respondent's GERD was considered 100 percent industrially related. Dr. Meth believed respondent was not capable of performing his work as a CO due to his ulcerative colitis.

i. Dr. Rush noted a March 2010 medical evaluation performed by a psychiatrist named Dr. Marusa, and respondent was mentioned to have had an upper endoscopy which showed severe reflux symptoms and absence of Barrett's epithelium and dysplasia without obvious stricture.

j. Dr. Rush commented on a report of inflammation, and a surgical pathology report from a colonoscopy in which respondent had an edema of the rectal sigmoid colon that was benign. Respondent had anxiety, although what state was not specified. He was diagnosed with ulcerative colitis, but there was no corresponding pathology report for review.

k. A Minnesota Multiphasic Personality Inventory (MMPI) was administered to respondent, resulting in findings of intensified pain fear conditioning.

l. Another examination by Dr. Meth in February 2010 was unremarkable.

m. An October 2006 surgical pathology report revealed a descending colon showing chronic inflammation, but it did not suggest a specific inflammatory disease, and it did not make mention of ulcerative colitis.

15. In conclusion, Dr. Rush's impressions were that respondent presented with: 1) chronic anxiety disorder; 2) IBS; 3) GERD; and 4) hypertension, stable on medications. Regarding his impression of ulcerative colitis, Dr. Rush wrote:

> There is a questionable history of ulcerative colitis. After a thorough review of his medical records I did not see a pathology report documenting ulcerative colitis. There were reports of reports, which are ambiguous. Some showed inflammation, but nothing definitive of ulcerative colitis. There are no pathology reports of the endoscopy of his upper GI tract. There are reports of reports showing possible dilatation. To summarize a

diagnosis for ulcerative colitis is not clear cut in my opinion according to the records I have received and reviewed. His weight has been stable. There is no history of anemia. The bleeding he has had is compatible with hemorrhoid bleeding. There is no arthritis, which sometimes is accompanied by ulcerative colitis.

16. At hearing, Dr. Rush stated that in his review he was seeking objective, scientific evidence, such as test results, which would confirm respondent was suffering from ulcerative colitis. He sought biopsy reports, but could locate none. Crohn's disease, ischemic bile disease, and cancer were on his list of related conditions to rule out, but he found no evidence of these. His physical findings from his examination of respondent were normal. Dr. Rush believed respondent's history of stress and anxiety on the job as CO, which was not in dispute, could not make respondent substantially incapacitated because stress and anxiety are treatable. For these reasons, he determined that respondent was not presently substantially incapacitated for the performance of his job duties as a CO.

17. Dr. Rush agreed that symptoms of IBS, which include constipation, cramping pain, and diarrhea which is sometimes severe, are unpredictable. One cannot tell when, why, or how these symptoms will affect a patient. Bentyl, which respondent is prescribed for IBS, can decrease these symptoms, but it does not eliminate them. Stress can aggravate these symptoms. IBS does not result in bleeding, in general. The only way a patient with IBS can control the diarrhea and constipation is by going to the bathroom and evacuating the bowels. Dr. Rush presumed respondent would have available bathroom access as a CO in order to do his job, and he agreed that if such access was not available, respondent would be at risk of defecating in his clothes.

18. In reviewing respondent's medical history, Dr. Rush noted that when Dr. Meth had evaluated respondent, he commented that Alvin Au, M.D., a gastroenterologist, had performed a screening colonoscopy in October 2006 which revealed aphthous ulcers of the sigmoid colon, and chronic inflammation of the left colon. Dr. Au stated that these findings were suggestive of inflammatory bowel disease (IBD).[6] Because these findings consist of two of the three symptoms for IBD, Dr. Rush felt he could not rule out IBD, yet he could not find evidence in respondent's records that respondent had been subsequently treated for IBD. To Dr. Rush, this was a "source of consternation," as IBD could be potentially life-threatening. Dr. Rush further opined that respondent could suffer from a severe case of IBS. If a patient experiences stress, it could aggravate any of these diseases. Although IBS symptoms do not usually last hours at a time, they might.

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[6] IBD involves chronic inflammation of part or the whole of the patient's digestive tract. IBD primarily includes ulcerative colitis and Crohn's disease and can be debilitating. Common symptoms are severe diarrhea, pain, fatigue and weight loss. (Mayo Clinic, Diseases and Conditions, at http://www.mayoclinic.org/diseases-conditions/inflammatory-bowel-disease/basics/definition/con-20034908 [as of May 11, 2017].)

Respondent's Evidence

19. Respondent testified that his IBS symptoms are set off by anxiety, and conversely, they are less frequent when he is experiencing less stress and anxiety. His symptoms begin with cramps and constipation, which leads quickly to diarrhea, although sometimes the diarrhea will be the first symptom to appear. An episode may last 60 days, with diarrhea dominating his condition. Stress-inducing experiences can include respondent seeing a parolee, which reminds him of his work as a CO, or by his reevaluation by CalPERS, as has occurred in this case. He can have multiple, twice-weekly episodes up to 100-plus times per year. When he is in the bathroom with diarrhea, he may be using the toilet for several minutes or up to an hour at a time. It is often a "physically terrible" experience for him. He still takes Bentyl weekly, which does not relieve his symptoms other than to stop nighttime cramping, which helps him sleep. He has experienced weekly stress followed by bouts with diarrhea ever since he was in the academy, training to be a CO. Presently he still has vivid memories of his work as a CO, and dreams about CDCR, both of which can trigger episodes. These days he assists his wife photographing weddings on weekends.

20. Respondent worked "all over" the Avenal prison facility in countless posts, which is a requirement for any CO. Due to his episodes, respondent had to take frequent sick days, and eventually his supervisors became annoyed. As a result, respondent's watch sergeant harassed him because he assumed respondent was abusing his sick time. Respondent was given the worst assignments. If he was not at his post while accessing the bathroom during a bout of diarrhea, the sergeant would falsely report him as being away without official leave (AWOL) from his position. Respondent had to contend with working several posts that had no bathroom access, including the guard tower, outside patrol, the dining room, and transportation of prisoners. Other posts, such as the control room, had bathrooms, but if respondent was in the bathroom for an extended time during an episode, he could not do his job at all. Like every other CO at the prison, respondent was on call for duty at all times. Because at times his episodes lasted for days, he was considered AWOL when he could not complete a mandatory work shift. If he had to leave his post during an episode, he would be leaving a partner alone. He had to get a supervisor to approve his departure so that other staff could cover for him. Respondent feels his condition would render him incapable of dealing with a prison riot or disturbance, which all COs must respond to as part of the job. He soiled his prison uniform on one occasion while working as a CO. By 2009, respondent was missing so much time from work that he had exhausted all of his sick and family leave time. He was on the verge of losing his job when his physician requested that he be placed on medical leave.

21. William Holvik, M.D., is an internal medicine physician and has been treating respondent for IBS for approximately 10 years. He considers respondent's IBS to be moderate to severe due to respondent's long history of symptoms, including severe constipation, explosive diarrhea, difficulty swallowing, and frequently rushing to the bathroom. Respondent's frequency of episodes has generally been unpredictable, but the frequency heightens with stressful situations. IBS is physiologic and cannot be treated

anatomically. The most effective treatment is medication and stress reduction through counseling and time away from work. With treatment, respondent's episodes will still reoccur, but with less frequency. Severe anxiety is a part of IBS. Dr. Holvik's two key concerns regarding respondent is that his IBS makes it difficult to maintain his job, and his psychological condition undermines his ability to do his job. Because respondent's CO position induces severe anxiety in him, and because respondent cannot completely control his ongoing symptoms, Dr. Rush believes he cannot work as a CO.

22. Sandra T. Bennett, a licensed clinical social worker and psychotherapist since 1976, testified that she has been treating respondent with therapy sessions every two to three weeks since 2014. She believes respondent has suffered from post-traumatic stress disorder (PTSD)[7] since he became ill with IBS while working as a CO, exhibiting anxiety and symptoms of depression. In her experience, approximately 80 percent of IBS patients suffer from anxiety and depression. Respondent has difficulty with sleeplessness, fearfulness, inability to concentrate, feelings of inadequacy regarding not providing for his family, and dreams regarding episodes he experienced while at work. His anxiety persists, and because Ms. Bennett cannot help him lessen his IBS symptoms, they work on his coping skills. Respondent still has episodes of diarrhea and has repeatedly cancelled their appointments as a result. Ms. Bennett has discussed sources of anxiety and depression with respondent, provided emotional support, and helped him find ways to cope with his challenges. She described his current progress in therapy as "less than satisfactory," because this CalPERS hearing process has been stressful for him and has exacerbated his medical condition.

Assessment of Respondent's Disability

30. It is uncontroverted that respondent suffers from moderate to severe IBS, chronic anxiety disorder, and GERD. Whether he still suffers from ulcerative colitis, or whether he may also suffer from IBD, is questionable according to the IME performed by Dr. Rush. Notably, neither CalPERS nor Dr. Rush addressed whether the multiple medical conditions respondent presently suffers from would indeed continue to render him substantially incapacitated. Instead, Dr. Rush opined that because there was not enough objective evidence to prove respondent suffered from ulcerative colitis, respondent was thereby capable of performing all of the duties in the CO job description. Yet this conclusion was not self-evident. Because Dr. Rush did not opine about whether respondent's other conditions, even in the absence of ulcerative colitis, when reviewed together, continue to make him substantially incapacitated from the performance of the duties of a CO, his evaluation was incomplete. In the absence of an opinion from Dr. Rush on this issue, CalPERS failed to meet its burden of establishing that respondent is no longer incapacitated and should be returned to CO work.

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[7] PTSD is a disorder that develops in some people who have experienced a shocking, scary, dangerous, or life-threatening event (or events). (National Institute of Mental Health, Post-Traumatic Stress Disorder, at https://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd/ [as of May 11, 2017].)

31. Respondent presented credible, uncontroverted evidence that he continues to be treated for IBS, GERD, and stress and anxiety, and that the best he can do is to attempt to reduce the frequency of his episodes by taking his medication and minimizing his stress and anxiety through psychotherapy and coping skills.

32. The evidence did not establish that the CO position has changed in any way which would now accommodate respondent's condition, or allow him to perform his duties in every CO post he is expected to fill. Dr. Rush qualified his opinion that respondent could fulfill his job duties as based on the assumption that respondent had bathroom access in all of his assigned posts. But respondent testified credibly that such was not the case.

33. Based on all of the evidence presented, CalPERS did not establish that respondent was no longer substantially incapacitated from performing the usual activities as a Correctional Officer at a State Correctional Facility. The IME opinion of Dr. Rush was unpersuasive, as it only raised doubt regarding whether respondent suffered from ulcerative colitis, yet it failed to address whether respondent's other impairments would still substantially incapacitate him from performing his usual work duties. Respondent submitted competent evidence of continued impairment, contravening CalPERS' position that respondent was no longer disabled.

LEGAL CONCLUSIONS

1. By reason of his employment, respondent is a state safety member of CalPERS and eligible for disability retirement under Government Code section 21151, subdivision (a).

2. The burden of proof flows from the type of process initiated and lies with the party making the charges. (*Martin v. State Personnel Board* (1972) 26 Cal.App.3d 573, 582.) Respondent has been receiving industrial disability retirement benefits since approximately December 2013. CalPERS filed this Accusation to force his involuntary reinstatement from disability retirement. As such, the burden rests with CalPERS to prove its contentions based on competent medical evidence by a preponderance of the evidence.

3. 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, and upon his or her application for reinstatement, shall cause a medical examination to be made of the recipient who is at least six months less than the age of compulsory retirement for service applicable to members of the class or category in which it is proposed to employ him or her." (Gov. Code, § 21192.)

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

this system. If the recipient was an employee of the state or of the university and is so determined to be not incapacitated for duty in the position held when retired for disability or in a position in the same class, he or she shall be reinstated, at his or her option, to that position . . . ." (Gov. Code, § 21193.)

5. The role of disability retirement is to address the needs of employees who are unable to work because of a medical disability. (Gov. Code, § 21153.) Pursuant to Government Code section 21192:

> [W]hile termination of an unwilling employee for cause results in a complete severance of the employer-employee relationship [citation], disability retirement laws contemplate the potential reinstatement of that relationship if the employee recovers and no longer is disabled. Until an employee on disability retirement reaches the age of voluntary retirement, an employer may require the employee to undergo a medical examination to determine whether the disability continues.

An employee on disability retirement may apply for reinstatement on the ground of recovery. (*Ibid.*) If an employee on disability retirement is found not to be disabled any longer, the employer may reinstate the employee, and his disability allowance terminates. (Gov. Code, § 21193.)" (*Haywood v. American Fire Protection Dist.* (1998) 67 Cal.App.4th 1292, 1305.)

6. CalPERS did not meet its burden of proving by competent medical evidence that respondent is no longer substantially disabled for performance of his duties as a Correctional Officer at a State Correctional Facility. For the reasons set forth in Factual Findings 30 through 32, Dr. Rush's professional opinion that respondent is not substantially incapacitated for performance of his duties as a CO was not comprehensive and, ultimately, was unpersuasive. Although CalPERS did not meet its burden, respondent notably submitted competent medical evidence of impairment to contravene CalPERS' evidence.

ORDER

CalPERS failed to establish that respondent is no longer substantially incapacitated from the performance of the usual duties of a CO. The Accusation is dismissed.

DATED: May 15, 2017

DocuSigned by:
John DeCure
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JOHN E. DeCURE
Administrative Law Judge
Office of Administrative Hearings