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:

GREGORY S. COVERT,
Respondent,

and

CALIFORNIA STATE PRISON,
CORCORAN, CALIFORNIA DEPARTMENT
OF CORRECTIONS AND
REHABILITATION,
Respondent.

Case No. 2017-0841
OAH No. 2018020241

PROPOSED DECISION

This matter was heard before Administrative Law Judge (ALJ) John E. DeCure,
Office of Administrative Hearings (OAH), State of California, on July 2, 2018, in Fresno,
California.

Christopher Phillips, Senior Staff Attorney, represented the California Public
Employees’ Retirement System (CalPERS).

Gregory S. Covert (respondent) was present at the hearing and represented himself.

There was no appearance by or on behalf of the California State Prison, Corcoran,
California Department of Corrections and Rehabilitation (CDCR). 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, argument was heard, the record was closed, and the matter
was submitted for decision on July 2, 2018.
ISSUE

On the basis of a psychological condition, is respondent permanently incapacitated from the performance of his usual duties as a correctional officer for CDCR?

FACTUAL FINDINGS

1. Respondent is 44 years old. He became a Correctional Officer (CO) with CDCR in 2001, and was employed as a CO at Corcoran Prison for approximately 11 years when he submitted an application for disability retirement in December 2012. Respondent’s employment for CDCR established him as a state safety member of CalPERS.

Respondent’s Disability Retirement Application

2. On December 11, 2012, respondent submitted a Disability Retirement Election Application (Application) to CalPERS. The Application identified the application type as “Industrial Disability Retirement.” In the Application, respondent’s disability was described as: “Psychological — stress, anxiety, depression.”

3. The Application identified the date respondent’s disability occurred as September 16, 2010. In response to the question asking how the disability occurred, the Application stated:

   On September 16, 2010 I responded to an alarm. When I arrived to the cell an inmate had brutally attacked his cell mate and then used a television to strike him in the head. I had to perform CPR on the inmate while in the Emergency Response Vehicle. While performing CPR blood and brain matter were spilling from the inmate’s head with every compression.

4. The Application described respondent’s “limitations/preclusions” due to his injuries as:

   I am unable to work due to my stress, mental state, anxiety, depression and my ability to cope with my job. I am not able to handle any type of situation if the need may arise.

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

   I am not able to handle the stress that occurs on a daily basis while working at the prison. My stress level and anxiety levels shoot through the roof as soon as I drive on the grounds. While off of work when I have to go to the facility to pick up my pay
check I find myself having a panic attack as soon as I drive on the prison grounds. After this incident I was unable to do my job as required by upper management because I feared that not only another incident like this would occur but any type of incident would occur that could prove traumatic to me and to my fellow coworkers. We have to move inmates and place them with other inmates that could potential [sic] cause another incident like I experienced in September 2010. I have expressed my concerns but we were still instructed to make the moves. I have been unable to handle the stress and control my anxiety since this incident. My well being and health have became [sic] increasingly worse and made it to where I am unable to work and at times leave my home. Not only has the [sic] affected my ability to do my job but it is now affecting my home life. I am withdraw from my family and friends. I have found myself sleeping all of the time and staying in my room. I have four children that are losing out on their father being a part of their lives because I am unable to be around anyone.

6. In the Application, respondent indicated he was not working in any capacity. In the space provided for “other information,” no information was included.

7. On December 18, 2013, CalPERS notified respondent in writing that his application for disability retirement had been approved. Respondent retired for disability effective August 24, 2013.

8. Government Code (Code) section 21060, subdivision (a), provides that a member shall be retired from service upon his written application if he has obtained age 50 and is credited with five years of state service. Pursuant to Code section 21150, subdivision (a), a member credited with five years of state service may retire from service for disability regardless of age. Code section 21192 provides that CalPERS may require a recipient of a disability retirement allowance under the minimum age for voluntary retirement to undergo an examination to determine whether he is still incapacitated, physically or mentally, for duty in the position he held when retired for disability, and for the duties of the position.

9. CalPERS determined respondent was under the minimum age for voluntary service retirement applicable for safety members when he underwent the medical examination which led to CalPERS’ approval of his Application. On March 30, 2016, CalPERS notified respondent in writing that his file was under review for a potential reexamination. CalPERS also asked him to complete an authorization form which would

1 Respondent, whose exact birthdate was withheld by CalPERS to preserve his privacy rights, was approximately 39 years old when CalPERS approved his disability application.
allow CalPERS to obtain information from his treating physicians, and to provide contact information for his treating medical professionals. On March 28, 2017, Robindra Paul, M.D., performed a reexamination of respondent on behalf of CalPERS and wrote a subsequent report detailing his findings.

10. Upon review of Dr. Paul’s report and other documentation regarding respondent’s psychological condition, CalPERS determined that respondent was no longer disabled or incapacitated from performance of his duties as a CO. On April 4, 2017, CalPERS notified respondent and CDCR of its determination and informed both of their appeal rights. Respondent timely appealed CalPERS’ determination. All jurisdictional requirements have been met.

Relevant Work History

11. Respondent was approximately 26 years old when he entered the state of California’s correctional academy for training, after which he soon obtained employment at Corcoran State Prison. In 2010, the traumatic incident he described in his Application occurred, causing the death of the inmate respondent had attempted to revive. Respondent was traumatized by the experience. His wife gave birth to their baby son the following day, but respondent was still deeply affected by the inmate incident and “could not get it out of my head.” Respondent returned to work, but he experienced continuing anxiety in the workplace. When an alarm would sound, he would revert to an anxious state. He began to take time off from work to deal with anxiety and depression. At home, his family life was affected, and he had difficulty sleeping. He thought of the murdered inmate and could not recall what the inmate looked like because he was so badly mutilated. Respondent experienced a few more inmate incidents and sustained an injury to his thumb while taking down an inmate. He was receiving psychological treatment during his times off work and eventually received a doctor’s recommendation to retire for disability.

Duties of a Correctional Officer

12. As set forth in CDCR’s Essential Functions, the Correctional Officer must: 1) work in both minimum and maximum security institutions and male and female institutions; 2) wear protective equipment and breathing apparatus; 3) range qualify, maintain firearms in good condition, and fire weaponry in combat or emergencies; 4) swing a baton as a striking weapon; 5) disarm, subdue and restrain inmates; 6) inspect inmates for contraband and do body searches; 7) walk, run, and climb stairs, ladders, and bunkbeds; 8) crawl, crouch, stoop and bend over; 9) lift and carry medium to heavy weights during the workday; 10) wear a 15 pound equipment belt; 11) push, pull, and reach; move the head and neck; 12) move the arms, hands, and wrists to grip and squeeze; 13) work inside or outside; and 14) have a mental capacity to deal with very unpleasant situations including inmate graphic suicides. A CO also must be able to judge a situation and use appropriate force, including lethal force, under the threat of serious injury or death.
13. CDCR submitted a CalPERS Physical Requirements of Position/Occupational Title form containing information regarding the physical requirements of the Correctional Officer position. The requirements include: 1) sitting, standing, running, walking, crawling, kneeling, climbing, squatting, bending and twisting at the neck, wrists and waist, reaching above and below the shoulders, pushing and pulling, power grasping, keyboard and mouse use from occasionally up to three hours; 2) sitting, standing, walking, twisting the neck, reaching above and below the shoulders, pushing and pulling, fine manipulation, simple grasping, and repetitive use of hands from three to six hours; and 3) walking, reaching below shoulder, fine manipulation, simple grasping, and repetitive use of hands for over six hours. Regarding lifting and carrying, the requirements include: 1) occasionally to up to three hours of lifting and/or carrying 26 to 100-plus pounds; 2) three to six hours of lifting zero to 25 pounds; and 3) constantly (over six hours) lifting from zero to 10 pounds.

Further requirements include: 1) from zero up to six hours of walking on uneven ground; and 2) from occasionally to up to three hours of driving, exposure to excessive noise, exposure to extreme temperatures, humidity, and wetness, dust gas fumes, or chemicals, working at heights, operating foot controls, using special visual or auditory equipment, and working with biohazards.

Expert Opinion

14. CalPERS called Robindra Paul, M.D., as its expert witness. Dr. Paul is board certified in psychiatry and forensic psychiatry and has been in private practice in San Diego, California, since 2008. He specializes in adult and forensic psychiatry, has performed civil and criminal evaluations as an independent medical evaluator, and has performed evaluations as a qualified/agreed medical evaluator certified by the Division of Workers’ Compensation. Dr. Paul examined respondent on March 15, 2017, took a history, reviewed his medical records and job duties, and issued an Independent Medical Examination (IME) report.

15. In his IME report, Dr. Paul reviewed the history of respondent’s problems that led to his filing a disability claim. Respondent described his personal history, beginning with his family life. His parents were married when he was born, and neither parent was abusive, nor did they have mental illnesses, substance abuse problems or physical disabilities. Respondent described his relationship with his mother as “great,” and with his father as “good.” They divorced when he was 18 or 19 for reasons unknown to him, which caused him “some” non-specific depression or anxiety. He has several siblings and half-siblings with whom he has had good relationships, and none of them had mental illnesses, substance abuse problems or physical disabilities. While growing up, respondent never experienced any physical, sexual or emotional abuse in the home. To date, respondent reported maintaining good relationships with his mother and father, although his relationship with his father, who is remarried, has grown more distant over time.

16. Dr. Paul reviewed the Qualified Medical Evaluation (QME) report Michael Kesselman, Ph.D., wrote on January 23, 2012, after a QME Dr. Kesselman conducted with
respondent. Dr. Paul noted that a substantial number of entries in the personal history Dr. Kesselman gathered reflected the same history Dr. Paul took in his IME.

17. Respondent’s history of relationships involved a 10-year marriage which ended in 2005 when his wife, Angela, cheated, after which he “probably” went through depression and anxiety for approximately six months. Respondent had two adult children from the marriage and maintains good relations with both; neither had any history of mental illness, behavioral problems or physical disabilities. Respondent met his second wife, Melissa, in approximately 2006 and married her in 2008 or 2009. They were divorced in 2016 due to respondent’s depression and being “unhappy and kind of miserable.” He and Melissa shared joint custody of their two grade-school-age children, with whom respondent reported to have “great” relationships. Neither child had any history of mental illness, behavioral problems or physical disabilities. Respondent had not been in a significant relationship since his divorce from Melissa and was not dating. Dr. Paul also reviewed Dr. Kesselman’s QME report and noted that several entries in the relationship history Dr. Kesselman had gathered were similar to what respondent reported to Dr. Paul.

18. Dr. Paul reviewed hospital records from Aurora Encinas Hospital (Aurora) showing respondent was admitted by Aurora on May 9, 2013, underwent a psychiatric history and evaluation, and was discharged on May 13, 2013. Those records indicate respondent was unable to work for the previous three months due to Post-Traumatic Stress Disorder (PTSD) symptoms, and depression and anxiety. Respondent had reported that after he witnessed a brutal murder, he found it difficult to return to work, and his work performance suffered.

19. Respondent’s medical history included deviated septum surgery in 2004, and shoulder surgery in approximately 2011 for a torn labrum. Respondent also sustained a left-ankle fracture in 2004, caused by a dirt bike accident, which led to several corrective surgeries. None of these medical conditions caused him depression or anxiety. In approximately 2015, respondent had an appendectomy which was successful. At the time of his IME with Dr. Paul, he was taking Klonopin 1mg, one to two tablets per day as needed, for anxiety.

20. Dr. Paul reviewed respondent’s history of treatment by R. Douglas Owen, D.O., which indicated that on July 30, 2012, respondent complained of stress. He was assessed as having generalized anxiety disorder and adjustment disorder with depressed mood. Dr. Owen prescribed Paxil 40mg in the morning, and Xanax 1mg three times per day. Respondent saw Dr. Owen again on August 27, 2012, complaining of acid reflux, but reporting his anxiety was “okay.” Dr. Owen assessed him as having acid reflux esophagitis, which was also treated.

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2 PTSD is a mental health condition triggered either by witnessing or experiencing a terrifying event such as combat, a natural disaster, a car accident, or sexual assault. Symptoms include flashbacks, nightmares, severe anxiety, and uncontrollable thoughts about the event.
adjustment disorder with depressed mood, and generalized anxiety disorder. Respondent returned to see Dr. Owen on September 25, 2012, with continuing symptoms which now caused respondent to be concerned. Dr. Owen again assessed respondent as having reflux esophagitis, adjustment disorder with depressed mood, and generalized anxiety disorder, and opined respondent was disabled from his usual and customary employment until the next year. Dr. Owen referred respondent to psychiatry for a consultation and opinion regarding medical retirement. Respondent saw Dr. Owen four times in November 2012 and was assessed as having adjustment disorder with depressed mood, and generalized anxiety disorder.

21. Respondent’s treatment records for 2013 indicate that he saw Dr. Owen in January 2013 following a motor vehicle accident in which he had forearm and chest wall contusions, and was suffering from generalized anxiety disorder. In February 2013, he reported to Dr. Owen that he had tried to return to work but was unable to, and he experienced nausea, vomiting, and insomnia at the thought of working. Respondent had worse symptoms when he actually attended work. Dr. Owen assessed him as having adjustment disorder with depressed mood, and generalized anxiety disorder. A May 22, 2013 assessment noted respondent was treated at a mental hospital (Aurora), which helped his condition. Respondent was assessed as having adjustment disorder with depressed mood, and generalized anxiety disorder. Respondent was also assessed as disabled from employment until the next visit. On June 24, 2013, Dr. Owen saw respondent for a “work note” and disability paperwork.

22. Respondent described his history of drug and alcohol use to Dr. Paul, stating he had never had problematic alcohol consumption, although he was arrested for driving under the influence (DUI) in 2013 or 2014. He drank one or two beers on a typical day and five beers at a single time a few times per week. Respondent drinks “too much” about twice per year. He reported never having misused prescription medications, and has never tried illicit drugs.

23. Respondent described a psychiatric history in which a clinical psychologist, Yosef Geshuri, Ph.D., diagnosed respondent with social anxiety in 2000 or 2001. Dr. Geshuri recommended Paxil, which respondent found to be helpful, and which he took until a year or two before Dr. Paul’s IME. Respondent had not seen Dr. Geshuri in “years.”

24. Respondent could not recall if a specific stressor led him to file his CalPERS retirement claim, but he knew it was based on “psychiatric issues.” He was not working when he submitted the Application. He did not know what a Workers’ Compensation psychiatric QME had concluded regarding his psychiatric condition. He saw a private psychiatrist for one year and was prescribed antidepressants, but the treatment was ineffective. At the time of his IME, respondent had not taken any antidepressant medication “in a year or two” because he disliked the side effects and “was feeling better anyway.” Respondent said he “wanted to see how I would do without them,” and determined that without them, “I did fine.” Respondent also saw Kenneth Bluestein, M.A., for psychological
services over a five month period following the traumatic work incident and before he retired.

25. Dr. Paul noted respondent had not thought about the traumatic work incident “probably in a year” leading up to the IME. Respondent reported no depression or anxiety, and no symptoms. He was unsure whether returning to his CO position would cause him to regress and experience the same PTSD symptoms.

26. Dr. Paul reviewed the portion of Dr. Kesselman’s QME that cited to records predating the traumatic workplace incident. He reviewed treatment records kept by Ravi Reddy, M.D., showing a history of Paxil prescriptions for anxiety from 2001 until 2005, and for Ambien in 2004. Respondent was being treated then for anxiety and depression, and suffered from social anxiety. The QME also detailed various records of treatment by Carol Crofts, Ph.D., in 2007 for depression, anxiety, and insomnia, and records of treatment by psychiatrist Michael Barnett, M.D., in 2011, which noted respondent’s social anxiety was stable.

27. Dr. Paul noted the record dated December 6, 2013, by Andrea Bates, M.D., in which she wrote she estimated “60% of the temporary disability is due to the industrial injury.” Dr. Bates explained “that non-industrial factors needed to account for some of the basis for the disability,” and concluded, “I think if not for the industrial injury he would not be otherwise disabled from working as an officer . . . .”

28. When testifying, Dr. Paul stated that respondent’s reported symptoms in Dr. Kesselman’s QME were revealing. On one hand, respondent said he suffered from sleeplessness and would lie in bed thinking about how he had too much work to do, and thinking about the violence he had witnessed. He could not get his mind off work, which caused him stress and an inability to focus. He felt overwhelmed, unable to cope, trapped, and caught in a dilemma. However, he also reported to Dr. Kesselman that he “was so joyous after his child was born that this was his main focus.” He did not recall having sleeplessness or awaking from nightmares. He had flashbacks and intrusive recollections, and avoided talking about the traumatic incident. He also avoided places that reminded him of the incident and avoided thinking about the incident. He was hypervigilant about his safety at work. This lack of symptomology and ability of respondent to cope with the traumatic workplace incident led Dr. Paul to believe respondent was not substantially incapacitated from performing his usual job duties as a CO.

29. Another issue Dr. Paul discussed was that while respondent dealt with workplace pressures, he also apparently experienced other stressors in his life unrelated to work, such as social anxiety. Dr. Paul opined that these other stressors had the effect of exacerbating the original PTSD respondent experienced due to the traumatic incident.

30. Dr. Paul also distinguished respondent’s current stressors as potential rather than acute. For instance, respondent related his concern that at work, the Secured Housing Unit (SHU) where respondent was stationed had changed its inmate housing policy in 2010,
and was now placing an increasing number of previously separated inmates together as cellmates, causing a more dangerous situation. This policy made respondent anxious about the prospect of returning to work. However, when Dr. Paul evaluated respondent, he found only "possible" stressors, such as the SHU policy change, to be present, yet he did not find evidence to indicate respondent was subject to any notable current stressors. Respondent got along well with his parents, children, and ex-wife, and was working full-time at an automotive paint and body shop owned by his uncle, functioning more or less normally and with no complaints of psychological problems. At the time of his IME, respondent displayed no symptoms of depression, anxiety, suicidal ideations, or any other psychological conditions.

31. Dr. Paul administered the Personality Assessment Inventory (PAI), a 344-item instrument containing 22 non-overlapping scales which provide a broad-based assessment of mental disorders. The PAI includes multiple “validity indices” which gauge whether the results of the testing were distorted; those factors include failure to complete test items properly, carelessness, reading difficulties, confusion, exaggeration, malingering, or defensiveness. Respondent’s PAI scores suggested he attended appropriately to test items and responded consistently. The PAI also measures whether the symptomology is reported in a distorted manner, and here, respondent’s scores indicated he was not completely forthright. Respondent’s responses suggested he portrayed himself as being relatively free of commonly admitted shortcomings and reluctant to recognize his minor faults.

32. Respondent’s PAI clinical profile revealed no elevations indicating the presence of clinical psychopathology, and was “entirely within normal limits.” In his self-reporting, he described no alcohol or drug dependence and no significant psychological problems, thoughts, behaviors, symptoms, anxiety, moods, or difficulty functioning. His self-evaluation was stable and his self-esteem was reasonable. His recent level of stress was low and his level of social supports, involving a large number of people to whom he could turn for support when needed, was highly developed; these factors indicated a “favorable prognostic sign for future adjustment.” Respondent was satisfied with himself in his current condition, and was not experiencing marked distress, so he saw little need for change in his behavior. However, he reported several strengths that would make for a smooth treatment process if he were to seek further treatment.

33. Dr. Paul administered the Structured Inventory of Malingered Symptomology (SIMS), a 75-item, self-report measure used to assess potential malingering of psychosis, neurologic impairment, amnesia, low intelligence, or affective disorder. Respondent’s total score was not significantly elevated above the recommended cutoff score for the identification of likely feigning. In other words, his reportage of psychiatric and cognitive symptoms was consistent with the symptoms described by individuals with a genuine disorder, or no impairment at all.

34. Dr. Paul noted that on a the Psychosis, Neurologic Impairment, Amnestic, Disorders, Low Intelligence, and Affective Disorder scales, respondent’s scores on every
scale were not significantly elevated above the recommended cutoff for the identification of feigned or exaggerated symptomology in each of those areas.

35. After examining respondent, Dr. Paul diagnosed him as follows:

1. Unspecified Depressive Disorder, in remission.
2. Unspecified Anxiety Disorder, in remission.
3. Unspecified Trauma Related Disorder, in remission.

36. In his IME report, Dr. Paul opined that respondent had the current capacity to work, but it was “possible that [respondent] may decompensate under stress.” When asked about returning to work, respondent stated “I don’t know. Sometimes I start to think about things and remember how I felt. Then I know I can’t do that. . . .” However, Dr. Paul noted respondent had not thought about the incident for a year prior to his IME with Dr. Paul. Thus, Dr. Paul opined that “there is insufficient evidence that [respondent] decompensating under stress is probable.”

37. Dr. Paul further supported his opinion by noting that respondent had adequate cognitive capacities during his evaluation, showed no indications of significant psychopathology, was currently working, showed no evidence of acute relationship issues or acute emotional issues, was not depressed or anxious, and was not reporting acute problematic alcohol use. There was insufficient evidence that respondent was malingering. In sum, Dr. Paul found that respondent was not presently incapacitated for the performance of his usual job duties as a CO.

**Respondent’s Testimony**

38. Respondent summarized a personal and work history similar to what he had described to Dr. Paul during the IME. He described the traumatic incident as a “major, life-changing” event that altered his physical and mental being, and has ever since left him coping “hour by hour” through both good and bad days. He was in a car accident several years ago in which he struck a tree and sustained multiple injuries. His family members have suggested that his car accident actually may have been a suicide attempt. Respondent “blocks out” the notion that he may be suicidal, but he thinks of death “almost daily.”

39. Respondent has sought counseling, which made him feel better and helped get him off antidepressant medications. He described his overall mental condition as “not great,” but “significantly better.” The notice he received from CalPERS that he was going to be reevaluated triggered substantial anxiety in him, and felt like a “disaster.” Respondent still sleeps less than four hours per night, and believes the PTSD from witnessing the traumatic work incident will not go away. He does not know how he will respond if he returns to his CO position, and although he is “okay” now, he has “no idea” if he will be fit for duty in a work situation.
40. Respondent has no plans to ever work in a prison setting again. He has seen psychotherapists from time to time over the last six years, but much of those treatment costs are not covered by insurance, which makes therapy a substantial expense for him to bear. Respondent surmised he may have had a “good day” on the date Dr. Paul evaluated him, but he disagreed with Dr. Paul's assessment that he was fit for work. “I know I cannot do the job,” he said.

**Discussion**

41. When all the evidence is considered, respondent failed to offer sufficient competent medical evidence to establish that, at the time he was reevaluated for disability retirement, he was substantially and permanently incapacitated from performing the usual duties of a Correctional Officer. The medical evidence established that he suffered from an unspecified depressive disorder, and an unspecified anxiety disorder, received treatment for both conditions, and improved to the point that he reported no depression or anxiety to Dr. Paul during the IME. Dr. Paul noted no symptoms of either condition, or of any other psychiatric maladies. Regarding respondent’s trauma related disorder, Dr. Paul determined respondent to be in remission because respondent had not thought about the incident for a year prior to CalPERS notifying him of the upcoming IME. Despite some flashbacks and intrusive recollections, respondent avoided seeing things that reminded him of the incident and was hypervigilant for his safety at work. No evidence was presented to indicate respondent suffered from debilitating depression or anxiety, nor was he maligned by any other psychological conditions which would prevent him from working.

42. In reaching his opinion that respondent was not substantially and permanently incapacitated from performing the usual duties of a Correctional Officer, Dr. Paul employed the standards that apply in these types of disability retirement proceedings. His opinion that respondent’s psychological condition was not adequately supported by objective medical evidence to establish substantial incapacitation from his job duties was persuasive and consistent with the medical records offered at hearing. Dr. Paul's testimony was credible, even-handed, and persuasive.

43. Respondent testified convincingly that witnessing a horrific murder while on the job was a life-changing experience for him, the aftermath of which he must face from day to day. The evidence showed that his reportage on his history and condition was thorough and consistent. His candor as a witness was unmistakable. He was honest about his recovery, which he asserted is incomplete, yet his descriptions of his condition and progress also led Dr. Paul to credibly conclude that respondent had substantially improved in the years since the traumatic event. Respondent offered no medical testimony or documentary evidence at the hearing to challenge Dr. Paul’s findings.

44. In sum, when all the evidence is considered, respondent failed to establish that, at the time he was reevaluated for disability retirement, he was substantially and permanently incapacitated from performing the usual duties of a Correctional Officer. Consequently, his disability retirement appeal must be denied.
LEGAL CONCLUSIONS

1. By virtue of his employment respondent is a state safety member of CalPERS. To qualify for disability retirement, respondent had to prove that, at the time he applied, he was “incapacitated physically or mentally for the performance of his duties in the state service.” (Gov. Code, § 21156.) As defined in Code section 20026,

"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.

2. The determination of whether respondent is substantially incapacitated must be based on an evaluation of whether, at the time he applied for disability retirement, he was able to perform the usual duties of a Correctional Officer, and not just the usual duties of his most recent position. (California Department of Justice v. Board of Administration of California Public Employees’ Retirement System (Resendez) (2015) 242 Cal.App.4th 133, 139.)

3. 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.) The employee in Mansperger was a game warden with peace officer status. His duties included patrolling specified areas to prevent violations and apprehend violators, issuing warnings and serving citations, and serving warrants and making arrests. He suffered an injury to his right arm while arresting a suspect. He could shoot a gun, drive a car, swim, row a boat (with some difficulty), pick up a bucket of clams, pilot a boat, and apprehend a prisoner (with some difficulty). He could not lift heavy weights or carry a prisoner away. The court noted that “although the need for physical arrests do [sic] occur in petitioner’s job, they are not a common occurrence for a fish and game warden.” (Mansperger, supra, 6 Cal.App.3d at p. 877.) Similarly, the need for him to lift a heavy object alone was determined to be a remote occurrence. (Ibid.) In holding that the game warden was not incapacitated for the performance of his duties, the Mansperger court noted that the activities he was unable to perform were not common occurrences and that he could otherwise “substantially carry out the normal duties of a fish and game warden.” (Id. at p. 876.)

4. The court in Hosford v. Board of Administration (1978) 77 Cal.App.3d 855, reached a similar conclusion with respect to a state traffic sergeant employed by the California Highway Patrol. The applicant in Hosford had suffered injuries to his left ankle and knee, and had strained his back. The court noted that the sergeant “could sit for long periods of time but it would ‘probably bother his back;’ that he could run but not very adequately and that he would probably limp if he had to run because he had a bad ankle; that he could apprehend persons escaping on foot over rough terrain or around and over obstacles
but he would have difficulty and he might hurt his back; and that he could make physical
effort from the sedentary state but he would have to limber up a bit.” (Id. at p. 862.)
Following Mansperger, the court in Hosford found that the sergeant:

is not disabled unless he is substantially unable to perform the
usual duties of the job. The fact that sitting for long periods of
time in a patrol car would “probably hurt his back,” does not
mean that in fact he cannot so sit; . . . [¶] As for the more
strenuous activities, [a doctor] testified that Hosford could run,
and could apprehend a person escaping over rough terrain.
Physical abilities differ, even for officers without previous
injuries. The rarity of the necessity for such strenuous activity,
coupled with the fact that Hosford could actually perform the
function, renders [the doctor’s conclusion that Hosford was not
disabled] well within reason. (Ibid.)

In Hosford, the sergeant argued that his condition increased his chances for further
injury. The court rejected this argument, explaining that “this assertion does little more than
demonstrate that his claimed disability is only prospective (and speculative), not presently
existing.” (Hosford, supra, 77 Cal.App.3d at p. 863.) As the court explained, prophylactic
restrictions that are imposed to prevent the risk of future injury or harm are not sufficient to
support a finding of disability; a disability must be currently existing and not prospective in
nature. (Ibid.)

Respondent, who is 44, was approximately 39 years old when CalPERS made
its determination to approve his Application for industrial disability retirement. Code section
21060, subdivision (a), provides that a member shall be retired from service upon his written
application if he has obtained age 50 and is credited with five years of state service.
Respondent was under the minimum age for voluntary service retirement applicable for
safety members when he underwent the medical examination which led to CalPERS’
approval of his Application. (Gov. Code, § 21151, subd. (a).)

Code section 21192 provides that CalPERS may require a recipient of a
disability retirement allowance under the minimum age for voluntary retirement to undergo
an examination to determine whether he is still incapacitated, physically or mentally, for duty
in the position he held when retired for disability, and for the duties of the position. Code
section 21193 provides that if an employee of the state is determined to be not incapacitated
for duty in the position held when he retired for disability or in a position of the same class,
he shall be reinstated, at his option, to that position.

When all the evidence in this matter is considered in light of the courts’
holdings in Resendez, Mansperger, and Hosford, respondent did not establish that his appeal
of CalPERS’ determination that he is no longer disabled or incapacitated from performance
of his duties as a Correctional Officer should be granted. There was not sufficient evidence
based upon competent medical opinion that he is permanently and substantially incapacitated
from performing the usual duties of a Correctional Officer due to a psychological condition. In fact, respondent offered no testimony either from treating doctors or from a medical expert. Respondent’s concern that he may be unable to return to his position without experiencing substantial anxiety, which could interfere with his ability to competently perform his duties, was earnest and seriously set forth; but his consternation over potential future problems, however genuine, does not serve to establish that he is substantially incapacitated from performing the duties of a Correctional Officer. Consequently, his appeal of CalPERS’ determination must be denied.

ORDER

The appeal of respondent Gregory S. Covert from CalPERS’ determination that he is no longer disabled or incapacitated from performance of his duties as a Correctional Officer, and thus, no longer eligible for industrial disability retirement, is denied. Respondent is thereby reinstated, at his option, to that position.

DATED: July 25, 2018

JOHN E. DeCURE
Administrative Law Judge
Office of Administrative Hearings