ATTACHMENT C

RESPONDENT'S ARGUMENT
URGENT

Email: [REDACTED] 2018-0803

Re: Julie Hauge

Please see & accept reply.

I'm including a corrected copy of the Dr's report. I'm feeling really bad and something like this use to be everyday thing. But now I'm embarrassed that it's come to this limiting me.

Thank you

Sabrina please let me know when you receive.

Thank you
To Whom it May Concern: Please review all my reports. Doctor's report has been 100% validated.

Re: Julie Hawpe 

This is the best I can do anymore. I'm not capable of doing this on my own. My health is not good. I have many medical problems. My ears are constantly buzzing with pressure and headaches. I have lost my concentration and ability to comprehend. I'm sorry but given all the circumstances this is the best I can do anymore. Even at the hearing, I might not have appeared sick on the outside, but I was very sick. I have a constant headache and ear buzzing. My eyes are also bad. Supported by my Doctor's reports, the strain of MRSA I have is very, very rare. They've tried everything the strongest antibiotics available. Only to have my Infectious Disease Dr. Younes finally tell me that document in his notes "There's nothing more I can do for you." The MRSA I have is incurable, degenerative as are the antibiotics required to treat continuing flare-ups. Constant headaches + Inner ear nerve damage has taken me from a very good Analyst with a career to barely able to complete this explanation/Justification. This type of stuff really causes me...
At this point everything that could go against me has, and it's not right that I be discriminated against and denied disability retirement when it's automatic for some with MRSA but not me. The Dr's report initially 100% disabled? allot of anxiety and stress because of my impairments and disabilities. My ENT Christopher Church @ Loma Linda just referred me to an ophthalmologist there and I have an appointment 1st week of October 2019. I have to double check my memory has become really bad too.

This whole PER's Retirement process has been very bad for me. I thought I would of been given correct information when filling out my application but that was wrong. It had to be redone when I did it at the actual PER's office on Hospitality Lane. Then because my main Dr. John Finazzo, ENT for Worker's Compensation passed away it left me without a doctor since my Infections Disease Dr. Younes had already determined there was nothing else he could do. I was forced to find all new Doctors on my own because Work Comp kept delaying and wouldn't help me at that time, approximately end of 2014. So late 2014 I waited as long as I could approximately a year during which time my condition became very very bad due to lack of specialty treatment doctors. The MRSA Infection had gotten very bad that green pea colored discharge would pour out my nose & down my throat. My Ear's & Hearing got very bad, so much pain, pressure & sensitivity.
My vertigo was also very bad, so bad I couldn’t turn my head to the right or lay flat without feeling like I was on a very fast merry go round. I fell allot and still have to be very careful due to sensory nerve damage to my inner ear’s and unstable crystals which are in the inner ear normally. However, my inner ear tube that controls balance, tinnitus & hearing were displaced. I was in serious condition because the infection was also affecting my immune system. See with my type or strain of MRSA I could look pretty normal on the outside but at anytime MRSA can get in my bloodstream (sepsis) which usually causes death. This according to my doctor’s & posted information about my condition / infection, I finally found an ENT, Balance & Infectious Disease doctor all whom were new to my treatment. They manage my flare ups and damage / side effects from such a serious and potentially deadly MRSA infection. I see Dr. Church, ENT @ Loma Linda every month or two depending on how I’m doing. I also have a special compound Vancomycin antibiotic on hand at all times. So when I have flare ups he advises me on dosage. See my antibiotics are special & have to be specially ordered from a pharmaceutical company usually out of Pennsylvania, back east. I receive them by mail.
I also take daily medications which consist of, Wellbutrin, Xanax, Norco-10 (pain medication), Ibuprofen + Zofran (nausea). The Wellbutrin is to help with depression, Xanax helps to relax which helps my whole body & head. Pain medication Norco 10/325. And I take Ibuprofen for headaches (very severe) and also for my joint & ear pain. I've been taking all these plus numerous antibiotics including Infusion's almost constantly for 9 yrs. now. All of these have several side effects and are very hard on my digestive system as well as other parts of my body. So every time I have to take Vancomycin for my MRSA infection it causes more damage & increases pain & pressure in my inner ears. I also see my balance doctor at Eisenhower. He treats me for Vertigo, balance and Inner ear problems. He's treats the crystals in my inner ears so they don't block the tubes which increases Vertigo effects.

I also have back problems from several falls & prior injury requiring surgery which they said I wouldn't be able to work again back in 1999, but I fought back from that & was able to return to work with special ergonomics in my work area. For my back injury I have a titanium plate in my T6 area of my upper back. Although I went back to work I had back surgery there was always pain of various levels from my back injury but I dealt with it.
This MRSA Infection I can't go on a bike or treadmill because it's not a matter of getting stronger, it's a matter of keeping the Infection down so my Immune System doesn't become completely compromised which likely result in immediate death. I could look normal one minute but if sepsis infection gets in my blood stream then death is likely. I asked for a experienced doctor dealing with MRSA but no. Now I would like to continue my dispute of the pencil whipped Supplemental which wasn't necessary. Although the doctor's report is very poorly written and he attacked my character or person as well as my job performance. In the report/eval answer's 100% disabled to each question. Why I was Denied with such a serious strain of incurable MRSA is not Fair & very wrong. When correctional officers, because they are service contract MRSA it's an automatic presumption and approved based on their contract + CCPOA. As a matter of fact, CCPOA filed their MRSA/staff cases against CDCR in August 2007, I believe. I was diagnosed July 2007, one month earlier. Also just one day after my hearing May 6, 2019, there were several LAPD Officer's exposed/contracted MRSA while clearing out some homeless Area's. That was on May 7, 2007, because of MRSA, they were immediately given medical treatment & placed on Medical Leave.
Re: Julie Hawpe

# 2018-0803

Why am I being denied Disability for my Incurable, very rare strain of MRSA for which I've been treated for 12 years now. Requiring more and more doctor visits, antibiotic, daily Inhaled (Brea) and many other drugs on a daily basis; several dosages of each per day. This isn't how I planned for my career to end or spend the rest of my life depending on so many doctors and so much medications. I've lost my taste, smell, Impaired hearing, Tinnitus, Vertigo, Stomach problems, Sensitivity and pain in my ears, daily Headaches, restless leg and joint problems; sleepless nights because my bowels hurt, Lung Impairment, Immune System affected my whole life changed, I was always ambitious, hard worker, had hopes of continuing my promotions and returning to work after being taken off work by doctors for more than 24/7, just for Infusions (like chemo) everyday including weekends and holidays. I endured the pain and nausea with expectations of being able to return to work. I feel like my life has turned into a nightmare; actually, I guess it has.

I also request that this committee take a close look at the IME Dr. Giannanco's actual credentials and training.

The dates on some of them are more than 20 yrs, what is he actually work as, and when was the last time he treated a MRSA case or sinus or on regular basis. He admitted that mine was the only IME he ever done. If you look on line or look closely at the dates on certificates he presented, they nowhere does it say he's a practicing ENT. They show he's a practicing Plastic Surgeon. Why him?

I feel he not qualified up to date as ENT to have been asked to do this.
Ambulatory referral to Ophthalmology

Associated Dx: Vision changes (H53.9)
Dx Display Text:
Referred to Specialty: Ophthalmology
Referred to Department: FMO OPHTHALMOLOGY

Reason for Referral: Specialty Services Required
Referral Priority: Routine

Referral Details: Vision changes

DEPARTMENT PHONE NUMBER: 909-558-2154

Patient Instructions:
If you are a Managed Care patient then your referral needs to be processed by the Central Authorization Services. If it is needed, you will be notified within seven to ten (7-10) business days regarding the status of your referral. If you have not been notified after ten (10) business days, please call the following numbers based on your insurance payer.

For Insurance/Payers:
PPOs, IEHP, Tricare, and Medi-Cal: 909-651-1702
United HealthCare and Blue Cross HMO: 909-651-1700
Risk Management: 909-651-4010

11370 Anderson Street
Ophthalmology: (909) 558-2154

Please deliver report/results to the requesting provider and the patient’s PCP.

Entered by: Church, Christopher Alan, MD
Requested by: Church, Christopher Alan, MD
(E-Sig, Jul 10, 2019, 10:52 AM)

PCP: Mofu, Emmanuel, MD
No address on file
Phone: None
Fax: None

LIC #: A63474
NPI #: 1932137171
DEA #: BC5641510
MRSA and correctional health

Frequently asked questions about MRSA and correctional health
Not necessarily. Many people, including inmates and corrections officers, carry staph (including MRSA) in their nose or on their skin and do not know they are carrying it. They do not get skin infections. They do not have any signs or symptoms of illness. However, there are some conditions that can lead to MRSA/staph infections in prisons and jails, and in other settings where people have close contact and in which skin damage (cuts, scratches, scrapes) can occur, like on sports teams.

What kinds of conditions can lead to a MRSA/staph infection in corrections?

**Direct contact:** To get a MRSA or other staph infection, you first must get the bacteria on your skin or in your nose. Staph, including MRSA, are spread by direct skin-to-skin contact. In corrections facilities, there may be regular, frequent direct contact among and between inmates and corrections officers. For example, when one person shakes hands with another, tackles or wrestles with another person, gets "patted down", or has some other direct contact with the skin of another person, staph can be passed from one person to another. This happens in any such situation where there is direct contact, not just in jails or prisons.

Staph are also spread by contact with items that have been used by people with staph on their skin, like towels, or athletic equipment shared in the gym or on the field.
Think about:

Whether you live in a prison or jail, or you work in one, think about items that are handled or shared from one person to the next without washing, like clothes, towels, handcuffs, or even weights and sports equipment. This direct contact and sharing can allow bacteria like MRSA and other staph to spread.

Lack of handwashing: Another condition that can lead to spread of MRSA and other staph is lack of handwashing. MRSA and other staph can be removed from your hands by washing with soap and water or by using a hand sanitizer. The best way to prevent skin infections, and many other infections, is to wash your hands frequently. Daily showering is helpful to remove bacteria from the skin. Wearing shower shoes can protect your feet from bacteria and fungi as well.

Think about:

Direct contact with other people and with shared equipment is very common. Think about ways to increase the number of times you wash your hands after direct contact with others or using shared equipment. Frequent handwashing can remove MRSA and other staph from your skin. Remember, you should wash your hands for 15 - 30 seconds to remove MRSA and other staph from your hands.
Cuts and scrapes: MRSA and other staph need to get into the skin before an infection occurs, often through a scrape, scratch, or wound. MRSA can also enter the body when non-sterile equipment is used in body piercing and tattooing. Take care of your skin (that is, avoid dry skin, avoid cuts and scrapes, and keep cuts and scrapes clean and covered) to help prevent a MRSA or other staph infection.

- **Think about:**

- When you have a wound, scrape or scratch, do you keep it clean, dry and covered, if possible? Do you avoid getting extremely dry, cracked skin? Do you see a healthcare provider or put in a request to be seen by medical if you have any cut or sore that is warm, painful, red or swollen? Do you engage in any practices that harm or puncture the skin - like "jailhouse" tattooing or skin cutting?

Dealing with infections: People with MRSA and other staph skin infections - especially boils or wounds that are swollen and have pus - can most easily spread staph to others. It is particularly important that the infected area be kept covered. Any bandages should be disposed of appropriately. Sharing personal items like towels should be avoided. Handwashing should be a high priority.

- **Think about:**

- Do inmates and officers recognize and take care of skin infections? Are skin infections kept covered? Are bandages disposed of appropriately? Are people with skin infections told how to care for their infection, so that bacteria are not spread to others? If antibiotic treatment is necessary, tests should be done to determine what is causing the infection and what antibiotic might work best.
Pimples, rashes, pus-filled boils, especially when warm, painful, red or swollen, can mean that you have a staph skin infection.

To summarize, frequent direct contact with the skin of others, lack of adequate handwashing, lack of attention to cuts, scrapes and skin care, and lack of proper care for skin infections may all contribute to the spread of MRSA and other staph in correctional facilities.
Remember: Request to see a healthcare provider if you have a skin infection. He or she will decide what treatment is necessary, if any.

The Five C's: Factors that Allow Staph to Spread

- Contact – frequent from skin to skin
- Contaminated surfaces and shared items
- Crowding
- Cuts and scrapes
- Cleanliness, lack of
What about my family and friends outside the prison or jail?

It is normal and reasonable to be concerned about spreading MRSA and other staph to family and friends outside the jail or prison. There are many ways to reduce the risk of spreading MRSA and other staph, starting with frequent handwashing. See additional prevention steps below. Keep in mind that many people, inside and outside correctional facilities, carry staph on their skin and do not have an infection. These people do not know that they are "colonized" with staph. In some places, such as hospitals and nursing homes, MRSA and other staph infections are relatively common. In other words, there are many ways that people are exposed to MRSA and other staph. If you are living in a corrections facility, or working in a corrections facility, it does not mean that your family and friends have a greater risk of getting MRSA and other staph infections from you.

How can MRSA be prevented and controlled in correctional facilities?

Unfortunately, MRSA is becoming more common across the United States, in every community. As with other infectious diseases, basic infection control practices, our best defenses, should be followed:
For inmates:

- Take care of your skin and any cuts or scratches. If you notice any lumps, bumps or lesions, never try to open them yourself. Always follow up with the healthcare staff for evaluation as soon as possible.
- Do not share personal items such as towels, razors, and toothbrushes.
- Cover damaged skin (cuts, scrapes and scratches) and draining wounds with bandages.
- Carefully dispose of bandages containing pus or blood.
- Shower regularly with soap and warm water (very hot water may dry the skin and make it more prone to cracks and other damage).
- Use a barrier (shirt and pants) between your skin and equipment that is shared with others, like exercise equipment in the gym.

For corrections officers:

- Encourage inmates to take regular showers with soap and warm water.
- Discourage sharing of personal items such as towels, razors, and toothbrushes.
- Be observant. Encourage inmates with skin lesions to follow up with the healthcare staff as soon as possible.
- Use personal protective equipment (PPE) whenever you expect to have contact with an inmate's blood or body fluids.
- Follow your agency's infection control policy.
Other ways to reduce transmission:

- Launder sheets, towels, uniforms, and underclothing with hot water and detergent and dry on the hottest setting or use a detergent which has the same effect.
- Wear gloves when handling dirty laundry.
- Regularly clean sinks, showers and toilets.
- Whenever possible, disinfect athletic equipment after each use.
- Use contact precautions (gown and gloves) for wound care.
- Cover draining wounds and damaged skin (sores, cuts, scratches and scrapes) with bandages.
- Carefully dispose of bandages containing pus or blood.
- Disinfect contaminated portable equipment, such as stethoscopes, blood-pressure cuffs, equipment handles, tourniquets, handcuffs, shackles, pagers, and cell phones.

MRSA can survive on objects and surfaces such as linen, sinks, floors, medical equipment, and all surfaces commonly touched by the hands of inmates, corrections officers, and healthcare providers. Appropriate application of surface disinfectants (see package labeling) is recommended for environmental cleaning when MRSA is a concern.
July 24, 2017

CalPERS Disability
P.O. Box 2796
Sacramento, CA 95812-2796

RE: Examinee: Hawpe, Julie Ann
Date of Injury: June 30, 2013
SSN: XXX-XX
ACCT#: 
Employer: California Department of Corrections

INDEPENDENT MEDICAL EXAMINATION

Dear Kayleigh Matisevich:

This is an INDEPENDENT MEDICAL EVALUATION performed in the County of Riverside at the office of HealthPointe located at 1171 Railroad St., Corona, CA 92882 on July 24, 2017.

PRESENT COMPLAINTS

1. Headaches; constant, dull, and sharp. The pain is better with pain medications and worse all the time.
2. Infection of MRSA, aspergillosis, and sinus problems.
3. Ear pain/sensitivity with hearing loss and tinnitus.
4. Pressure-like sensation in right ear.
5. Loss of balance and vertigo (falls and trips).

WORK HISTORY WITH CALIFORNIA DEPARTMENT OF CORRECTIONS

Ms. Hawpe worked as a Supervisor from 1993 until she retired.
Request for Required Information

THIS SHEET MUST BE THE TOP DOCUMENT
OF THE PACKAGE YOU SUBMIT TO CalPERS

CalPERS
Benefit Services Division
P.O. Box 2796
Sacramento, CA 95812-2796

RE: Julie Hawpe

DATE: June 14, 2017

SUBJECT: Additional Information Required to Process DR/IDR Application

We have received a Disability or Industrial Disability Retirement Application from the above named CalPERS member. However, for CalPERS to continue processing the member’s application, we need additional information. Please refer to the checked box below:

☐ Medical report(s) from treating physician (i.e., narrative, consultative, x-ray, MRI interpretive reports, etc.) - MEDICAL REPORT

☐ Detailed job description - JOB DESCRIPTION

☐ Information requested from employer - MISC EMPLOYER INFO

☐ Medical information from the worker’s compensation carrier - SCIF/WC MEDICAL INFO

☒ Medical report(s) from CalPERS Independent Medical Examination and/or Supplemental Independent Medical Examination reports - IME REPORT

☐ Job Assessment report(s) - JOB ASSESSMENT REPORT

☐ Other supporting document(s) - SUPPORTIVE DOC (DISABILITY)

Please fax all IME reports and correspondence to (916) 795-IMES (4637).

Thank you for your assistance.

[Handwritten notes: It wasn't necessary for CalPERS to request clarification. Doctor's report said 100% Disabled. Then clarification or liner changes the finding with no explanation why?]
RE: HAWPE, JULIE ANN
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OCCUPATIONAL REQUIREMENTS

The job description and the Physical Requirements of the Position/Occupational Title have been reviewed under the Record Review section of the report, including a discussion with Ms. Hawpe as to the job description after she read the enclosed "job analysis."

The most demanding part of her job is that she does have to work with/around inmates, supervise inmate and clerks, assist food manager with all areas within food service in ordering and providing inmate population with proper daily meals, and tracking expenditures and inventory. She constantly has to do repetitive hand work/motion. She frequently has to twist. She intermittently has to stand and walk. She occasionally has to drive, squat, kneel, crawl, push, pull, bend, climb, sit, reach; lift above shoulder, lift from waist to shoulder, and lift from floor to waist.

SUBSEQUENT EMPLOYMENT HISTORY

Ms. Hawpe denied any subsequent employment.

HISTORY OF THE PRESENT INJURY AS RELATED TO THE PATIENT

The patient is a 56-year-old white female, who went to work in the food services building, supervising inmates in California Department of Corrections. She was around inmates daily in a supervisory capacity. She was in a building that had no heating, temperature in the 40s, no hot water, no sink's soap/disinfectant in single bathrooms, and claims that the department was neglected, did not comply with mandated MRSA training, at least with regards to the department that she was in which she thinks was overlooked. This was in 2006, 3 years after hiring. During her first 3 years she had performed well and advanced in leadership roles often as supervisor of the section assigned. This was a requested assignment to where she had been in charge in 2004. Due to no heating in large cement building, temperatures were very cold in the winter, approximately 40-50 degrees all day, and states that everyone had a runny nose all the time and had to blow and wipe it frequently and what she thinks was shared contact with everyone's noses as a result of that exposure. During that time, she claims that she became very sick and she blames it on contracting MRSA, which was apparently treated by private physician without the diagnosis of MRSA. She was treated for 2 years by a doctor who never did any cultures. From 2004, she had at least four to five visits and more without cultures and finally in 2007, she developed greenish drainage and MRSA was diagnosed. Following which, she was on many different regimes of oral antibiotics, IM and IV antibiotics, and sinus surgeries since she had findings in her right maxillary sinus and others on the right side. She was operated twice by Dr. Finazzo who subsequently expired after both of these operations took place in 2010. Following those surgeries, she was on vancomycin which she did not tolerate well, but following the unsuccessful surgery she did go on a routine work for more than a year. She was on something every day, having four different PICC lines that were put in and allowed to stay in for three months. She lost weight and felt sick all the time from the medications. This led to more and more head pain due to sinus infections and having to take Norco 10 mg and usually as many as one or two to start and a total of five a day, 10 mg each dose. She started to have hearing loss and ringing in her ears and on the same time started to have dizzy spells on head position changing and positional vertigo. She had treatment with medications and since she was very nauseated with these attacks, the thing that helped her the most was the ondansetron or Zofran.
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Since the time of onset of the diagnosis of the MRSA in 2007, she has virtually had difficulty
working because of the multiple symptoms that I have described so far and also muscle spasms
and tightness in her legs and definite unsteadiness in her balance that made her uncertain of
everything which did result in her falling several times and having other injuries. She has been
told that from all the antibiotics that she has taken that her immunity has been compromised and
she would probably never fight off the infection completely, even though she has a remission in
the last 10 years, she complained that it is coming back according to the doctors that she has seen
and the doctors who have operated on her; namely Dr. Church, Dr. Burton, Dr. Howland, and Dr.
Finazzo. Dr. Younes is an infectious disease expert who followed her in the earlier days also.
Her most recent injury in January 2017 was a result of her hearing about her son being ready for
something and she spun around quickly to the point where she had positional vertigo and fell and
broke her “shoulder” which was actually her proximal humerus.

PAST MEDICAL HISTORY

Childhood illnesses
Childhood injuries
Adult illnesses
Surgery
Hospitalizations
Medications:
Allergies:

Usual
Denied
Noted above
Partial hysterectomy in December 2015 and sinus surgeries
The patient denies any other hospitalizations
Norco, Xanax, Wellbutrin, tobramycin, mupirocin, and
Zofran.

Levaquin
Vancomycin
BREC

SOCIAL HISTORY

The patient is married. She denies smoking and did not drink alcoholic beverages during the
years she worked actively

FAMILY HISTORY

There is a family history of cancer in mother and arthritis in sister.

SYSTEM REVIEW

Ms. Hawpe complains of joint pain, joint stiffness/swelling, weakness of muscles/joints, muscle
pain/cramps, back pain, cold extremities, difficulty in walking, glasses/contact lens, blurred/double vision, hearing loss/ringing, earaches, chronic sinus problems, nosebleeds, sore
throat/voice change, swollen glands in neck, bronchitis, chronic/frequent coughs, spitting up
blood, shortness of breath, sleep apnea, wheezing, anemia, swelling of extremities but not nuer
ankles, nausea/vomiting, constipation, rectal bleeding, blood in stool, abdominal pain, frequent
urination, varicose veins, hemorrhoids, lightheaded/dizzy, numbness/tingling sensations,
tremors, paralysis, migraines, headaches, excessive thirst/urination, heat/cold intolerance, skin
becoming dryer, bleeding/bruising tendency, enlarged glands, anxiety, depression, memory
loss/confusion, nervousness, insomnia, bad general health lately, recent weight change, fatigue,
skin cancer, chickenpox, measles, and mumps.
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My strain of MRSA is very rare and incurable along with being degenerative.

Except as noted under the history of present injury and past medical history, the system review is positive for everything and she elaborately filled out our question and answer pages with involvement in every system. And only 3 out of 40 symptoms as sequelae were left blank while she had all the other 37 symptoms.

PHYSICAL EXAMINATION

VITAL SIGNS

Height: 5'3"
Weight: 140 pounds

This is a right-hand dominant individual.

HEAD

Normocephalic. Some tenderness along her occiput, which was not tender on the day of our exam, but is the location of her commonly felt headache which sometimes is at its worst with photophobia and visual disturbance.

EYES:

She denied diplopia. Extraocular movements were intact with some nystagmoid jerks and extremes of gaze, both right and left.

EARS:

Both ears canals were clear and both tympanic membranes were intact. TTF indicated weber test in the midline and both Rinne tests were positive.

NOSE:

The examination of her nose with nasal speculum in light revealed membranes that were slightly moist and pale with 1+ hypertrophy bilaterally and I could see into the right maxillary sinus and through the inferior meatus where it appeared hollow and the coloring grayish base posterior wall.

THROAT:

Very wrong - never checked

Nasopharynx, hypopharynx, and larynx were within normal limits. Anterior neck displayed no adenopathy. Thyroid was non-nodular.

REVIEW OF RECORDS

I have reviewed approximately four inches of records and reports that were provided to me on July 24, 2017, with a request for an IME report within 15 days. The report consists of my answering multiple questions addressing topics and answering specific questions that were provided to me based on my history taking and my physical exam and my review of the multiple
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records mostly doctor's office records, op reports, and many expert reports.

Recommendations of Dr. Burton, Dr. Younes, and Dr. Finazzo were all gone over multiple times as they were reviewed by each of the people giving QME and IME type reports. A good record by Ernest C. Levister, Jr, ABS, CHE, MD, SCD, FACP, and FACPM and a second supplementary by Dr. Ernest Levister was gone over as well. A report by Dr. David Wood dated January 21, 2013, University of Spine and Orthopedics located at Colton. This was quite detailed and informative. Dr. Geoffrey, QME and separate hemodynamic studies by Dr. Ernest C Levister, Jr as well as records of Cynthia Thalk, M.D. on the same subject were reviewed evaluating her for effects of her hypertension condition specifically looking for HCVD which the studies concluded that she did not have as a problem and an echocardiogram with the same conclusion.

Review of x-rays reports suggested that there was more inflammation, more hypertrophy to the turbinates and the septal lining and described more what looked like rhinitis that I saw visibly. In my history taking, she attempted to emphasize the frontal maxillary headaches which she attributed to her chronic sinus condition and ringing in her ears that affected her balance and loss at times when she was more tired describing tuberculosis as well as fluctuation in her hearing secondary to her chronic rhinosinusitis.

DIAGNOSES

1) Methicillin-resistant Staphylococcus aureus colonization and infection.

2) Chronic Rhinosinusitis.

DISCUSSION AND CONCLUSION

Before I go on I know that I am to comment on and answer the questions that proposed, I would like to just make a statement with regards to causation asking weather the patient is a misfortunate victim.

1. Based on your objective findings, are there specific job duties that you feel the member is unable to perform because of a physical or mental condition? If so, please explain in detail for each disabling condition. (In order to answer this question, we have enclosed for your review the member's duty statement/job description and physical requirements of his/her current position.)

The patient Julie Hawpe was more or less pushed out of her positions by the people around here who didn't think she was helpful and could be replaced by someone better. Before leaving to be treated for MRSA in 2009 she was sure her supervisor disliked her and was turning in bad reports to her supervisor and the warden. Because she is aware of that she is not anxious to return to work. On our history forms she listed her complaints to include pain (moderate) in every part of her body but her ankle. Listed headaches as the worst pain and the only one she took medication for, taking Norco or Percocet as needed.
RE: HAWPE, JULIE ANN
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She calls herself stigmatized by her co-workers and listed physical handicaps such as unable to lift, reach, stretch, as a problem, with flexing, bending, pulling, coughing, standing, sneezing, carrying, sitting, driving, walking on uneven ground, stooping, squatting, lifting, extending, walking long distance, gripping, twisting, and fine manipulation as things she has difficulty doing. She was bothered by changes in the weather, temperature, and humidity. She must walk slowly and carefully when getting up specially changing head level since she had positional vertigo whenever her head was turned to the right and lifted forward. When asked whether she would be able to perform critical physical activities, she acclaims that she is fully capable given enough time and no problem especially doing an investigatory report. Her present condition is very normal appearing and presenting herself well groomed, but somewhat humiliated by having to have a boss that would talk about her badly to a colleague. Her diagnoses are MRSA and Chronic Rhinosinusitis. She can’t return to earlier days when lacking confidence because she feels impaired and unable to do as well as she used to. I recommend that you agree to her request, but keep in mind that she brought her hereditary allergic constitution to the Department for a job. The job did not change her and the job would not have bothered her if she were like most employees who had better health to start with. How many kinds of employees turned out like her? The same job done well by most people suggests that her constitution did not measure up to the job demands and she could not help that but neither could the correctional facility. The only valid criticism she has is: the conditions for the food handling section with only one bathroom with no heat and with a wet leaking ceiling and dampness all around and people with runny noses and wiping and a prison where there is an incidence of MRSA did not comply with what should have been required for the employees. One bathroom and no soap dispenser. The leaks and constant temperature in the 40's had effects on her allergic constitution that she brought to the workplace.

2. In your professional opinion is the member presently, substantially incapacitated for the performance of his/her duties? Please explain in detail.

I think she is substantially incapacitated because of the downward deterioration in her condition with a disease without a cure and treatment which requires degrading her immunity and obligates her to take Otoxic drugs (antibiotics effecting her hearing) and balance with some degree of vertigo, mostly positional but basically the only choice. I think she is unstable and anxious for free ride to some extent in return for what she is curtailed with. In her own words “I can do everything it just will take me longer.

a. If yes, on what date did the disability begin? Please refer to the attachment, section titled “MEDICAL QUALIFICATIONS FOR DISABILITY RETIREMENT”.

Her disability began when her fellow workers pointed her out as not doing her job and not being capable any more, and when she was demoted by her boss.
b.) If incapacitated, is the incapacity permanent or temporary? If temporary, will the incapacity last longer than 12 months? Please explain in detail.

I think the incapacitation is permanent and her desire to retire, stronger than any other desire. If forced to go back to work in some lesser demanding job, she might be capable of handling it, but would do it unhappily, clumsily and with further complications developing.

3. Is the member cooperating with the examination and putting forth their best effort, or do you feel there is exaggeration of complaints.

I believe she was exaggerating when she listed every part of her body except her ankle as a locus of pain and claimed that the pain was moderate as was every pain listed. I think she thinks she is being cooperative in supplying whatever she can that might help her request to be granted.

4. What part of the disability, if any, is due to non-industrial or pre-existing conditions? Please explain

One half of the cause is her hereditary childhood allergy that left her hypersensitive to things that the majority of us are unaffected by. Like most functional endoscopic sinus surgery patients underlying problem is allergy, which tends to become polypoid and obstructive when sinus membranes are involved interfering with adequate aeration of the sinus cavity. Everything that happened to her from 1995 on would not have happened if she did not have that allergic tendency. She would not have needed the surgery and she would not have gone on to have the problems that she did when she joined the food handling part of the job. I consider having the personal make up that she had was equally significant in her contracting MRSA and had she been normal in this regard beyond that she would have never gotten MRSA. The other half of the cause was the cold environment she was exposed to with runny noses and a temperature of 45 degrees and no heat and only one bathroom and the Department's possible non compliance. I realize that large scale maintenance requires almost continuous refrigeration of the food right up to its being cooked and I'm sure much of that coldness was necessary to prevent spoilage, waste and disease or food poisoning from spoiled food.

Causation is 50% to the environment provided and 50% the constitution that she brought with her. The worst part of getting MRSA for the patient was the fact that she had to take ototoxic drugs to get rid of it and it was resistant to so many other antibiotics. The ototoxic drugs induced tinnitus and neurosensory hearing loss and vertigo. All of which made her life much more complicated. The vertigo caused her to fall and injure herself which lead to her needing crystalloid repositioning exercises as therapy. Recently, on January 27, 2017, she fell again and broke her proximal arm; what she referred to as shoulder and did not have to be operated but had to wear a sling.
Request for Required Information

THIS SHEET MUST BE THE TOP DOCUMENT
OF THE PACKAGE YOU SUBMIT TO CalPERS

CalPERS
Benefit Services Division
P.O. Box 2796
Sacramento, CA 95812-2796

RE: Julie Hawpe

DATE:

SUBJECT: Additional Information Required to Process DR/IDR Application

We have received a Disability or Industrial Disability Retirement Application from the above named CalPERS member. However, for CalPERS to continue processing the member's application, we need additional information. Please refer to the checked box below:

☐ Medical report(s) from treating physician (i.e., narrative, consultative, x-ray, MRI interpretive reports, etc.) - MEDICALREPORT

☐ Detailed job description – JOB DESCRIPTION

☐ Information requested from employer – MISC EMPLOYER INFO

☐ Medical information from the worker's compensation carrier – SCIF/WC MEDICALINFO

☒ Medical report(s) from CalPERS Independent Medical Examination and/or Supplemental Independent Medical Examination reports – IME REPORT

☐ Job Assessment report(s) – JOB ASSESSMENT REPORT

☐ Other supporting document(s) – SUPPORTIVE DOC (DISABILITY)

Please fax all IME reports and correspondence to (916) 795-IMES (4637).

Thank you for your assistance.
August 16, 2017

CalPERS Disability
P.O. Box 2796
Sacramento, CA 95812-2796

RE: Examinee: Hawpe, Julie Ann
Date of Injury: June 30, 2013
Date of Birth: XXX-XX-
SSN: XXX-XX-
ACCT#: California Department of Corrections
Employer:

SUPPLEMENTAL REPORT

Dear: Mira Tonis

This is a supplemental report regarding letter dated August 11, 2017, received on August 11, 2017 in our office. I have been asked to clarify my opinion on the following questions listed below.

1. Based on your objective findings, are there specific job duties that you feel the member is unable to perform because of a physical or mental condition? If so, please explain in detail for each disabling condition. (In order to answer this question, we have enclosed for your review the member's duty statement/job description and physical requirements of his/her current position.)

The patient is able to perform all job duties that were listed on her current job description.

2. You list that the member is permanently incapacitated. Therefore, Please opine on what date her disability began. Please be specific.

To clarify, the patient feels that she is substantially incapacitated but based on her objective findings the patient is not incapacitated and therefore can perform her full job functions as listed.

HEALTHPOINTE LOCATIONS:
1717 E. Lincoln Ave. [Anaheim, CA 92805] [714] 955-3602 + 250.10th St., #132 [Garden Grove, CA 92841] [714] 254-4232 + 11721 Placentia Ave. [Corona, CA 92879] [858] 272-1401
7221 Orangeview Ave. #F [Garden Grove, CA 92841] [714] 929-3000 + 6296 Oak Knoll Ave. [Yorba Linda, CA 92887] 800-402-3311
1020 Valley View Ave. [La Mirada, CA 90638] [562] 941-0341 + 2501 N. Penmar Ave. #120 [Long Beach, CA 90803] [562] 926-0341
8230 La Timp Blvd. #317 [Las Angeles, CA 90045] [510] 213-4300 + 754 N. Marshall Ave. [Ontario, CA 91762] [805] 458-4156
2525 Medical Center Dr., #130 [Pomona, CA 92971] [323] 327-400 + 27443 Temple Ave. Suite A [Temecula, CA 92590] [909] 809-8258
www.healthpointe.net
5. Is the condition either caused, aggravated, or accelerated by his/her employment? Please explain. Would these complaints be present if the member had not been employed in this job?

What she did not mention was that when she had sinus problems and did have sinus surgery in 1995 using private insurance and off the record no mention of the procedure nor documentation was ever sent to the county. It was never mentioned in anything that she spoke about or wrote down. Could she have developed MRSA from the procedures and exams of the record or even leading up to the 1995 sinus surgery? I think it is possible to become a carrier and at any time later become infected in a surgical wound. She did see multiple doctors following multiple treatments with antibiotics and no cultures being taken until 2004, but some of her history is left out. Following that she went to Dr. Finazzo who was the first person to operate on her sinuses and who at the time of the surgeries on both sides, removed the content of the right maxillary antrum, which was full of disease probably not cultured pre-op and unclear whether cultured post-op including part of the right ethmoid and portion of the right sphenoid. Her condition then was treated when the first culture de facto was positive for MRSA and she was treated for the aspergillosis as well, which did not turn out to be a chronic ongoing problem existing until today, unlike the MRSA which the patient is convinced she will never get over and has been told by doctors that she will not recover from it. (For many patients it is incurable.)

A remission for four to six months for her is possible but eventually it will come back as she was told. This is based on the result of having had several sinus procedures by several different doctors with coinciding opinions along that same direction.

Two operations by Dr. Finazzo in 2011 where he operated both right and left sides the first time, and the second time concentrated on the right side only. There are possible documentations of the findings and procedures carried out by multiple people including Dr. John Finazzo, Dr. Richard Lures, and Dr. Jonas Cohr. Alludes to the surgery by Dr. Gebhardt in 1995. There is an allusion to it made by Dr. Lures in 2010. The patient had sinus problems, bad enough for surgery back in 1995. In that period in time that she blames for the onset of the MRSA positive cultures not done at that time.

Julie was continually writing and was not speaking very fast and within three sentences she wanted to get to the subject that she had contracted MRSA in 1995 and that it was because of several failures on the part of her employer who had her in a situation where the temperature was only 45 degrees and very moist. Everybody had a runny nose and was wiping nose and were close to other and had a lot of pain with food packages and doing so much exchange of and opportunity to transmit this MRSA if anybody in the group had it and many checked themselves. An interesting thing that she skipped over was the fact that in 1995, in her past medical history, she had a history of asthma as a child that she eventually grew out of. Had allergic tendencies that had persisted into adulthood and she did not mention the fact that she had sinus surgery as a PVT patient using her own insurance and going outside of the Workers Comp rulings. The next two years after having the sinus surgery, she began to have sinus trouble all over again and was seen by several doctors and had x-rays and reports from several radiologists that I reviewed. Supposedly, this attack of sinusitis in 1995 two years after joining the
Department of Corrections and being California as an Office Technician, she managed to come down with a condition bad enough to require surgery, which did not respond to medical treatment at once. Following the surgery, she did well and did not have recurrence of sinusitis for another almost two years and when she began to have treatment for this, she got only partial improvement and along the way, she had cultures which did not show MRSA at first and showed other pathogens which were treatable, but she has still stayed with one doctor to decided that she should stay on antibiotics for a whole year and she did that and at the end of the year she still had trouble with sinusitis and increasing pain in her sinuses. During that time, she was cared for by infectious disease expert Dr. Burton who this area and Dr. Burton stopped taking Workers Comp and referred her to an ENT surgeon recommending surgery because use of antibiotics had failed. She saw Dr. Finazzo, the ENT specialist. Managements consisted of saline nasal rinses and use of vancomycin, Furisol, mupirocin, Salinex, and mecclazine, and in the process of being cared for by ENT, she did have vertigo that was diagnosed and was confirmed on EMG, showing a right canal weakness and was examined by Dr. Finazzo who eventually was the first person to operate on her sinuses in 2011. She had another surgery unrelated, another medical problem that involved the throracic spine and ended up with a fusion with a cage that was visible on X-ray in 1999.

Prior to being diagnosed with MRSA, she was found to have aspergillosis which was blamed on the continuous use of antibiotics over the one year period, and from there, she was started with medical management taking Diflucon for it. And there was a need for thoracic spine fusion surgery performed by Dr. Church in 1999 on her back went well and she had no further problems with that. There was a period from 2001 to 2004 when no cultures were taken at all and during that period of time, the amount of symptomatology increased with more pain and after finding the black fungus aspergillosis, she went on VFEND which is one of the conazoles that is used for fungus and developed secondary illness from taking the VFEND which while it helped get rid of the fungus temporarily, it aggravated the vertigo and tinnitus and gave her worse balance problems. The balance problems lead to some physical injuries falling into a bathtub and striking her head and injuring her foot which required surgery for fractured metatarsal. The medication she took contributed to the vestibulopathy but the head injuries too, time and effect too, and she was followed by another doctor to who explained to her positional vertigo in terms of crystaloids being disturbed in the labyrinth of her inner ear and the need for resting, avoiding neck turning, and to avoid positional vertigo. She complained of ear pain and hearing loss in 2011 and tinnitus that increased in 2012 because she took ototoxic meds like tobramycin and vancomycin. She complained about injury to her rotator cuff in 2017, and she has not worked for the past six years but has had multiple cultures taken that were positive for MRSA.
RE: HAWPE, JULIE ANN  
July 24, 2017  
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These cultures along with cultures that were free of MRSA as well including films became more frequent in 2011 which is when Dr. Finazzo decided to operate. Pre-op films including films back from Palm Springs and surgery done by the hospital in 1995. Subsequent films showed that there was formation of opacification in the maxillary sinus and cells missing from the ethmoid area on the right side and a sphenoïdotomy accomplished. Dr. Finazzo’s report described a fairly normal nasal lining with ostomeatal complexes that appeared to be undisturbed. Persistent disease showed up postoperatively bringing her back to the OR approximately three months later.

In the past, the patient had tried to file a claim but the claims were turned down. During the time, she was under Dr. Barton’s care, he was able to write a letter which enabled the claim to be filed and accepted by Workers Comp. In the period of time after the surgery had been accomplished and irrigation and cleansing of the nose with saline was advised and the use of prescriptions for antibiotics continued, the aspergillosis completely cleared up and there were many cultures that were negative for MRSA which could either mean that the wrong area was swiped (swabbed) or that there actually was a complete disappearance (less likely) of MRSA from her system. At that point, she was labeled not contagious. Her problems became worse in terms of her balance and her strength and the amount of pain she had to put up with which all were disabling in terms of her returning to work after being off, starting in 2015. At this point, in her history giving, she seemed somewhat rattled about that and not wanting to ever go back to work, not being strong enough to do it, unable to handle it, and particularly upset that her fellow employees including one of her immediate bosses had stigmatized her and she had become labeled as unfit, not capable, and “contagious”, and was treated poorly by everybody leading up to the time when she finally took off from work.

The patient emphasized that she had been determined to have 42% whole person disability based on her bad back which had accounted for some time off in 2010.

Causation is 50% to the environment provided and 50% the constitution that she brought with her. There was part of getting MRSA for the patient was that she had to take ototoxic drugs to get rid of it and was resistant to so many other antibiotics. The ototoxic drugs induced tinnitus and neurosensory hearing loss and vertigo. All of which made her life much more complicated. The vertigo caused her to fall and injured herself which lead to her needing crystalloid repositioning exercises as therapy. Recently, on January 27, 2017, she fell again and broke her proximal arm and she referred to as shoulder and did not have to be operated but had to wear a sling.

6. Is the member mentally able to handle his/her own financial affairs and enter into legally binding contracts?

The patient seemed very anxious and was talking excessively. For an expert opinion however, I would defer to a qualified psychologist or psychiatrist.

7. Is the member competent to endorse checks with the realization of the nature and consequence of the act?

Long term illness has caused serious problems including depression never before.
RE: HAWPE, JULIE ANN
July 24, 2017
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My answer to the questions would be the same as noted above in #6. However, I would defer to a qualified psychologist or psychiatrist for an expert opinion in this matter.

The preparation for this, IME report, required 1 hour face-to-face visit with the patient and 6 hours of review of the provided charts and 1 hour of dictating.

Should you have any further questions concerning this patient, please do not hesitate to contact me.

SOURCE OF ALL FACTS AND DISCLOSURE
The source of all facts was the history given by the patient and review of the previous examiner's medical reports. I personally interviewed the patient, performed the physical examination, reviewed the history with the patient, reviewed the medical records provided, dictated this report and it reflects my professional observations, conclusions, and recommendations. I declare under penalty of perjury that the information contained in this report and its attachments, if any, are true and correct to the best of my knowledge and belief, except as to the information that I have indicated I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as notes herein, that I believe it to be true.

Date of Report July 24, 2017 Signed this 9th day of August, 2017 at
at Riverside, California.

Sincerely,

[Signature]

Pierre F. Giannamico, M.D.
Diplomate of American Board of Otolaryngology
License Number C31603

PFG: hzl/sts
Dear Dr. Giammanco,

Julie Hawpe was seen by you for an Independent Medical Examination (IME) on July 24, 2017. Clarification of the IME report is needed. I have attached our letter to you dated 07/14/17 for your reference listing questions 1 through 3. Your responses to question #1 and #2 are not listed in your IME report. You list her complaints of physical handicaps but we are specifically looking for job duties that she is unable to perform based on your medical record review, and objective findings. Based solely on the medical records review, your interview of the patient and objective findings, we are asking for specific job duties that the member was unable to perform since her last day on pay of 06/30/13. You also respond that her disability began “when her fellow workers pointed her out as not doing her job and not being capable anymore and when she was demoted by her boss”. However, we are specifically asking the actual date her disability began.

Please note that for determination purposes, we ask the IME specialist give his or her opinion of whether a member can return to full duty based on the review of medical records, and the interview and examination of the patient, not the member’s subjective findings.

In accordance with your IME Agreement, you are required to submit a report that clearly answers each of the specific disability questions in our initial appointment confirmation letter. If you do not provide a complete report, we may delay your payment or remove your name from the approved CalPERS' IME list of physicians.

At this time, please clarify your opinion to the following questions listed below. Your report must document and discuss the specific medical reports. Please clearly substantiate your opinion by providing detailed and complete explanations for your findings. If there are limitations, please quantify them: constant, frequent, occasional, etc.

1) Based on your objective findings, are there specific job duties that you feel the member is unable to perform because of a physical or mental condition? If so, please explain in detail for each disabling condition. Please refer to the member's job description and physical requirements form when listing the specific job duties that she is precluded from.
2) You list that the member is permanently incapacitated. Therefore, please opine on what date her disability began. Please be specific.

Please review this information and advise us of your final recommendations and conclusions by August 11, 2017.

You must attach the Request for Required Information sheet to the top of your report.

Our telephone number and address are listed at the top of this letter. Please fax all IME reports and correspondence to (916) 795-IMES (4637).

Thank you for your continued cooperation in this matter.

Sincerely,

Mira Tonis  
Retirement Program Specialist  
Disability Retirement Section  

Enclosure