

**ATTACHMENT A**

**THE PROPOSED DECISION**

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

In the Matter of the Application for Industrial  
Disability Retirement of

MAXIMILLIAN J. SEBOLINO,

Respondent,

and

CALIFORNIA DEPARTMENT OF  
CORRECTIONS AND REHABILITATION,  
SALINAS VALLEY STATE PRISON,

Respondent.

Case No. 2018-0611

OAH No. 2018090834

**PROPOSED DECISION**

Perry O. Johnson, Administrative Law Judge, State of California, Office of Administrative Hearings (OAH), heard this matter on April 10, 2019, in Monterey, California.

Senior Staff Attorney Rory J. Coffey represented Anthony Suine, Chief, Benefit Services Division, California Public Employees' Retirement System, State of California (CalPERS).

Attorney Brittany C. Jones of Martin and Vanegas, APC, represented Maximillian E. J. Sebolino (respondent). Respondent was present for the entire proceeding.

No appearance was made by or on behalf of respondent Salinas Valley State Prison (Salinas Valley Prison), California Department of Corrections and Rehabilitation (the department). Having established satisfactory service upon the department of the Notice of Hearing, the matter proceeded against Salinas Valley Prison and the department as a default hearing pursuant to Government Code section 11520.

Following conclusion of the presentation of evidence at the hearing, the record was held open to afford the parties opportunities to file with OAH, and to serve upon the opposing party, written closing arguments, and for respondent to file a digital image of the

PUBLIC EMPLOYEES RETIREMENT SYSTEM

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*July 18 2019*  
*[Signature]*

therapeutic instrument used by respondent. On April 12, 2019, OAH received four photographic images depicting both a plastic, 14-inch long "Thera-Cane" device and respondent holding the device, which were collectively numbered as exhibit "B". On April 29, 2019, OAH received "Respondent Maximillian Sebolino's Closing Brief," which was marked as exhibit "C." On May 15, 2019, OAH received from CalPERS's counsel "Memorandum of Points and Authorities in Support of CalPERS' Determination," which was marked as exhibit "19." Because of CalPERS's seemingly inadequate arguments, which did not address respondent's arguments that an error on the part of the administrative law judge occurred at the hearing regarding CalPERS's motion during the proceeding to exclude portions of respondent's psychiatric expert witness's report, an Order was issued to reopen the record for the parties to file supplemental written arguments. On May 31, 2019, complainant filed a "Supplemental Post-Hearing Brief," which was marked as exhibit "20." On June 3, 2019, respondent filed an unredacted version of the report by his expert witness (LeKisha Alesii, Ph.D.), which contained excerpts from the report of a psychiatrist (Joel Scheinbaum, M.D.), who was unwilling or unable to comply with complainant's notice to appear at the hearing to undergo cross-examination. So as to assure completeness of the record for this controversy, respondent was given 10 working days from the date of the filing of complainant's Supplemental Post-Hearing Brief to file with OAH a reply brief; and, on June 13, 2019, respondent filed with OAH a reply to complainant's final written argument, which was marked as exhibit "D."

On June 13, 2019, the parties were deemed to have submitted the matter for decision, and the record was closed.

## ISSUE

At the time of the filing with CalPERS of his application for industrial disability retirement, was respondent permanently disabled or incapacitated for the performance of the usual and customary duties of a medical technical assistant at the Salinas Valley State Prison Psychiatric Program treatment facility due to claimed injuries purportedly adversely impacting both his psychiatric well being as well as his cervical spine (neck) health?

## CASE SUMMARY

Respondent has a civil service classification as a medical technical assistant-psychiatric with the department that makes him a safety member of CalPERS. On April 6, 2015, within a place near the psychiatric clinic at Salinas Valley State Prison, an inmate-patient became agitated so as to aggressively attack another health care professional and then turned to twice punch respondent's head. Numerous medical records were introduced at the hearing, including CalPERS calling both a psychiatrist and an orthopedic surgeon to respectively render expert witness testimony, and through its legal counsel CalPERS cross-examined respondent's sole expert witness, an out-of-state psychologist. Also, CalPERS caused an investigator to provide testimony and to establish the foundation for introduction

of a sub-rosa video recording of respondent's activities in public places over a course of six distinct days during October 2017. Contrary to respondent's contentions, the weight of competent medical evidence, coupled with the sub-rosa video film depicting respondent's activities of him engaging in extensive, independent functions, demonstrated that respondent is not permanently incapacitated for the performance of the usual and customary duties of a medical technical assistant-psychiatric with the department. CalPERS's preliminary determination was correct and justified in deciding to deny respondent's application for industrial disability retirement.

## FACTUAL FINDINGS

### *Preliminary Matters*

1. Beginning in approximately August 2010, the department employed respondent as a medical technical assistant-psychiatric at the Salinas Valley Prison. By reason of his employment, respondent is a state safety member of CalPERS.

2. On approximately August 10, 2017, CalPERS received respondent's application for industrial disability retirement. In the application's "Disability Information" section, respondent identified his disabilities as "[n]eck) [c]ervicalgia myalgia facet syndrome of the cervical spine and cervical disc disorder [and], (Psychological stress) Posttraumatic Stress Disorder." Respondent stated, under penalty of perjury, that the date for the onset of the disorders was April 6, 2015.

The application advances that respondent was injured while escorting a prison inmate to a treatment room when the individual violently assaulted another medical technical assistant and then punched respondent twice, once upon the face and against his forehead. Respondent was neither rendered unconscious nor deemed to be in urgent, emergency medical care by reason of the two blows inflicted by the prison inmate.

Respondent's application identified Anuradha Reddy, M.D., of Salinas, California, as his primary treating physician. Also, the application for disability retirement listed Martha Corona, Ph.D., as the provider of mental health in treating his "psychological stress."

Respondent set out in the August 2017 application for disability retirement that the limitations or preclusions due to his injuries or illnesses consisted of "no prolonged sitting, standing, or walking, raising arms above the shoulder level and heavy lifting." (Respondent's application failed to state the nature of the limitations or preclusions caused him by reason of a purported psychiatric injury.)

Respondent's application further claimed that the injuries or illnesses precluding his ability to perform his civil service job were "due to [his] psychological and physical conditions, as well as [his] physicians (sic) restrictions [so that he was] no longer able to perform the essential functions of [his] job."

The August 2017 application reflected respondent's response of "no" to the question as to whether he was currently "working in any capacity (full-time, or part-time)."

Under the application's section that asks for "other information," under the document's section three, respondent wrote, "to date surgery has not been conducted due to [his] neck injury; however, [he had] undergone two (2) epidural injections and a medial branch block injection. Furthermore surgery has been discussed but is not a good option due to [his] age. As a result of [his] neck and stress injuries, [he had] been advised that [he is] no longer fit to perform [his] usual and customary duties with the DSH or CDCR."

And, on the application, respondent indicated "no" to the inquiry as to whether a "third person" caused his injury.

3. At the time of the application for industrial disability retirement, respondent was approximately 31 years of age.

4. By a letter, dated March 13, 2018, CalPERS informed respondent that his application for industrial disability retirement had been denied because neither his claimed orthopedic (neck) condition nor his claimed psychological condition was disabling. Accordingly, CalPERS had determined respondent not to be substantially incapacitated for the performance of his usual and customary job duties as a medical technical assistant (psychiatric) with the department's Salinas Valley Prison Psychiatric Inpatient Program.

5. By a letter, dated April 11, 2018, through his attorneys, respondent filed with CalPERS an appeal contesting the proposed agency action determining respondent was not entitled to industrial disability retirement. Accordingly, respondent demanded an administrative adjudication proceeding to contest the determination by CalPERS. On April 10, 2019, the hearing for this matter ensued.

#### *Procedural Issue*

6. At the hearing to this matter, CalPERS made a motion, which was granted, to exclude from consideration as evidence any mention of the findings, determinations, or opinions of Joel Scheinbaum, M.D., a psychiatrist and Qualified Medical Evaluator (QME) from respondent's workers' compensation claim. The CalPERS motion was made on the ground that respondent had failed to disclose to CalPERS, or to produce the report by Dr. Scheinbaum in a timely manner before the hearing date. At the hearing, CalPERS had compellingly argued that respondent's failure to identify the QME's report had deprived its psychiatric expert the opportunity to review the report of Dr. Scheinbaum, and to comment upon that psychiatric report. Because of respondent's post-hearing argument in his Closing Brief that suggested ethical practices by CalPERS to thwart the adjudicative process, an order issued to reopen the record so that the parties might clarify the matter. Through its Supplemental Post-Hearing Brief, CalPERS demonstrated that respondent had grievously erred in his failure to timely serve upon CalPERS the report by Dr. Scheinbaum so that the

proper remedy had been to redact all references to that report in the document crafted by respondent's expert witness, Dr. Alesii. Hence, disposition of this matter is not based in any manner upon the findings, conclusions, or diagnoses made by Joel Scheinbaum, M.D. The order, as rendered at the April 10, 2019, hearing, which excluded consideration in the adjudicative process of any aspect of Dr. Scheinbaum's report, is affirmed.

*Employment History and Background*

7. Respondent is the seventh of nine children. He immigrated to the United States from the Philippines when he was an adolescent male.

8. Respondent attended high school in Monterey County and he graduated from Hartnell College in Salinas with a degree in nursing. Thereafter, he worked as a server at Monterey Plaza Hospital from 2004 to mid-2009. From July 2009 until late 2010, Pacific Coast Care Center employed respondent in the capacity of a registered nurse.

9. In approximately August 2010, the department hired respondent as a medical technical assistant for the psychiatric inpatient program at the state prison in Monterey County. Over the course of working as a medical technical assistant, respondent provided health care services to psychiatric patient-inmates incarcerated at Salinas Valley State Prison

*Predominant Aspects of the Duties, Functions, and Responsibilities of Respondent's Civil Service Position.*

10. As a medical technical assistant-psychiatric, respondent was tasked with providing a basic level of general behavioral psychiatric nursing care to inmate-patients, who had been diagnosed with various mental disorders. Respondent participated in the overall psychiatric treatment programs for inmate-patients. Also, respondent was tasked with maintaining order and supervision of inmate-patients. And, a medical technical assistant is required to maintain the safety of persons and property within the correctional facility.

Under current department policy, a medical technical assistant is expected to devote 40 percent of his time by observing inmate-patient behaviors both as to physical and psychiatric conditions, including self-injurious or suicidal acts and assaultive behaviors. The civil service position required the provision of first aid or medical psychiatric interventions in all situations. A medical technical assistant is anticipated to offer assistance to all inmate-patients as necessary after an incident, which may include assault or suicide.

The essential functions contemplate that a medical technical assistant is expected to expend approximately 30 percent of such civil servant's time conducting routine and random clothed and unclothed body searches, cell searches, contraband control and emergency cell entries using "Therapeutic Strategies and Intervention" techniques. The worker is to apply mechanical restraints to inmate-patients as needed. The employee is to escort inmate-patients to consultation visits, hearings, and other appointments. The worker is expected to respond to alarms and emergencies as well as other requests for assistance by any other

Salinas Valley Prison unit. The medical technical assistant is required to supervise and serve meals, to supervise inmate-patients situated on patios outside the clinic area, and to oversee off-unit groups activities as may be assigned to the employee.

Approximately 25 percent of the functions of a medical technical assistant entail assisting, supervising, and providing inmate-patient education to ensure that activities of daily living (eating, clothing, bathing, grooming, toileting, and preserving personal living space) are maintained. The employee must obtain reports from outgoing shifts regarding inmate-patients' conditions and needs especially with regard to safety and nursing care. A medical technical assistant must attend morning report and shift change report sessions. When assigned, the employee must provide one-to-one supervision to inmate-patients. The work requires the provision of nursing care to inmate-patients in seclusion and restraints so as to ensure the safety, hygiene, comfort, nutrition, hydration, elimination, privacy, and dignity of the incarcerated individual. The employee must conduct fifteen minute nursing rounds to observe inmate-patients in order to pay particular close attention to any inmate-patients in five-point restraints in order to identify any need for special attention. The medical technical assistant must identify behaviors or acts that may result in patient injury or destruction of property. Also, a medical technical assistant is to document and inform the supervising registered nurse of observations of inmate-patients who may need immediate attention or assessment. And, the employee is to monitor inmate-patients for pain and to assist the individual with pain management.

Five percent of the functions of a medical technical assistant require the civil service employee to keep current with completion of all required training.

*Respondent's Contentions regarding Onset of Claimed Disabling Psychiatric Disorder*

11. Over his approximate six-year-long career of actually working in his civil service position with the department, respondent claims to have been battered on three occasions by prison inmates. The first two incidents caused respondent no significant injury resulting in the loss of substantial time off work due to illness or injury.

The third, and final, workplace incident, regarding a physical battery upon respondent, occurred on April 6, 2015. On that date, an inmate-patient, who was being escorted to a treatment room for a blood draw and another medical procedure, assaulted and battered respondent by punching respondent's cheek and forehead. Respondent was not rendered unconscious after being twice hit in the head (left cheek and left forehead) as he was able to activate an alarm and to fend off further attacks by the inmate-patient by the time correctional officers rushed into the area to subdue the inmate-patient. After the incident, department personnel transported respondent to the WorkWell Medical Group, where Anuradha "Anu" Reddy, M.D., became respondent's treating physician for purported neck discomfort and bilateral shoulder pains. On the day of initial treatment with the Work Well Medical Group, the single objective sign of any physical injury to respondent was noted as a "contusion of the face."

In time, Marta Corona, Ph.D., provided respondent with a psychological evaluation and treatment services relating to an adjustment disorder, anxiety, and depression.

After the April 2015 incident, the department took respondent off work. He did not return to work until October 6, 2015, at which time he was given a reduced work-week of three days per week based on the medical profile prescribed by his treating orthopedist. Because, department policy limits the time that an employee can use modified or restricted duty status, on approximately January 6, 2016, because the department could not extend to him further “reasonable accommodations,” respondent was separated from his civil service position. (No competent, corroborating evidence exists to show that during the period of October 2015 to January 6, 2016, respondent was engaged in activities other than the performance of the usual duties of a medical technical assistant. Even though he chose to work three days per week, no evidence indicates that respondent was unable to perform the substantial range of duties, functions, and responsibilities of a medical technical assistant-psychiatric.)

*Treating Doctors' Findings and Determinations regarding the Orthopedic Ailments and Psychiatric Complaints*

12. On the date of the injury (April 6, 2015) affecting respondent, medical care professionals at the WorkWell Medical Group diagnosed respondent with a “contusion [upon the] face.” The medical professionals prescribed “restricted duty” for respondent. Respondent remained off work for six months as to be returned to a restricted work schedule in October 2015.

A cervical spine X-ray on August 27, 2015, led Michael Bass, M.D., to note “*normal cervical spine.*” Because of respondent’s continuing complaints, a Magnetic Resonance Imaging (MRI) scan of the cervical spine, as interpreted by Dr. Bass, revealed “*slight kyphotic<sup>1</sup> deformity centered at C3-4 disc level. There is degenerative disc with some posterior annular bulging . . . Slight bulging of the desiccated C4-5 disc. No HNP [Herniation of the nucleus pulposus] or [no] stenosis [narrowing of anatomical space]. Normal cervical spine otherwise.*” (Emphasis added.)

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<sup>1</sup> “Kyphotic deformity” is a deformity of the spine of the upper back causing an exaggerated outward curve. Age-related kyphosis is often due to weakness in the spinal bones that causes them to compress or crack. Other types of kyphosis can appear in infants or teens due to malformation of the spine or wedging of the spinal bones over time. (www.mayoclinic.org.) (In the instance of respondent, who was 31 years of age on onset of the claimed neck disorder, a reasonable inference may be drawn that respondent’s neck malady is due to a congenital abnormality, rather than having been caused by an industrial, workplace injury affecting the cervical spine.)

Due to his claims of experiencing continuing neck discomfort, on March 18, 2016, respondent underwent a left C3-4 cervical epidural steroid infusion epidurography injection.

In 2015, treating doctors rendered a diagnosis of “acute stress reaction, sprain of ligaments of cervical spine, and contusion [to the] face-resolved.” By June 1, 2016, Marta E. Corona, Ph.D., a psychologist, concurred with a diagnosis of “acute stress disorder.”

On June 2, 2016, Gary Chang, M.D., a pain management specialist, recorded respondent’s complaint of experiencing pain reaching a level of eight out of a maximum level of 10 in intensity. The claimed significant pain was primarily located in the mid neck, “sometimes radiating into the jaw, shoulders, and mid back.” The physician noted a C3-4 cervical disc protrusion and determined the condition to reflect C3-4 facet syndrome. The pain management doctor recommended respondent to pursue psychological sessions.

On August 5, 2016, Dr. Chang administered to respondent a left C2-C3 interlaminar cervical epidural steroid injection.

On August 9, 2016, Dr. Reddy found that after respondent received the epidural steroid injection, respondent was “60 [percent] of normal.”

On August 7, 2016, psychologist Dr. Corona determined respondent’s mental condition to reflect “adjustment disorder, anxiety, depression, acute stress disorder, *in full remission*.” (Emphasis added.)

Approximately one week after the psychologist had determined the stress disorder to be in “full remission,” respondent on August 25, 2016, reported to medical providers at WorkWell Medical Group that he felt “pain, tightness in the neck and upper back [with] headaches, dizziness, tingling, numbness, and bilateral jaw area pain.” Hence, he was continued on restricted duties

In mid-September 2016, Dr. Chang opined that respondent had a sprain of the ligament of the cervical spine along with acute stress disorder. Dr. Chang recommended a “functional restoration program evaluation.” Respondent “failed” the interventional procedures so that a plan was created for him to undergo “chronic pain management.”

On January 6, 2017, Nader Achachzad, M.D., a Physical Medicine and Rehabilitation specialist, performed a Qualified Medical Evaluation of respondent. That medical doctor made a diagnosis of “cervical degenerative disc disease; cervical radiculitis versus radiculopathy; cervicogenic headache; and, acute stress disorder.”

On February 24, 2017, Gerald Wahl, M.D., issued a report noting that respondent’s “pain actually appears more mechanical<sup>2</sup> in type . . . . [Respondent] does appear

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<sup>2</sup> “Mechanical pain” is “a general term that refers to any type of back/spine-related pain complaint that is caused by placing abnormal stress and strain on muscles of the

neurologically stable . . . .” The neurologist wrote that he did “not perform nerve conduction” testing as that inquiry would not affect the neurologist’s assessment that respondent had an emotionally-grounded or psychological condition.

On March 2, 2017, Dr. Reddy noted that no need existed for followup with a pain management physician.

In March 2017, Dr. Corona rendered an assessment of respondent for “adjustment disorder with mixed anxiety and depressed mood.”

Joel Scheinbaum, M.D., authored a Qualified Medical Evaluation report on August 2, 2017, that found respondent to be afflicted with “posttraumatic stress disorder, chronic, severe.” Following Dr. Scheinbaum’s QME assessment, Dr. Corona altered her diagnosis to render respondent as being afflicted with PTSD.

On August 9, 2017, RehabOne health care providers determined respondent to have moderate anxiety. As to orthopedic impairment, he was assessed as of July 5, 2017, to have the ability to “lift very heavy [objects] up to 55 pounds.” And, he could sit, stand, walk and drive for 60 minutes.

On October 18, 2017, the last known report on disability by Dr. Reddy opined that respondent was impacted by “acute stress reaction” reflecting “moderate depression.” From an orthopedic standpoint, Dr. Reddy expressed a conclusion that respondent had a “sprain of ligaments of the cervical spine” with “mild paracervical spasm” with respondent exhibiting movements suggestive of “constantly adjusting [his] neck.” The orthopedist, however, noted that any incapacity “would *not* be permanent.” (Emphasis added.)

#### *Respondent’s Psychological Expert Witness*

13. LeKisha Alesii, Ph.D., (Dr. Alesii) offered expert witness testimony at the hearing on behalf of respondent. Dr. Alesii, a licensed psychologist, operates and owns the Center of Health and Emotional Wellness, PLLC, of Durham, North Carolina. She is part of a directory of mental care evaluators associated with the American Medical Experts Company, which enabled respondent to procure her expert witness services.

14. Approximately three weeks before the hearing in this matter on March 7, 2019, Dr. Alesii interviewed respondent via a computer-driven “webcam” HIPAA-compliant encrypted Internet portal. Through that computer arrangement, Dr. Alesii remained in her office in North Carolina, while respondent sat at a home computer situated within his residence at Salinas, California. The evaluating psychologist did not meet respondent for a face-to-face discussion until the day of the hearing in this matter.

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vertebral column. Typically, mechanical pain results from bad habits, such as poor posture, poorly-designed seating, and incorrect bending and lifting motions.” ([www.spine-health.com/glossary](http://www.spine-health.com/glossary).)

15. As a result of her one-hour-long webcam interview-grounded psychological evaluation, her review of both the treatment records of Dr. Marta Corona and the written report by an evaluating psychiatrist for respondent's workers' compensation claim, Dr. Alesii wrote a seven-page report.

The report's conclusions, and Dr. Alesii's responses to CalPERS's questions on cross-examination of that psychologist, are neither reliable nor substantial evidence in resolving the question of whether respondent is substantially incapacitated for the performance of the duties of a medical technical assistant for psychiatric inmate patients with the department.

16. Notwithstanding her learned, well-articulated and consistent testimony at the hearing of this matter, Dr. Alesii was not persuasive on the ultimate issue of whether respondent was permanently incapacitated for the performance of his civil service position as of the date of filing the subject application for industrial disability retirement.

Dr. Alesii was not persuasive when she opined that respondent has been rendered incapacitated for the performance of his usual and customary duties as a medical technical assistant-psychiatric due to posttraumatic stress disorder, or any other disabling psychiatric illness, that prevents him from functioning in the substantial range of duties, functions, and responsibilities of the civil service position held by him with the department.

17. The import of the opinions made by Dr. Alesii were undermined by the nature of the evaluation which was conducted through a computer webcam screen. In the considered view of the CalPERS psychiatric expert witness (Dr. Lopez) an evaluation is greatly diminished in its integrity where a mental health evaluator does not conduct a face-to-face, personal meeting with the patient/examinee.

Dr. Alesii was not believed when she expressed that the opinion of Dr. Lopez on the ultimate question of respondent's psychiatric condition was inaccurate or not well founded. In Dr. Alesii's flawed view the inaccuracy by the CalPERS evaluating psychiatrist was due to the agency's psychiatrist having seen respondent on a "good day," or that the CalPERS's evaluator's examination was flawed because of a supposed "snap-shot in time" meeting when respondent was not greatly impacted by PTSD symptoms. Respondent's evaluating psychologist was not compelling in explaining that Dr. Lopez may have seen respondent when the applicant for disability retirement had avoided situations, places, or thoughts associated with the traumatic event relating to posttraumatic stress disorder. Dr. Alesii's observations regarding Dr. Lopez were not persuasive or reliable.

18. Dr. Alesii was not persuasive when she opined that should respondent return to work for the department as a medical technical assistant for psychiatric patient-inmates that within a reasonable medical certainty respondent would be gravely impacted. Her opinion is not credible.

*CalPERS's Medical Evaluator as to the Claimed Psychiatric Disorder – Alberto G. Lopez, M.D.*

19. The most convincing evidence that respondent is not impaired on a mental health basis by a permanent disability for the performance of the duties, functions and responsibilities is found in the thorough, reasonable, and logical report by Dr. Alberto G. Lopez, M.D., M.P.H.

For approximately 33 years, Dr. Lopez has been designated as a board certified specialist by the American Board of Psychiatry and Neurology. In June 1980, he completed a medical and psychiatric internship at the University of California, San Francisco Medical Center. And, he was awarded a medical doctor's degree in June 1979 from Stanford University School of Medicine. From August 1986 to the present time, Dr. Lopez has been an Assistant Clinical Professor at the University of California at San Francisco, School of Medicine, Department of Psychiatry. Dr. Lopez has given more than 30 formal presentations and several written learned articles on psychiatric conditions, including post-traumatic stress disorder over the past four decades.

20. On January 25, 2018, Dr. Lopez prepared a 12-page Independent Medical Examination report pertaining to respondent. That report was based on: Dr. Lopez's face-to-face interview of respondent, the psychiatrist's administration of psychological tests, and the evaluator's review of a set of treatment records and documents made available to him. At the time of the evaluation by Dr. Lopez, respondent was 32 years old.

The January 2018 report by Dr. Lopez is credible, persuasive, and compelling in aiding in the resolution of the paramount issue involved in this case regarding respondent's claimed psychiatric malady.

Dr. Lopez has participated in treatment and evaluation of numerous persons with a diagnosis of Posttraumatic Stress Disorder. The independent evaluating psychiatrist found that respondent failed to present himself as coming within the established criteria of the DSM-5 to currently be determined to be afflicted with Posttraumatic Stress Disorder. Contrary to respondent's PTSD claimed ailment, Dr. Lopez did not make findings that respondent was impacted by: a startle response; a degree and frequency of nightmares expected of a person with the disorder; intrusive memories of claimed traumatic event on a frequent basis expected of a person with the disorder; an "avoidance" propensity of the typical sufferer; a sense of foreshortened future as exhibited by persons with the subject mental malady; or, an emotional numbing disposition, where those criteria resulted in the individual being unable to function in a wide spectrum of ordinary daily living.

Dr. Lopez showed through his well-reasoned opinion, which was expanded upon and rendered even clearer with his hearing testimony on April 10, 2019, that respondent was not incapacitated for the performance of the duties of a medical technical assistant for the department's psychiatric inpatient program at the subject state prison. The psychiatrist's vivid testimony arose from the following critical findings of:

- Through a battery of psychological tests, including the Minnesota Multiphasic Inventory-2 (MMPI-2), respondent gave responses “in a very inconsistent manner.” Respondent’s false or inexact answers rendered “not valid” the psychological testing results.
- Respondent has a very large family living in the greater area from Seaside, Salinas, Soledad, and Marina in Monterey County. As of the date of Dr. Lopez’s evaluation, respondent had been married for two and one-half years and had a 19-month-old son. (Since Dr. Lopez’s examination of respondent, he had fathered a second child.) The psychiatrist found respondent maintained a social life with his large, extended family.
- In early 2018, respondent was attending college courses with a goal of obtaining a bachelor’s degree.
- In January 2018, respondent sparingly interacted with treating psychologist Marta Corona, Ph.D., as he then saw the treating psychologist approximately every two months. At the time of the evaluation by Dr. Lopez, respondent was not receiving any psychiatric treatment from a medical doctor/psychiatrist, and respondent had no prescription for depression or anxiety medication, although in the past he was treated initially with Ativan and then Cymbalta.

The independent evaluating psychiatrist did not focus blindly on respondent’s self-reported symptoms (which even at the April 2019 hearing respondent’s account came across as being well-rehearsed and robotic); but, rather Dr. Lopez gathered and assessed evidence regarding respondent’s demonstrated abilities or inability to “function.” At the time of the evaluation in January 2018, respondent was not impacted by clinical depression. Although respondent had “some level of anxiety present,” that condition impacted him “only occasionally, perhaps one time per week.” Any nightmares by respondent had “resolved and stopped.” Respondent “no longer has intrusive recollections” of a claimed traumatic event. His appetite for dining was intact. Also, he slept approximately six hours per night with some sleep interruption. And, respondent’s “sexual libido and functioning [was] normal.”

On the question of respondent’s ability to perform the usual and customary duties of a medical technical assistant for psychiatric patients in late 2015, Dr. Lopez wrote: “[u]pon his return to work, [respondent] was able to function, although he was self-conscious about his movements . . . . [H]e was able to continue to do his work, including patting down inmates . . . .”

At the hearing of this matter, the psychiatrist instructed the record for this matter that PTSD is an anxiety disorder of a profoundly debilitating nature so that on that basis alone, respondent is excluded from coming within a current, valid diagnosis of the malady. During the evaluation, Dr. Lopez found that respondent did not appear to be either anxious or depressed. His “form of thought” was intact and his speech was clear and normally paced.

Cognitively, respondent was “intact.” And, respondent denied having “any psychotic symptomatologies.”

During the course of the psychiatric evaluation in January 2018, respondent’s appearance was noteworthy in that he continuously used a “Thera Cane” to apparently rub the back of his neck and upper back. And, in an “almost continuous” fashion, respondent engaged in “wringing” his neck and both shoulders. (Respondent told Dr. Lopez that the rapid movement of his neck in rapid, circular motions supposedly gave him relief from neck pain, which he reported to be at level “eight” on a scale of one to 10, with “10” as absolutely grave pain requiring hospitalization.

Dr. Lopez determined diagnoses for respondent of psychiatric natures as:

- Post-Traumatic Stress Disorder, *nearly resolved*.
- Psychological Factors Affecting Medical Condition.

Because of respondent’s abnormal movements of his neck, Dr. Lopez did not consider respondent to have been consciously feigning an ailment as the psychiatric evaluator observed respondent’s unusual movements while he sat through the psychological testing and rested in a waiting room. Hence, Dr. Lopez assessed a diagnosis of “psychological factors affecting medical condition.” (Dr. Lopez noted that an evaluating orthopedist (Donald Pompan, M.D.) found no objective, physiological basis for respondent’s neck movement as a result of a physical examination.)

Dr. Lopez rendered a summary of his observations of a sub-rosa set of video films of respondent over six distinct days over the period of October 10, 2017, through October 20, 2017. Dr. Lopez noted the respondent was seen freely making use of his upper extremities, and that he exhibited no repetitive wringing of the neck, and respondent used the orthopedic-oriented cane in only one video scene when he was merely carrying the plastic device.

In concluding his report, Dr. Lopez persuasively proclaimed “. . . there are no job duties that [respondent] is not able to perform . . . . [H]e was able to do so until he was taken off work because limited hours of duty were not available to him. [Respondent] was anxious and guarded, but he was able to do the job. Moreover, since that [the] time . . . he stopped working he has actually been improving. He has minimal residual symptoms only at this time . . . .”

Dr. Lopez answered “no” to the question, “in your professional opinion, is [respondent] presently, substantially incapacitated for the performance of his . . . duties?”

*Findings, Determinations, and Opinions by CalPERS's Medical Expert regarding Respondent's Orthopedic Condition (Cervical Vertebrae Spine Strain, Bilateral Upper Back/Trapezius Muscle Pain) - Donald C. Pompan, M.D.*

21. Donald C. Pompan, M.D., participated in the hearing of this matter as CalPERS's medical expert witness regarding the claims of respondent's orthopedic ailments affecting the neck, upper back and shoulder regions.

Dr. Pompan is an orthopedic surgeon with offices in Salinas, California. He earned a medical doctor degree in 1987 from the University of California, Irvine. Dr. Pompan pursued residency training at Harbor-UCLA Medical Center over the period of 1988 through 1992. He gained certification as a specialist in October 1996 from the American Board of Orthopedic Surgery. Dr. Pompan has written several articles and given multiple presentations on topics pertaining to orthopedic-type injuries, treatment and rehabilitation for muscle skeletal ailments or maladies.

22. On January 10, 2018, at the request of CalPERS, Dr. Pompan wrote a comprehensive evaluation report that focused on respondent's claimed chronic pain "across the pain [which] . . . migrates into the upper back and shoulders" and where the left shoulder pain "migrates to the left elbow, and then into the left hand, involving the ring and long fingers." Dr. Pompan based his report on the orthopedic surgeon's interaction during a single face-to-face meeting with respondent as well as on the medical doctor's review of extensive medical treatment records as well as a sub-rosa video filming of respondent.

At the time of his evaluation of the subject applicant for industrial disability retirement, respondent was 32 years old.

**EVALUATING PHYSICIAN'S FINDINGS ON A PHYSICAL EXAMINATION REGARDING RESPONDENT'S NECK AND UPPER BACK AREAS**

23. In his examination of respondent, Dr. Pompan observed that respondent had full range of forward flexion of his cervical spine (neck). He exhibited "near full backward extension," and he engaged in right-sided and left-sided rotation, but with unmeasurable pain complaints. When Dr. Pompan engaged in palpation (light tapping of the evaluator's finger tips), the orthopedist could not elicit "any palpable trigger points."

For shoulder range of motion, respondent attained full forward flexion. He attained adequate extension of both shoulders with full abduction of 170 degrees bilaterally. Respondent exhibited full strength of external rotation in an isolated supraspinatus testing.

The examination by Dr. Pompan found "no side-to-side muscle atrophy" affecting respondent. Both biceps measured 30 cm and the forearms measured 27 cm bilaterally, which were symmetrical and well within normal limits. Respondent's reflexes were bilateral and symmetrical. Dr. Pompan concluded that respondent was not impacted with any neurological deficits.

24. Based upon his thorough examination of respondent's neck and upper back/shoulders, Dr. Pompan determined that respondent did "not have any objective findings on [the] physical examination . . ." Respondent's complaints of experiencing "tenderness" in his musculature was determined by Dr. Pompan to be "subjective" claims by respondent. Importantly, Dr. Pompan found respondent to produce "a normal neurological examination." Respondent demonstrated full rotation of his neck and showed "some mild decreased range of motion" based upon his self-regulated movements.

Dr. Pompan interpreted the MRI scan of respondent's cervical spine to show no herniated disc. And, the physical examination did not demonstrate respondent to have any nerve root compromise. The MRI scan of the 32-year-old respondent showed "some degenerative changes at the C3-C4 and C4-C5 vertebrae levels. (It may reasonably be inferred that those degenerative changes are associated with a congenital condition and not related to the workplace incidents reported by respondent as resulting in injuries to him.) As Dr. Pompano pointed out that "according to the most recent medical evidence, [respondent's] type of disc degeneration and bulging are quite common in even asymptomatic individuals," in fact "disk protrusions are common in all age groups, including those in their 20s."

Dr. Pompan was compelling when he proclaimed in his report that, "there are no objective findings" of pathology affecting respondent's cervical spine. And, the learned medical evaluator determined respondent's "subjective complaints do not correlate with what is objectively seen on his magnetic resonance imaging scan or in regard to the neurological findings on his physical examination."

25. Regarding respondent's claimed current disability, Dr. Pompan persuasively pointed out in his January 2018 report that respondent's claim reflects aspects regarding the purported disability that are unusual, and contraindicative of a chronic neck (cervical spine vertebral) disorder. The significant subjective complaints as voiced by respondent are not expected of a person afflicted with an orthopedic disorder affecting the cervical spine. The independent, objective medical evaluator emphasized the following, ". . . in my many years of evaluating patients with neck pain, [Dr. Pompan had] not seen anyone who has to constantly [move his] neck . . ." At the hearing of this matter, Dr. Pompan emphasized that persons having cervical spine pathology do not wring or gyrate the neck as such patients tend not to move the head and neck at all, but rather such neck-pathology sufferers turn the upper body as a unit. The orthopedic surgeon opined that through his education, training, and experience, he knows that persons impacted by objectively discernible marked cervical spine injury, pathology or disease do not (and probably cannot) move the head and neck as rapidly and frequently in the manner as shown by respondent even during the course of the hearing in this matter. (Over the course of the hearing and during recesses, respondent rapidly gyrated his head and neck from five/eight seconds, to 10/15 seconds, to as much as a 30 to 45 seconds intervals. But, his face remained devoid of any grimace or sign of pain. Respondent seemed, in common ordinary experience and knowledge, to have a "nervous tic" or a system of having involuntary, repetitive movements.)

**EVALUATING PHYSICIAN'S OPINIONS REGARDING NECK (CERVICAL SPINE) INSOFAR AS THE USUAL QUESTIONS POSED BY CALPERS TO EVALUATORS**

26. As to the question of respondent being unable to perform specific job duties, Dr. Pompan persuasively proclaimed that "there are no objective findings regarding [respondent's] physical condition that would preclude him from performing his activities at the prison as a senior medical technical psychiatric assistant . . . ."

On the question of whether respondent is presently substantially incapacitated from the performance of his duties," Dr. Pompan declared, "[f]rom an orthopedic standpoint, there are no objective findings that support a determination that respondent is substantially incapacitated for the performance of his duties. Any orthopedic incapacity would be based solely on subjective grounds."

*Factors that Demonstrate Respondent Is Not Permanently Incapacitated*

27. By his demeanor while testifying; by the dubious character of substantial portions of his testimony on significant issues in this matter; by existence of his significant interest and motive to exaggerate matters; and, by statements previously made by him to treating doctors and evaluating physicians that were inconsistent with testimony at the hearing, respondent demonstrated that he was neither a credible<sup>3</sup> nor persuasive witness at the hearing.

Respondent unpersuasively advanced that he has an array of emotional or psychological ailments that impact him and render him incapacitated for performance of the duties of a medical technical assistant for psychiatric patient-inmates with the department. Yet, on cross-examination, respondent demonstrated that he could spontaneously voice quick, emotionally-unencumbered responses on being confronted. At the hearing of this matter, respondent gave pointed responses to questions that showed him not to be either depressed, frightened of others, or withdrawn. And, at the hearing, respondent was clear, lucid and focused in advancing his own case to acquire the benefits associated with disability retirement status; and, he showed no obvious indicators of being impacted by emotional or psychic pain or grave limitations to his mental facilities. By his demeanor at the hearing, respondent showed that he was neither truthful nor straightforward.

28. Respondent functions adequately with his immediate and extended family. Respondent is married. He has two children, who have ages of two and one-half years and seven months. His second child was born after the date he was purportedly impaired by physical and mental injuries. Within an acceptable geographic area to his residence, respondent has a large extended family with whom he interacts.

29. Respondent functions well in the employment realm. At the time of the hearing, respondent was employed by Hartnell Community College in Salinas as a "clinical

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<sup>3</sup> California Government Code section 11425.50, subdivision (b), third sentence, and Evidence Code section 780.

instructor.” He works two days per week for approximately 15 hours per week. Over the past few years, respondent has attended college course in a quest to earn a bachelor’s degree from a local college.

30. Respondent was not credible at the hearing when he testified that he has diminished mental processing and cognitive ability, which began to manifest in the past few years. Also, respondent was not persuasive regarding the effects of the claimed mental illness that purportedly affect him in his activities of daily living. The acts of engaging in productive endeavors militate against respondent being psychiatrically or medically impaired for the pursuit of gainful employment. And, respondent’s level of activity indicates a capacity to “function” in the world contrary to a person being disabled or markedly impaired by the grave mental malady known as posttraumatic stress disorder.

31. Respondent has exaggerated his complaints with evaluating medical experts. He told orthopedic surgeon Dr. Pompan that he “always” carries a Thera Cane to gain relief of supposed neck and upper back pain. But, sub-rosa video recordings showed respondent engaging in various physical endeavors without the Thera Cane. No medical doctor prescribed a Thera Cane for respondent to use to treat his claimed neck ailment. And, Dr. Pompan credibly asserted that that orthopedic surgeon has never prescribed a Thera Cane to any patient.

32. Having been a medical technical assistant for psychiatric inmate-patients, respondent has had access to professional articles, diagnostic manuals, and textbooks regarding psychiatric illnesses. It may be reasonably inferred that respondent has studied the symptoms that suggest posttraumatic stress disorder. His testimony at the hearing of this matter demonstrates respondent’s learned rehearsal of symptoms for the condition.

33. No corroborating reliable evidence supports respondent’s assertions of being plagued with uncontrolled irritability, emotional upheaval or repeated nightmares. His reports to the CalPERS medical expert for psychiatry and records from a psychologist in the past indicate respondent’s accounts that any form of acute anxiety or aspects of posttraumatic stress disorder have long been resolved so as not to incapacitate respondent for the performance of work as a medical technical assistant for psychiatric patient inmates with the department.

34. At the hearing of this matter, respondent rendered conclusory remarks that were either wholly without merit or lacking in authentication by reliable corroborating evidence, and in some instances not established by expert witness testimony. Among other things, he stated that the “tics” involving his neck movements render him to be weak in the view of inmates so that speculatively he may be a target by inmate attacks. And, when he stated that he has a fear of returning to the department’s prison medical clinic because his irritability and possible emotionality may result in a future injury.

*CalPERS Investigator – Gina Carvalho*

35. CalPERS Investigator Gina Carvalho provided the record for this matter with reliable, compelling, persuasive, and credible testimonial and documentary evidence.

On January 6, 2017, Investigator Carvalho issued an Investigative Report. In the report, Investigator Carvalho documented her personal surveillance of respondent over a course of several days beginning on October 10, 2017. The report notes that respondent moved in a manner that did not reflect any form of orthopedic disability. Respondent fluidly entered and exited an SUV-type automobile, easily emptied trash, and lifted an infant in and out of the vehicle. The report noted respondent decorating the exterior of his residence for Halloween festivities, which included him carrying a ladder. Respondent readily raised his arms above shoulder level, threw plastic decorations upon facsimile spider webs, and ran away and caught a scampering male toddler.

Investigator Carvalho's investigative report's findings, along with her vivid testimony at the hearing of this matter, wholly refuted representations made by respondent in his application for industrial disability retirement that due to the supposed injuries sustained on April 6, 2015, that: he was unable to sit, stand, or walk for prolonged periods; he could not raise his arms above shoulder level; and could not engage in heavy lifting.

*Sub-Rosa Video for Respondent - October 2017*

36. The sub-rosa video recording of respondent from October 10, 2017, to October 20, 2017, having been reviewed twice by the under-signed administrative law judge, establishes that respondent has no form of incapacitating disorder or malady affecting his cervical spine or other body part. The recording depicts, among other things:

- Respondent carries trash out of a residence to easily deposit the trash into a disposal container.
- Respondent escorts a toddler then lifts the young child onto his shoulders and places without difficulty the toddler into the back portion of the vehicle and maneuvers the child into a child's car seat.
- Without hesitation or suggestion of impairment, respondent enters the vehicle's driver's seat and drives away.
- At a grocery market, respondent pushes a shopping cart without difficulty.
- With one hand respondent pushes the shopping cart from the market as he used the other hand to escort the toddler. Again, respondent lifts, without any sign of discomfort or hesitation, the toddler from the shopping cart's child holder to place the very young boy into the vehicle.

- On the second day of the video filming, respondent walks outside a house, which seems to be his residence, while carrying a shopping bag. As he walks he casually moves his neck in a manner suggestive of loosening his neck. Respondent readily rotates both arms in a full extension maneuver in the way of an exercise-type stretch. The film shows him again at a grocery store where he is filmed pulling a shopping cart with both arms reflective of no discomfort. He is shown in the film to walk out of the store pushing the shopping cart.
- On October 18, 2017, the film shows respondent at a gasoline station pumping gas into his vehicle. He is seen reaching into the interior of the vehicle with both arms extended in a fluid set of movements. Respondent seems to comfortably lift the back door of the SUV. He lifts groceries in an apparent comfortable manner into the rear portion of the vehicle. He unloads an object, appearing to be a large pumpkin, without any display of discomfort or hesitancy. During the maneuver, respondent is able to reach up with his right hand at approximately 180 degrees of forward flexion in order to close the back of the vehicle. Then, he pushes the cart around the vehicle using only his right arm in a seemingly comfortable manner. Later, respondent uses both arms to unload the shopping cart. Respondent moves his head and neck in an apparent comfortable manner to both sides while he hold the toddler on his shoulder. He looks around by rotating his head and neck without moving his torso to survey his surroundings. Respondent demonstrates that he is very adept in lifting and carrying the toddler in and out of the vehicle by holding the child with one arm while maneuvering his other arm to engage upon other activities such as shutting a door and locking the vehicle's door.
- Also on October 18, 2017, respondent carries items from his vehicle to transport the same into his house. He carries a pumpkin into the residence. And, he carries several items in both hands, balances the items, and easily walks to and from the house. Although respondent moves his head and neck to the left and right, as though to loosen the neck, periodically, he continues with engaging his various activities including bending, reaching, and lifting objects with no apparent limitation. Respondent demonstrated his ability to fully flex forward his right arm in order to close the door of a hatchback of the vehicle. Later in the day, respondent is seen walking towards a vehicle then turns his head and neck fully to the left to look back towards the residence. He then carries a ladder with his right arm in a comfortable fashion. Respondent carries decorations and places the same in the yard of the house. He positions the ladder with his right arm with no sign of discomfort. He maneuvers the ladder to various portions of the house's exterior in a manner suggestive of attaching decorations upon the house. The film shows respondent using his right arm in a full forward flexed position towards the house's roof and then he descends while balancing himself on the ladder. The video shows respondent being able to move his head and neck comfortably in both flexed and extended

positions along with forward movements, to the right and left, as he works atop the ladder as he decorated the house's exterior for Halloween.

- Over a span of approximately 45 minutes, respondent engages in decorating the house for Halloween. He repeatedly moves his head in a side-to-side rotation with no apparent discomfort. The movements suggest a loosening of muscles. Although a few individuals join respondent as he decorates the exterior of the house, respondent performs all of the work himself. He uses his arms in a very comfortable appearing manner. And, he hoists the ladder without difficulty. In a scene he uses his right arm and simultaneously stands on tiptoes to reach straight upward to decorate the house at a level well above his head. He then again climbs the ladder to reach further above the ground. The film shows respondent adeptly holding the ladder in his right hand as he holds a Halloween-type mannequin with his left hand. Later, respondent holds the toddler in his left arm while using his right hand to take photographs of the Halloween decorations.
- On October 19, 2017, respondent goes shopping again. He is shown carrying the toddler in his left arm while using his right hand to open the door to his vehicle. The film depicts respondent periodically moving his head and neck from the left to right sides as a "tic" rather than as suggestive of a pain experience. Later on that date, the video film shows respondent on his knees in an area outside his apparent residence as he bends over with neck fully flexed as he worked upon the ground of his house's yard. (As analyzed by Dr. Pompan, respondent "demonstrates full forward flexion of his cervical spine and full extension while he is bent over.")
- On October 20, 2017, outside of his residence, respondent holds a child in his left arm as he uses his right arm to open the door of a vehicle. That morning, respondent continues to work on Halloween decorations as he demonstrates full range of motion of both shoulders as well as his neck (cervical spine). He capably squats underneath decorations and works again above his shoulders with his head in a fully extended position.
- Later on October 20, 2017, the video film again shows respondent at a grocery market in the company of his child, who rides in a shopping cart. Respondent easily pushing and pulling a shopping cart using one arm, and he shows the ability to lift the child to and from a vehicle. And, he periodically effects some rotation and lateral bending of his neck. Respondent gracefully and without apparent discomfort reaches above his head to close the back door of a hatchback vehicle.

## *Ultimate Findings*

37. By the weight of competent, reliable medical evidence, at the time of the filing of his application for industrial disability retirement, respondent was not incapacitated for the performance of his duties by reason of “(neck) cervicalgia myalgia facet syndrome<sup>4</sup> of the cervical spine and cervical disc disorder.”

38. By the weight of competent, reliable medical evidence, at the time of the filing of his application for industrial disability retirement, respondent was not incapacitated for the performance of his duties by reason of “(psychological stress) posttraumatic stress disorder.”<sup>5</sup>

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<sup>4</sup> “Cervicalgia” refers to a type of injury that occurs in the neck region that causes pain. The condition is designated “cervicalgia” when the ailment is centered in the neck region and not other areas such as the arms or lower back. ([www.medicalnewstoday.com/articles](http://www.medicalnewstoday.com/articles).) “Myalgia” pertains to muscle pain. “Cervical facet osteoarthritis, sometimes called cervical facet joint syndrome, is *a degenerative condition that causes pain and stiffness in the cervical, or neck, region of the spine*. The cervical spine includes the top seven levels of the spine, labeled C1 through C7. There are two facet joints on either side of the back of each vertebra in the neck. These joints provide stability, while also enabling neck movements such as turning or nodding the head. Cartilage lines each facet joint in the neck, and this cartilage is surrounded by a capsule filled with synovial fluid. This synovial fluid helps lubricate the facet joint, enabling smooth movements of the joint complex. In *cervical facet osteoarthritis*, this cartilage begins to degenerate, or break down. The cartilage begins to thin and may even disappear completely, causing bone-on-bone friction of the facet joints in the neck. This friction can lead to the development of osteophytes, or bone spurs. If these osteophytes impinge on any cervical nerve roots, pain, weakness, or tingling may radiate along the path of the nerve into the arm and hand. Cervical facet osteoarthritis may cause pain in the neck and upper back as well as the shoulders and between the shoulder blades . . . . Patients with cervical osteoarthritis will often have tenderness or swelling over the site of the affected facet joints, *as well as reduced range of motion in the neck*”. ([www.spine-health.com](http://www.spine-health.com).) (Emphasis added.)

<sup>5</sup> “The essential feature of posttraumatic stress disorder (PTSD) is the development of characteristic symptoms following exposure to one or more traumatic events.

Diagnostic criteria for PTSD must manifest: (A) exposure to actual or threatened death, serious injury, or sexual violence in one or more ways of: (1) directly experiencing the traumatic event; (2) witnessing, in person, the events as it occurred to others; (3) learning that the traumatic event occurred to a close family member; or (4) experiencing repeated or extreme exposure to aversive details of the traumatic events; (B) presence of one or more of the following intrusion symptoms associated with the traumatic events, beginning after the traumatic events occurred: (1) recurrent, involuntary, and intrusive distressing memories of the traumatic events; (2) recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic events; (3) dissociative reactions (e.g. flashbacks) in

39. By the weight of competent, reliable medical evidence, CalPERS established by competent, credible, and highly reliable evidence that respondent is currently not permanently incapacitated for the performance of the duties of the civil service classification of Medical Technical Assistant with the department.

40. CalPERS has been reasonable, prudent, and procedurally correct in making a determination that respondent's application for disability retirement must be denied, and that respondent, a 33-year-old male, has the option to pursue reemployment to the civil service position of medical technical assistant-psychiatric unit.

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which the individual feels or acts as if the traumatic events were recurring; (4) intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic events; (5) marked psychological reactions to intense or external cues that symbolize or resemble an aspect of the traumatic events. (C) persistent avoidance of stimuli associated with the traumatic events, beginning after the traumatic events occurred, as evidenced by one or both of the following: (1) avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic events; (2) avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic events. (D) negative alterations in cognitions and mood associated with the traumatic event, beginning or worsening after the traumatic event occurred, as evidenced by two (or more) of the following: (1) inability to remember an important aspect of the traumatic events (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs). (2) persistent and exaggerated negative beliefs or expectations about oneself, others, or the world . . . (3) persistent, distorted cognitions about the cause or consequences of the traumatic event that lead the individual to blame himself/herself or others; (4) persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame); (5) markedly diminished interest or participation in significant activities; (6) feelings of detachment or estrangement from others; (7) persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, loving feelings): (E) marked alterations in arousal and reactivity associated with the traumatic events, beginning or worsening after the traumatic event, as evidenced by two, or more, of the following: (1) irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects; (2) reckless or self-destructive behavior; (3) hypervigilance; (4) exaggerated startle response; (5) problems with concentration; (6) sleep disturbance; (F) duration of the disturbance is more than [one] month; (G) the disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning; (H) the disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition. (American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition, (DSM-5), Washington, D.C., American Psychiatric Association, 2013, pages 271, 271, and 274.)

## LEGAL CONCLUSIONS

### *Burden and Standard of Proof*

1. Evidence Code section 500 provides that, except as otherwise provided by law, a party has the burden of proof as to each fact the existence or nonexistence of which is essential to the claim for relief or defense that the party is asserting.

2. Evidence Code section 115 defines "burden of proof" as a party's obligation "to establish by evidence a requisite degree of belief concerning a fact in the mind of the trier of fact or the court." Unless specified, the burden of proof requires proof by a preponderance of the evidence.

3. In this proceeding, respondent had the burden of proving by a preponderance of the evidence that he is substantially incapacitated from performing the duties of a medical technical assistant and that he should be retired due to permanent disabilities.

### *Applicable Statutes*

4. Government Code section 20026 defines the terms "disability" and "incapacity for performance of duty," when used as a basis for retirement, to mean a "disability of permanent or extended and uncertain duration" that is based on "competent medical opinion." At a minimum, the disability must span no less than 12 consecutive months.

5. Government Code section 21151, subdivision (a), sets forth that a state safety or state peace officer who is "incapacitated for the performance of duty as the result of an industrial disability shall be retired for disability . . . regardless of age or amount of service."

6. Government Code section 21156 sets out:

If the medical examination and other available information show to the satisfaction of the board, or in case of a local safety member, . . . the governing body of the contracting agency employing the member, that the member in the state service is incapacitated physically or mentally for the performance of his or her duties and is eligible to retire for disability, the board shall immediately retire him or her for disability. . . .

### *Appellate Authority*

7. "Incapacitated for the performance of duty" means the substantial inability of the respondent to perform his or her usual duties. An employee who is incapacitated only to a limited extent is not entitled to disability retirement. When a respondent can perform his or

her customary duties, even though doing so may be difficult or painful, the public employee is not “incapacitated” and does not qualify for a disability retirement. (*Munsperger v. Public Employees’ Retirement System* (1970) 6 Cal.App.3d 873, 875-877, 886-887; *Sager v. County of Yuba* (2007) 156 Cal.App.4th 1049, 1057.)

8. Fear of further injury or further aggravation is insufficient. (*Hosford v. Board of Administration* (1978) 77 Cal.App.3d 854.) In *Hosford* the court rejected a contention that the employee’s medical condition created an increased risk that he would suffer further injury or aggravation in the future. In rejecting the contention that this increased risk rendered the employee presently disabled, the court stated that “this assertion does little more than demonstrate [the employee’s] claimed disability is only prospective (and speculative), not presently in existence.” (*Id.*, at p. 863.)

Thus, the disability must be presently existing and not prospective in nature. The employee must be presently incapable of performing the duties of a position. Prophylactic restrictions that are imposed only because of a risk of future injury are insufficient. An employee cannot retire for disability because he cannot perform certain duties that he may be occasionally called upon to perform. Moreover, a state civil service employee may not retire on account of a claimed disability if reasonable medical treatment may allow him to return to work. (*Reynolds v. City of San Carlos* (1981) 126 Cal.App.3d 208.)

*Ultimate Determination*

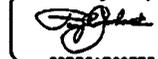
9. At the time of the filing with CalPERS of his application for industrial disability retirement, respondent Maximillian E. J. Sebolino was not permanently disabled or incapacitated for the performance of the usual and customary duties of a medical technical assistant at the Salinas Valley State Prison Psychiatric Program treatment facility due to claimed injuries or ailments impacting either his psychiatric well being or his cervical spine (neck) health.

ORDER

The application for Industrial Disability Retirement by Maximillian E. J. Sebolino is denied.

DATED: July 16, 2019

DocuSigned by:



28DBSAD00EE7453

PERRY O. JOHNSON  
Administrative Law Judge  
Office of Administrative Hearings