

**ATTACHMENT A**

**THE PROPOSED DECISION**

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

**In the Matter of the Appeal of Reinstatement from Industrial  
Disability Retirement of:**

**CAPRINA D. ZARATE, Respondent**

**and**

**DEPARTMENT OF DEVELOPMENTAL SERVICES, PORTERVILLE  
STATE HOSPITAL, Respondent**

**Case No. 2018-1285**

**OAH No. 2019041088**

**PROPOSED DECISION**

Danette C. Brown, Administrative Law Judge, Office of Administrative Hearings (OAH), State of California, heard this matter on July 25, 2019, in Fresno, California.

John Shipley, Senior Attorney, represented California Public Employees' Retirement System (CalPERS).

Thomas J. Tusan, Attorney at Law, represented Caprina Zarate (respondent), who was present.

PUBLIC EMPLOYEES RETIREMENT SYSTEM  
FILED August 21 20 19  
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There was no appearance by or on behalf of the Department of Developmental Services, Porterville State Hospital (Porterville). Proper service of the Accusation and Notice of Hearing was made to Porterville. The matter proceeded as a default against respondent Porterville, pursuant to Government Code section 11520.

Oral and documentary evidence was received. The record was closed and the matter was submitted for decision on July 25, 2019.

## **ISSUE**

This appeal is limited to the issue of whether respondent remains substantially incapacitated from the performance of her usual job duties as a Psychiatric Technician.

## **FACTUAL FINDINGS**

### **Jurisdictional Matters**

1. Respondent was employed by Porterville as a Psychiatric Technician. By virtue of her employment, respondent was a state miscellaneous member of CalPERS.
2. On January 26, 2016, CalPERS received respondent's application for industrial disability retirement. Respondent described her specific disability as "unable to perform daily duties due to neck injury and follow with neck surgery [*sic*] on C5 and 6 infusion." Respondent's disability occurred on September 2, 2012, when "a client choked [*sic*] me from behind and we both fell to the ground." Respondent indicated in her application that she also had a worker's compensation claim related to the choking incident.

3. On April 27, 2016, CalPERS approved respondent's application for industrial disability retirement based upon her "orthopedic (neck) condition." In its approval letter, CalPERS stated, "If you are under the minimum age for service retirement, you may be reexamined periodically to verify your continued eligibility for disability." Respondent was approximately 43 years old at the time she filed for industrial disability retirement, which was below the minimum age for service retirement.

4. On October 5, 2017, CalPERS notified respondent that her industrial disability benefits were under review to determine if she continued to meet the qualifications to receive those benefits pursuant to Government Code section 21192. That section authorizes the CalPERS Board of Administration (Board) to require respondent to undergo medical examination by a physician or surgeon appointed by the Board or employer. "Upon the basis of the examination, the board or governing body shall determine whether he or she is still incapacitated, physically or mentally, for duty in the state agency . . ."

5. On January 11, 2018, CalPERS notified respondent that, upon reevaluation of her qualifications for industrial disability retirement, it determined that respondent was no longer substantially incapacitated from the performance of her job duties as a Psychiatric Technician at Porterville due to her orthopedic (neck) condition. CalPERS informed respondent that she would be reinstated to her former position pursuant to Government Code section 21193, which requires respondent to be reinstated to her position upon a determination she is no longer incapacitated for duty in that position.

6. On January 25, 2018, respondent appealed CalPERS's determination. The matter was set for an administrative hearing before an administrative law judge of the Office of Administrative Hearings pursuant to Government Code section 11500 et seq.

### **December 5, 2017 Independent Medical Examination**

7. Robert Henrichsen, M.D., is a board-certified orthopedic surgeon. On December 5, 2017, Dr. Henrichsen conducted an Independent Medical Examination (IME) of respondent at the request of CalPERS. He reviewed respondent's medical, occupational, and treatment history, performed a physical examination, and prepared an IME Report dated December 5, 2017. Dr. Henrichsen testified at hearing consistent with his IME Report, in which he described respondent's symptoms at the time of the IME as follows:

[Respondent] has headaches, they are in the posterolateral part of her neck, more on the right than the left and they can be dull, they can sometimes start in the area of the right deltoid muscle, go up to the arm, to the neck, and then the head . . .

Additional current symptoms are that she has pain more on the right than the left and back of her neck, that move toward her shoulders, sometimes in the left it is throbbing when it is cold. Repeated movements, she states, will give her pain in the right deltoid area and then go up to the head with severe headaches, again which were first documented in the records on October 18, 2017.

8. Dr. Henrichsen conducted a physical examination of respondent, restricted to her neck and upper extremities. He noted a "healed right-sided ACDF<sup>1</sup> incision." He observed that respondent's cervical muscles were soft, and that respondent explained that her pain was "in the mid-part of the cervical spine posteriorly, but it is inside and not an area that I can palpate today." Downward pressure on her head was uncomfortable, and an upward pull made her neck feel better.

Dr. Henrichsen measured respondent's range of motion in her neck and shoulders. He found no abnormalities in her parascapular muscles, "as she can shrug her shoulders normally, she can adduct the scapulae and she does not have scapular instability to scapular muscle loading." Respondent's deltoid and rotator cuff muscles functioned normally, as did the neck muscles. Her shoulder range of motion was normal. Respondent did not have impingement or tenderness in her AC joints "or lateral acromion region."

Respondent's biceps were normal upon inspection. Dr. Henrichsen found no evidence that respondent's biceps caused pain into her arm. Her elbow range of motion was normal with no evidence of bursitis or tendinitis. There was normal range of motion in respondent's forearms, wrists, and hands.

Next, Dr. Henrichsen measured the circumference of respondent's arms and forearms and found that respondent did not favor one side over the other. The radial pulses of respondent's wrists measured at 2/1, or approximately normal. There was no

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<sup>1</sup> ACDF stands for Anterior Cervical Discectomy and Fusion.

tendon rupture of "either flexor or extensor areas on the wrist, either volar or dorsal." Respondent's hand movements and strength were normal.

Dr. Henrichsen checked for "mechanical compressive neuropathy," or nerve compression of respondent's ulnar nerve. Respondent's left side was asymptomatic, but the right side was tender with "no good referred pain." Respondent had "normal grade 5 strength in both upper extremities," and sensory evaluation was normal. Dr. Henrichsen examined respondent's lower extremities for long tract signs involving the spinal cord. Respondent's knee and ankle reflexes were normal, and there was no "ankle clonus," or contractions, or other long tract signs.

9. Dr. Henrichsen reviewed and summarized respondent's Job Analysis setting forth her job description and essential functions. The client population at Porterville consists of clients with "varying degrees of developmental and behavioral disabilities and mental retardation." Some clients frequently display physical difficulty and behavioral disorders, and may have physical disabilities "such as hemiplegia, quadriplegia or paraplegia, . . . and these individuals can be verbally and/or physically aggressive." Psychiatric technicians perform nursing procedures such as administering medications, injections, catheterizations, assessing health status and reporting to findings to the nurse or physician, and assisting with basic self-care, client mobility, and housekeeping duties.

10. The physical requirements of the psychiatric technician include the following essential functions: lifting up to 50 pounds, participating in client containment and restraining when necessary, working different shifts or overtime shifts; frequent standing, walking, bending forward, squatting, kneeling, balancing, climbing and twisting at the waist; occasional sitting; and occasional to frequent neck motion and lifting.

11. Dr. Henrichsen also reviewed and summarized the numerous medical records, dating back to 2013. Respondent's symptoms and treatment are briefly described below:

On or about May 14, 2015, Ali Najafi, M.D., a neurosurgeon, performed C5-6 ACDF surgery on respondent. On June 19, 2015, Dr. Najafi noted that respondent's neck pain was significantly better despite swallowing issues. X-rays of respondent's cervical spine taken on June 29, 2015, showed healed "disc space height," and "soft tissues unremarkable." On August 24, 2015, Antonio Durazo, M.D., noted that respondent was 100 percent better than she was prior to surgery, and that she did not have headaches or throbbing right shoulder symptoms. In November 2015, respondent underwent therapy of the left shoulder and neck pain due to tightness and tenderness on the left side of her neck. In a report to CalPERS, dated December 17, 2015, Dr. Durazo diagnosed respondent with tenderness of the neck with limited motion and an abnormal presurgical magnetic resonance imaging (MRI) scan. He restricted respondent from lifting more than 10 pounds and client containment. Finally, Dr. Durazo opined that respondent was permanently incapacitated due to her inability to lift more than 10 pounds, bend her neck three to six hours, or contain clients.

C.R. MacClean, M.D., is respondent's worker's compensation physician. On January 20, 2016, Dr. McClean noted that respondent had numbness in her ring and small fingers. An electrical study was previously recommended in November 2012, and again in January 2013. On April 22, 2013, respondent went to an emergency room and was diagnosed with (1) cervical strain/sprain with disc disease with neural foraminal narrowing with resolved pain and radicular symptoms, and (2) resolved cervicogenic headaches.

On February 16, 2016, Dr. Durazo noted that respondent experienced neck pain when the weather was cold. On August 12, 2016, he diagnosed respondent with cervical displacement and issued a permanent and stationary report for respondent's worker's compensation claim. He further explained that respondent's disability was caused by her work injury, and restricted respondent from lifting more than 10 pounds, standing, walking, and sitting more than eight hours per day, and having contact with potentially violent clients.

On October 8, 2016, Dr. Durazo provided a CalPERS report on disability. His diagnoses included tenderness, a healed incision, and limited motion of the neck. He opined that respondent was unable to lift, and unable to perform constant twisting of the neck, and frequent flexing of the neck. His examination findings were neck pain "persistent with limited motion."

Respondent was re-evaluated for CalPERS disability on October 17, 2017. During the evaluation, respondent referenced having neck surgery in 2015, and experiencing headaches. Respondent explained she had constant tension in her neck, throbbing pain down the right arm, and she could not lift over 30 pounds and that she had throbbing pain down the right arm. At that time, she was taking the medications Celebrex, Neurontin, and Wellbutrin.

On October 18, 2017, respondent was recommended for a neurology examination for her headaches. Dr. Henrichsen noted that this was the first postoperative reference to headaches he had seen in the records. Dr. Durazo noted that respondent was not using pain medications; her neck was nontender; she had good overall neck motion; and she had normal strength in both upper extremities.

On October 25, 2017, Dr. Durazo recertified respondent for CalPERS disability, finding that respondent had a "nontender stiff neck with limited range of motion and positive Spurling's."<sup>2</sup> Dr. Durazo opined that respondent was substantially incapacitated and had the following job limitations: no excessive bending; no frequent flexing of the neck; no lifting or carrying more than 25 pounds; and no containment of clients.

12. Dr. Henrichsen diagnosed respondent with: healed ACDF fusion at C5-6; multilevel cervical degenerative disease; history of depression; and recent onset of headaches. He noted that his examination was consistent with that of Dr. Najafi, in that "she has no objective abnormal findings except a small amount of limitation of motion." Dr. Henrichsen noted that respondent's medical records were incomplete and there was no explanation for respondent's recent onset of headaches, commenting, "[t]he workup is incomplete, there has been no head scan if appropriate, there is no evidence of eyeground examination." At hearing, Dr. Henrichsen explained that "usually in single-level neck fusion, the headaches are much less. Nobody has looked at [the cause of the headaches] critically," and that the headaches were "not based on objective thinking and evaluations." Dr. Henrichsen noted there were no diagnostic studies provided to or reviewed by him.

13. Dr. Henrichsen further opined that Dr. Durazo restricted respondent from work because he did not want her "to be accomplishing containments on a prophylactic basis." He continued, "however in the records I reviewed and also she

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<sup>2</sup> A Spurling's test is used to assess nerve root pain by turning the patient's head toward the affected side and applying downward pressure to the top of the head.

explained to me that after her initial injury in 2012, and some on and off work time, she then worked on a regular basis included the day prior to her surgery."

14. During the IME, respondent reported a pain level of "9." Dr. Henrichsen opined that this subjective pain level was "not a medically correct estimate of the pain she was in," noting respondent's pain level was a "2 at the most," and that she "had no visual manifestation of actually any symptoms during the evaluation."

15. In addition to respondent's "unusual" estimate of her pain, and the inability to perform her work due solely to prophylactic restrictions, Dr. Henrichsen opined:

While I understand she is in a different category, the physicians understand that individuals with exactly the same surgery and who postoperatively are healed and do not have radicular symptoms or findings, are active players in the Hockey League and the National Football League. That does not mean she can go and do that, but that is the current state of the individuals that do not have neurologic findings following those surgeries and have good neck mobility. She does have good neck mobility and she does not have abnormal neurologic findings.

16. Due to respondent's healed cervical spine, good neck mobility, and normal neurologic findings, Dr. Henrichsen opined that it is "more likely than not that [respondent's] headaches are unrelated to her cervical spine."

17. Dr. Henrichsen explained the CalPERS standards for industrial disability, which were set forth in an attachment to the CalPERS Re-Evaluation letter he received

on or after November 13, 2017. The attachment provided the medical qualifications for disability retirement:

To qualify for a disability retirement, a CalPERS member must be substantially incapacitated for the performance of his or her duties. This "substantial incapacity" must be due to a medical condition of permanent or extended duration that is expected to last at least 12 consecutive months or will result in death.

The law distinguishes between a person who suffers some impairment and one who suffers impairment sufficient to become eligible for disability retirement. The courts have concluded that the test is whether the member has a substantial inability to perform the usual and customary duties of the position. **Difficulty in performing certain tasks alone is not enough to support a finding of disability. It is the inability to perform the essential functions of the actual and present job duties that determines whether the member is substantially incapacitated for the performance of his or her job duties. (Bold in original.)**

18. Dr. Henrichsen concluded that there are no specific job duties that respondent was unable to accomplish at the time of his IME. He explained this was because "up until the day prior to her surgery, [respondent] was able to accomplish her occupational duties." Despite experiencing radicular symptoms and neck pain, respondent continued to work.

19. Using the CalPERS standards, Dr. Henrichsen concluded that respondent is not substantially incapacitated from the performance of her duties as a Psychiatric Technician. Though respondent cooperated during the IME, she demonstrated symptoms "significantly greater" than the medical findings, and "[h]er objective examination demonstrates that she has no nerve impingement residuals, the upper extremity nerves have returned to normal, and her neck motion is excellent."

20. Following the IME, Dr. Henrichsen reviewed two additional medical reports authored by Jonathan I. Wang, M.D., including: (1) an October 12, 2017 Neurology Panel Qualified Medical Examination (QME) Report; and (2) an October 12, 2017 Electromyography/Nerve Conduction Velocity Study for the bilateral upper extremities. In his reports, Dr. Wang opined that respondent's headaches were "cervicogenic" in nature and that she was able to continue in her regular occupation. In a supplemental report, dated September 20, 2018, Dr. Henrichsen wrote:

My review of Dr. Wang's evaluation and his electrical studies does not change my prior opinions and conclusions. The reason that the small abnormality in the electrical studies is not currently significant is that Dr. Wang has correctly explained that clinical correlation is required. Both his and my clinical evaluation does [*sic*] not demonstrate any neuromuscular disorder in the extremities or incomplete neurological information to the musculature.

21. Dr. Henrichsen explained that he did not know the origin of respondent's headaches at the time of the IME because "her cervical spine issues had not changed over time and her excellent result was continuing." Dr. Henrichsen did not consider that respondent's apparent cervicogenic headaches to be a restriction of her

employment. He confirmed in his report, and again at hearing, that his opinion that respondent was not substantially incapacitated had not changed.

### **Respondent's Medical Expert Joseph Capell, M.D.**

22. Dr. Capell is a board-certified Physical Medicine and Rehabilitation (PM&R)<sup>3</sup> physician in private practice. On May 15, 2019, Dr. Capell examined respondent for purposes of determining her CalPERS disability retirement status. Like Dr. Henrichsen, Dr. Capell reviewed respondent's medical records and conducted a physical examination. He wrote a report, and testified consistent with the contents of his report. Respondent reported headache symptoms occurring at the back of her head, and pain on the right side of her neck, shoulder top, and upper scapula, "radiating periodically to the hemicranium on the right side." Respondent's headaches would last from a few hours to up to four days, and were associated with nausea, sensitivity to light, and occasional dizziness after taking medication. Her symptoms were brought on by activities such as carrying one bag of groceries, mopping, sweeping, or gym exercises involving the upper extremities.

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<sup>3</sup> PM&R physicians, also known as physiatrists, treat a wide variety of medical conditions affecting the brain, spinal cord, nerves, bones, joints, ligaments, muscles, and tendons. They have completed training in the specialty of PM&R, and may be subspecialty certified in Brain Injury Medicine, Hospice and Palliative Medicine, Neuromuscular Medicine, Pain Medicine, Pediatric Rehabilitation Medicine, Spinal Cord Injury Medicine, and/or Sports Medicine. ([https://www.aapmr.org/about-physiatry/about-physical-medicine-rehabilitation/what-is-physiatry.](https://www.aapmr.org/about-physiatry/about-physical-medicine-rehabilitation/what-is-physiatry))

23. Dr. Capell noted that respondent recently received three courses of Botox injection treatment from Ramu Thiagarajan, M.D., a neurologist in Porterville, California. Each course of treatment consisted of 32 injections given at the same time about the head and neck bilaterally. The injections provided relief for approximately 12 weeks, but had to be repeated. Dr. Thiagarajan recommended the medication "Migraven" for migraines, but respondent did not find it helpful.

24. Dr. Capell palpated respondent's neck and shoulder areas, and measured her range of motion in those areas. Respondent had no tenderness in her neck and shoulders, or in the bicipital grooves, deltoid burse, or subacromial areas. However, she did experience tenderness at the "occipital tubercles . . . 3+ tender with some nodularity and spasm on the right, 2+ on the left." Respondent also had tenderness at the "levator scapula (3+ right side of neck, and 1+ left)." Dr. Capell described Grade 3 tenderness as "quite significant", and Grade 4 as "exquisite tenderness." Respondent's neck range of motion was slightly limited in extension, and tilting to the right and left were normal. Rotation was limited by approximately 30 percent. Dr. Capell did not note anything of concern regarding respondent's sensation in her upper extremities, or in her deep tendon reflexes.

25. Dr. Capell made the following diagnostic impression: (1) Cervical injury with disk [s/c] herniation soft tissue and ligamentous injuries on September 2, 2012, in the course of her employment; (2) Radiculopathy C6 nerve right side, status post ACDF at this level on May 11, 2015; (3) Cervicogenic headaches from #1 and #2; and (4) Right hip bruise, in the presence of TCP – resolved without sequelae. Additionally, he noted the following restrictions: (1) no work with hands at or above shoulders; (2) no prolonged sitting without periodic breaks; (3) no standing and walking more than 1/2

hour at a time; (4) no driving greater than two hours; and (5) no lifting greater than 10 pounds frequently or more than 20 pounds at all.

26. Dr. Capell's range of motion, deep tendon reflexes, and objective palpatory findings in respondent's neck and shoulders were similar to the findings by Drs. Durazo, Potter, and Wang. He opined that there was a "clear **worsening of objective symptoms from the time of Dr. Henrichsen's examination.**" (Bold in original.) Dr. Capell further opined that respondent's continuing restrictions are non-prophylactic, "that is, restrictions beyond which will inevitably bring about cervicogenic headaches, requirement for medication, rest and work cessation or things she simply cannot do." Dr. Capell did not know what Dr. Wang meant by his opinion that respondent's headaches were "cervicogenic" but that she could return to work, noting "I'm not sure a neurologic point of view is the only issue here." He noted that different specialists look at a patient differently. Dr. Capell explained why respondent should be restricted as follows:

[F]rom confrontations with potentially combative patients since these can cause additional harm and disability because of vulnerability engendered by her pre-existing condition of thrombocytopenia, a one-level cervical fusion causing limitation of neck range of motion, myofascial and ligamentous pain in the cervical spine and cervicogenic headaches. This, however, is not an issue in current deliberations.

27. At the conclusion of his report, Dr. Capell touched on, but did not answer the specific questions that CalPERS requires of its IME doctors:

1. Based on your objective findings, are there specific job duties that you feel the member is unable to perform due to her neck condition?
2. In your professional opinion, is the member presently substantially incapacitated for the performance of her duties? If incapacitated, is the incapacity permanent or temporary? If temporary, how long will the incapacity last?
3. Is the member cooperating with the examination and putting forth their best effort, or do you feel there is an exaggeration of complaints?

## **Discussion**

28. In general, respondent's medical records indicated no objective abnormal findings except for a small amount of limited motion in respondent's neck. Dr. Wang determined that respondent's onset of headaches was "cervicogenic," or related to her neck, but that she nevertheless was able to continue in her occupation. Dr. Capell "did not know what [Dr. Wang] meant by that," and opined that other medical issues, not at issue here, such as thrombocytopenia, myofascial and ligamentous pain in the cervical spine, and respondent's cervicogenic headaches prevented her from containing clients. Dr. Capell did not comment on other usual job duties respondent could or could not do. He simply opined that respondent's objective symptoms became worse after Dr. Henrichsen's examination, and that "different specialists look at a patient differently."

29. Dr. Henrichsen has performed ACDF surgeries similar to the one respondent underwent. It is a common surgery, and his opinion that respondent had

very good results from the surgery was persuasive. He found no nerve or blood vessel impingements, or overall dysfunction of the neck. He opined that respondent's subjective pain level at a Level 9 was not supported by objective medical evidence, and that her actual pain level was Level 2. Furthermore, notwithstanding her neck pain, respondent continued to work up until the time of her surgery in 2015. Dr. Henrichsen saw no objective reason why respondent cannot work with her arms above her shoulders, and opined that there was no objective basis for respondent's driving, standing, or walking restrictions. The restriction of no lifting over 10 pounds is a prophylactic restriction only. Dr. Henrichsen opined that respondent's neck condition was "much improved" after surgery. Finally, respondent's cervicogenic headaches are treated with Botox injections, which provide relief for 12 weeks at a time, and would enable respondent to perform her usual job duties.

30. When all of the evidence is considered, Dr. Henrichsen's opinion that respondent is not substantially incapacitated from her usual job duties was persuasive and supported by his physical examination and review of her medical records. Respondent's pain complaints were not supported by any objective findings. Moreover, Dr. Henrichsen's report and testimony were given greater weight than the examination and report of Dr. Capell, who specializes in physical medicine and rehabilitation, which encompasses a wide variety of medical conditions in all parts of the body. As a board-certified orthopedic surgeon, Dr. Henrichsen has greater specialized knowledge from an orthopedic standpoint. While Dr. Capell reported tenderness at the base of respondent's skull and neck, he made very little objective orthopedic findings to support his opinion of substantial incapacity.

31. Respondent did not provide any competent medical evidence to support her subjective reports of continued orthopedic neck problems and pain. In the absence

of sufficient competent medical findings to support respondent's continued pain complaints, it cannot be found that respondent continues to be substantially incapacitated from performing the usual duties of a Psychiatric Technician.

32. Because respondent is already receiving industrial disability retirement, the burden was on CalPERS to establish that respondent is no longer substantially and permanently disabled from performing the usual duties of a Psychiatric Technician. CalPERS met this burden. Consequently, CalPERS's request to reinstate respondent from industrial disability retirement should be granted.

## **LEGAL CONCLUSIONS**

1. In accordance with Government Code section 21192, CalPERS re-evaluates members receiving disability retirement benefits who are under the minimum age for service retirement. That section, in relevant part, provides:

The board . . . may require any recipient of a disability retirement allowance under the minimum age for voluntary retirement for service applicable to members of his or her class to undergo medical examination . . . The examination shall be made by a physician or surgeon, appointed by the board . . . Upon the basis of the examination, the board or the governing body shall determine whether he or she is still incapacitated, physically or mentally, for duty in the state agency . . . where he or she was employed and in the position held by him or her when retired for disability, or in a position in the same classification, and for the duties of

the position with regard to which he or she has applied for reinstatement from retirement.

2. Government Code section 21193 governs the reinstatement of a recipient of disability retirement who is determined to no longer be substantially incapacitated for duty. This section provides, in relevant part:

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

3. Government Code section 20026 defines "disability" and "incapacity for performance of duty," and, in relevant part, provides:

"Disability" and "incapacity for performance of duty" as a basis of retirement, mean disability of permanent or extended and uncertain duration, as determined by the board . . . on the basis of competent medical opinion.

4. In *Mansperger v. Public Employees' Retirement System* (1970) 6 Cal.App.3d 873, 876, the court interpreted the term "incapacity for performance of duty" as used in Government Code section 20026 (formerly section 21022) to mean "the *substantial* inability of the applicant to perform his usual duties." (Italics in original.) The court in *Hosford v. Board of Administration* (1978) 77 Cal.App.3d 854,

862, held that a disability or incapacity must currently exist and that a mere fear of possible future injury which might then cause disability or incapacity was insufficient. And, discomfort, which may make it difficult to perform one's duties, is insufficient to establish permanent incapacity from performance of one's position. (*Smith v. City of Napa* (2004) 120 Cal.App.4th 194, 207, citing *Hosford v. Board of Administration, supra*, 77 Cal.App.3d at p. 862.) Furthermore, in *Harmon v. Board of Retirement* (1976) 62 Cal.App.3d 689, 697, the court determined that a deputy sheriff's subjective complaints alone, without competent medical evidence to substantiate the complaints, were insufficient to support a finding that he was permanently incapacitated for the performance of his duties.

5. To reinstate respondent from industrial disability retirement, CalPERS had the burden of establishing that respondent is no longer substantially incapacitated from performing the usual duties of a Psychiatric Technician. As set forth in Factual Findings 7 through 32, CalPERS met its burden. Consequently, CalPERS's request that respondent be reinstated from disability retirement is granted.

## ORDER

CalPERS's request to reinstate respondent Caprina D. Zarate from industrial disability retirement is GRANTED.

DATE: August 19, 2019

DocuSigned by:  
*Danette C. Brown*  
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DANETTE C. BROWN

Administrative Law Judge

Office of Administrative Hearings