

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:

JACK F. HOWARD,

and

**PLEASANT VALLEY STATE PRISON, CALIFORNIA
DEPARTMENT OF CORRECTIONS AND REHABILITATION,**

Respondents

Agency Case No. 2019-0399

OAH No. 2019070788

PROPOSED DECISION

John E. DeCure, Administrative Law Judge, Office of Administrative Hearings (OAH), State of California, heard this matter on February 3, 2020, in Fresno, California.

Helen L. Louie, Staff Attorney, represented the California Public Employees' Retirement System (CalPERS).

CALIFORNIA PUBLIC EMPLOYEES'
RETIREMENT SYSTEM

FILED March 15 20 20
JFH

Tomas J. Tusan, Attorney at Law, represented Jack F. Howard (respondent), who was present.

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

Oral and documentary evidence was received. The record was held open for the parties to file closing briefs by February 14, and reply briefs by February 21, 2020. Complainant and respondent timely filed closing briefs, which were marked for identification as Exhibit 14, and Exhibit O, respectively. The record was closed and the matter was submitted for decision on February 21, 2020.

ISSUE

On the basis of orthopedic (right foot, right knee, lumbar and thoracic spine) conditions, is respondent permanently and substantially incapacitated from the performance of his usual duties as a Licensed Vocational Nurse (LVN) for CDCR?

FACTUAL FINDINGS

Jurisdictional Matters

1. On June 25, 2018, respondent signed a service pending disability retirement application (application). The application identified the application type as "Service Pending Industrial Disability Retirement." In the application, respondent's disability was described as right foot, right knee, lumbar and thoracic spine conditions.

Respondent identified the date his disability occurred as September 28, 2016. In response to the question asking how the disability occurred, respondent stated he "stepped off onto no ground."

2. Respondent described his limitations or preclusions due to his injury or illness as: "painful to walk, stand, sit, lay, [and] must change positions constantly." He further stated he was "unable to do any physical duties" including walking, running, stooping, moving in any direction, and going up and down stairs due to "the amount of pain in my feet, knee and back."

3. Respondent was a state safety member by virtue of his employment with CDCR as an LVN. On May 1, 2018, he retired for service. He has been receiving his retirement allowance since that date. On February 13, 2019, CalPERS notified respondent in writing that his application had been denied, and informed him of his right to appeal. Respondent timely appealed from CalPERS' denial. All jurisdictional requirements have been met.

Duties of an LVN

4. As set forth in the California Correctional Health Care Services "Licensed Vocational Nurse Essential Functions List," the LVN position involves assisting in the delivery of basic patient care services within the scope of LVN practice in a state correctional facility. Among other things, the LVN must: work long hours in any level security institution with inmates; cooperate with staff, inmates, inmate families, officials, wardens, legal and public agencies; function professionally under high stress and get along with co-workers, managers, and supervisors; communicate effectively orally and in writing; document, prepare and maintain reports and records; inspect, lock and secure clinical areas and medical materials; observe and report contraband

and dangerous or self-injurious inmate behavior. The LVN must respond quickly to emergencies over varying surfaces, maneuvering up or down stairs, and sometimes in inclement weather, while maintaining sufficient strength, agility and endurance.

5. According to the "Physical Requirements of Position/Occupational Title" data form completed by respondent's employer, the LVN occasionally (i.e., up to three hours) runs, kneels, climbs, squats, reaches above the shoulder, power grasps, uses a keyboard and mouse, and drives. The LVN is occasionally exposed to: excessive noise, extreme temperatures, humidity and wetness, dust, gas, fumes, or chemicals, and works with biohazards. The LVN frequently (three to six hours) sits, stands, walks, bends the neck and waist, twists the neck and waist, reaches below the shoulder, pushes and pulls, uses fine manipulation, does simple grasping, and makes repetitive use of the hands. The LVN occasionally lifts objects weighing between 51 and 100-plus pounds, and frequently lifts objects weighing from zero to 50 pounds.

CalPERS' Evidence

6. CalPERS relied upon Don T. Williams, M.D., as its expert witness. Dr. Williams is board-certified in orthopedic surgery and has been in private practice in Monterey County since 1986. He has performed a variety of orthopedic surgeries for many years involving the knees, shoulders, hands, and assisting in back surgeries. He also specializes in treating patients with a broad scope of orthopedic problems including, but not limited to, the shoulders, knees, hands, and knees. He has performed independent evaluations as both an agreed medical evaluator (AME) and qualified medical evaluator (QME) in workers' compensation cases, and has performed IMEs for CalPERS for approximately three years. Dr. Williams examined respondent on January 19, 2019, took a history, reviewed his medical records and job duties, and

issued an IME report. Dr. Williams also testified regarding his observations and findings.

7. In his IME report, Dr. Williams reviewed the history of respondent's problems that led to his filing a disability claim. Respondent, who was 52 at the time, described working for CDCR. In September 2016, while at work, his right knee fell into a hole, causing his knee to hyperextend the wrong way and twist as he fell forward. He experienced immediate pain and swelling and sought medical treatment in the emergency room. He thereafter returned to work for only one day.

8. Respondent had right knee surgery performed by Marshall Lewis, M.D., but reported the surgery made his condition worse. He also experienced pain in his back and both feet. He subsequently underwent approximately 13 MRIs to determine the source of his pain. His medical history included minor automobile accidents, but did not include any injuries other than the September 2016 fall at work. Major illnesses included diabetes and high blood pressure. He reported his current symptoms as primarily including right knee pain and swelling. Respondent also complained of lower back pain radiating into the legs and feet, bilaterally. His knee and leg pain is worse when walking, and increases if he sits and stands too long. He is unable to run and cannot do his job. He has trouble with activities of daily living, experiencing pain in the right leg and feet. He uses a cane.

9. Dr. Williams performed a review of systems and noted respondent had a history of diabetes, high blood pressure and anxiety, but no history of cardiac or pulmonary issues. Every other aspect of the review of systems was unremarkable.

10. Dr. Williams performed a physical examination and noted respondent walked with a cane and had a slightly antalgic (warding against pain) gait. His neck

and upper extremities had good motion. Upon examination, he could not walk on his heels or tiptoes, despite walking into the examination room with a heel-to-toe gait. When asked to touch the floor while standing, respondent flexed 60 degrees. But Dr. Williams observed that when respondent picked up his shoes, he "easily" flexed to 90 degrees. Respondent also flexed to 80 degrees to move a stool. Dr. Williams considered this a discrepancy between respondent's waist flexion upon testing and his actual flexibility. Respondent could squat to 50 percent of normal, indicating right knee problems as a result. His right knee showed loss of motion with lack of five degrees of full extension and decreased flexion to 110 degrees. The right knee showed palpable arthritic change, which Dr. Williams also noted in MRI results when he reviewed respondent's medical records. A McMurray test (used to detect meniscus tears) revealed no evidence of a meniscus tear and no "clicking" in the knee, which Dr. Williams considered "good." Respondent's ankles and feet showed good motion.

11. In his review of respondent's medical records, Dr. Williams observed several notable inconsistencies between respondent's subjective complaints and the objective medical findings contained in the reports of various medical evaluators. He first noted that an October 17, 2016, right knee MRI revealed a meniscus tear. However, a January 3, 2019 MRI report respondent brought to the IME showed a normal anterior and posterior meniscus, with no evidence of a tear. Dr. Williams also noted a February 2017 progress note by Benjamin Lewis, D.P.M., in which respondent reported increased right-side pain, severe pain in both feet, and pain in the hip, back, and right knee. Respondent also complained of a talar dome lesion (i.e., an injury to the cartilage and underlying bone of the talus within the ankle joint), which he apparently had been researching. But Dr. Lewis made findings inconsistent with respondent's complaints, and saw no radiographic or MRI evidence of talar dome lesions. On April 3, 2017, respondent saw Francis Lagattuta, M.D., complaining of back

pain and constant swelling into the right leg. But Dr. Lagattuta conducted electromyography (EMG) and nerve conduction studies and found no evidence of lumbar radiculopathy or nerve entrapment.

12. Dr. Williams found other medical records that, in his opinion, did not support respondent's disability claim. On August 2, 2017, Marshall Lewis, M.D., performed arthroscopic knee surgery on respondent's right knee, removing a meniscus tear and multiple "loose bodies greater than 5 [millimeters]." A January 2017 lumbar spine MRI report by Rasa Rajanayagam, M.D., revealed no large disc protrusions and no stenosis. Dr. Williams interpreted these findings as "enough to cause pain," but not substantial enough to warrant surgery. In February 2018, respondent consulted with Henry Aryan, M.D., who opined respondent should not undergo any structural spinal surgery. An October 2016 right ankle MRI revealed a partial tear of the anterior talofibular ligament, which Dr. Williams likened to a sprain not requiring surgical correction. The January 2019 MRI on respondent's right knee evidenced degenerative changes but no major pathology, indicating that respondent's condition had developed over "a long time."

13. Dr. Williams also discussed the September 2017 QME workers' compensation evaluation and report by Sanjay Deshmukh, M.D. In that report, Dr. Deshmukh opined respondent was temporarily totally disabled for four weeks following his August 2017 right knee arthroscopic surgery, then temporarily partially disabled with several work preclusions, including remaining sedentary, no repetitive kneeling and squatting, and no lifting, pushing and pulling over 10 pounds. Dr. Williams noted that the standards in CalPERS disability evaluations are different than those in workers' compensation cases, and opined that respondent could perform a "substantial portion" of his job duties.

14. After examining respondent, Dr. Williams diagnosed him as follows:

a. Chondromalacia of the right patella, post partial medial meniscectomy, sprain of the collateral ligament, healed.

b. Lumbar spondylosis, mild.

c. Ankle sprains, healed.

d. Congenital mid foot arthrosis.

e. Diabetes.

15. Dr. Williams summarized the objective findings of respondent's medical conditions as follows. The right knee showed palpable arthritis, discomfort in the patella, no meniscus tear, and good motion. The low back MRI changes were minor. Respondent's reflexes were "brisk." MRIs of the ankles revealed only sprains. MRIs of the feet revealed right foot congenital arthrosis, and an old fracture in the left foot.

16. In conclusion, Dr. Williams found respondent to have cooperated with the IME process but not to have made his best effort in flexing at the waist, or walking on heels and tiptoes. Dr. Williams equated this lack of effort with an exaggeration of respondent's complaints. He further noted that Dr. Deshmukh's work preclusions involved repetitive motions; however, Dr. Williams opined respondent could perform a substantial majority of these motions, and perform a substantial portion of his job duties as an LVN. For instance, respondent could not run quickly, but could likely run a short distance; he could likely lift up to 20 pounds, but could not lift up to 50 pounds without possible pain; and he could twist, but not suddenly. While respondent was concerned about performing his various job duties without experiencing significant pain, Dr. Williams' overall opinion was that the objective medical evidence indicated

respondent was physically capable of doing the job activities described in the essential functions for the LVN position. For all these reasons, Dr. Williams opined that respondent was not substantially incapacitated for the performance of his usual duties.

Respondent's Evidence

RESPONDENT'S TESTIMONY

17. Respondent began working at Pleasant Valley State Prison in 2007 as an LVN "safety nurse," which is the only position he held. He sustained no work injuries prior to his 2016 fall at work. He fell in a place where concrete had been excavated, twisting both ankles. He worked only one day after his fall, finishing his shift, but he could not walk without "unbearable pain" and never returned.

18. Respondent reviewed the LVN job description and agreed the stated physical requirements were accurate. He contended he: could not run at all; could walk, but with a cane to avoid falling; could not kneel, crawl, or climb; could not walk up stairs or squat without substantial pain; and could not push or pull for up to three hours, although he could push a shopping cart for 45 minutes. Walking on uneven ground is very slow and difficult. He does not lift objects; although he could "probably" lift 30 pounds, he believed he could not lift up to 50 pounds.

19. Respondent's primary care physician for workers' compensation is William Foxley, M.D., who submitted a "Physician's Report on Disability" dated April 30, 2018, stating respondent was currently incapacitated from the usual duties of his position with CDCR. Dr. Foxley's diagnoses included right knee internal derangement, degenerative disc disease (lumbar) with radiculopathy, and was based on objective findings of decreased range of motion and orthopedic examinations. Respondent stated he first saw Dr. Foxley monthly, but now sees him less frequently. Respondent

also saw Dr. Deshmukh for QME evaluations in March 2018, January 2019, and July 2019. When respondent saw Dr. Deshmukh recently, his feet "hurt badly." Respondent also saw Joseph Capell, M.D., twice, for evaluations involving a personal injury case and this CalPERS case, respectively.

20. Respondent recalled his right knee feeling "mushy" after his right knee surgery. He anticipated undergoing foot surgery, but that has not occurred. He takes methadone 10mg four times per day, four to five days per week for back and foot pain. He believes his ability to think is "slower" now. His conditions are "no better or worse" at present, and he tries to maintain a positive outlook despite feeling depressed over his circumstances. He has difficulty and pain while dressing, showering, doing laundry and other chores.

21. Respondent has not worked since he service retired. Before his fall at work he considered himself to be "pretty darn healthy," experiencing only "normal" lower back pain which was tolerable. He recalled sometimes having to respond to emergencies at work, lifting and carrying up to 20 pounds "as necessary," and occasionally to infrequently having to assist another person or persons in lifting an inmate onto a gurney. He also lifted 40-pound water bottles once per week. His LVN position required him to stand approximately three hours per shift, walk in the work area during the day, and walk for up to 20 minutes entering and leaving the workplace. He did very little running as an LVN, rarely kneeled, did not squat, pushed and pulled once per week. He is not currently receiving physical therapy but intends to install a swimming pool at home and will use the pool to do weightless therapy.

RESPONDENT'S EXPERT

22. Joseph T. Capell, M.D., has been licensed as a physician and surgeon in California since 1973. He has a private practice in Pinedale, California and specializes in physical medicine and rehabilitation.¹ Dr. Capell is board-certified in pediatric medicine, physical medicine and rehabilitation, pediatric rehabilitation medicine, and spinal cord injury medicine. He examined respondent on July 10, 2018, and December 16, 2019, documenting his findings in written reports following both examinations. Dr. Capell also performed three reviews of respondent's medical records, recording his impressions in three respective reports. In addition, he was familiar with the essential job functions of the LVN position at CDCR. Dr. Capell testified at hearing regarding his findings and opinions.

23. On December 16, 2019, Dr. Capell performed a "brief" physical examination of respondent in respondent's home. His findings were normal regarding the neck and upper extremities, and respondent's grip was full and equal. Deep tendon reflexes in the upper extremities were normal with no pathology noted. Respondent had tenderness in the lumbosacral junction, no paralumbar muscle tenderness, some bilateral sciatic notch tenderness (more on right than left), mild trochanteric bursal tenderness (right only), and bilateral paralumbar muscle tenderness (more on right than left).

24. Dr. Capell performed a McMurray's test on the knees, which was negative. A posterior drawer test (of the anterior cruciate ligament) was positive. Mild

¹ Recently, he closed his practice and began working for the Fresno County Health Department in the area of disability evaluations and children's health services.

joint effusion and patellar ballottement (i.e., a medical sign indicating increased fluid) was noted in the right knee, but not the left knee. The left knee extended fully and flexed to 120 degrees, while the right knee extended to minus-five degrees with guarding, and flexed to 110 degrees. Dr. Capell also noted moderate "grinding" in the right patellofemoral kneecap region, but none in the left knee.

25. Dr. Capell also observed and analyzed respondent's gait. Respondent could walk approximately 30 feet without using a cane, but while keeping close to the wall with Dr. Capell following closely behind in the event he faltered. Respondent demonstrated good heel-toe progression, but was unable to rise up to his toes without Dr. Capell helping him; when respondent rose to his toes with assistance, he reported discomfort. He also reported moderate increases in right knee, right ankle, and low back pain when walking without assistance. Dr. Capell heard a "definite click" in respondent's right knee, even from across the room.

26. Upon completing his examination, Dr. Capell made the following diagnoses:

- a. Diabetes, pre-existing.
- b. Hypertension on triple therapy, pre-existing.
- c. Lumbar degenerative disk disease and pre-existing minimal spondylolisthesis, exacerbated markedly by [fall at work] injury, see below.
- d. Obesity, worsened significantly by limited exercise tolerance and work with weight gain of approximately 60 pounds since the injury in question (currently, it is

estimated at 280 pounds but not measured. It was approximately 260 pounds at the time of the previous examination.

e. Right knee internal derangement, status post arthroscopy, secondary to hyperextension injury and compression injury with persistent intermittent medial meniscus tear, joint effusion, pre-patellar bursitis and patellofemoral grinding.

f. Bilateral ankle and foot pain, worse on the right, including a right ankle talofibular ligament (posterior and anterior) tear and scarring as well as a previous fracture on the left with degenerative changes at the medial and lateral cuneiform joints as well as the third and fourth metatarsal junctions. The old left sided fracture and adjacent degenerative changes are probably not² from the injury in question and pre-existing.

g. Anxiety/sleep disorder requiring Xanax, possibly pre-existing, worsened with the injury in question.

h. Bilateral trochanteric bursitis due to mechanical alteration in gait, markedly improved.

² (Emphasis original.)

i. Central sensitization syndrome (chronic pain syndrome), currently under treatment with narcotic weaning performed by Dr. Salazar.

27. Dr. Capell's medical records review and summaries did not significantly differ from the records review Dr. Williams detailed in the IME report. Dr. Capell opined that respondent showed certain objective evidence of incapacity, including limited range of motion and limited strength during his physical examination. Also, a knee MRI showed irregularity of the knee cap or knee joint, a medial meniscus tear, chondromalacia of the patella, and joint effusion (right knee fluid). Dr. Capell considered the grinding and clicking sounds respondent's right knee made upon movement, and noted that respondent had a "genu recurvatum" gait in which his knee bent back when he walked. In Dr. Capell's opinion, the joint effusion and persistent inflammation prevents respondent from safely lifting items, because to lift substantial weight, one must bend the knees and straighten the back. Respondent straightens the knee under a load to avoid knee pain, which also affects proper lifting. Dr. Capell opined respondent cannot stand for three hours per day, or walk regularly, as described in the LVN job duties. He opined respondent cannot walk unassisted by a cane without starting to wobble, nor can he lift over 20 pounds alone. In his examination report, he further opined that respondent:

is not able to participate in most, if not all, of the physical requirements of this job, including lifting, carrying, squatting, manipulating, bending, stooping and crawling. These represent an actual inability to perform the job duties and not a prophylactic restriction.

28. Dr. Capell disagreed with Dr. Williams' assessment that respondent was able to walk without a cane. This assessment was inconsistent with Dr. Capell's observations that respondent could walk alone only with "stand-by assistance" during the January 2020 examination; it was also inconsistent with respondent's reports, during Dr. Capell's July 10, 2018 examination of respondent, that when respondent is at home, he climbs the stairs one at a time, uses grab bars in the bathroom, near the shower and toilet, and walks near walls. Dr. Capell also disagreed with Dr. Williams' opinion that respondent was exaggerating in that he could bend only to 60 degrees from a standing position with his knees straight, but could flex to 80 degrees when reaching for his shoes with his knees and hips bent. In his current report, Dr. Capell explained:

This is not generally understood to be a sign of malingering or a non-organic sign (Waddell sign) but merely based on the fact that one can get closer to the floor by bending the knees even a small amount than with the knees held straight.

Analysis

29. Respondent testified candidly about the injuries he sustained as a result of his fall at work, and about the resulting pain and discomfort he still experiences. His expert, Dr. Capell, also offered reasonable opinions based on his two evaluations of respondent, and review of relevant medical records. The question is whether respondent offered sufficient, competent medical evidence to establish that, at the time he applied for industrial disability retirement, he was substantially and permanently incapacitated from performing the usual duties of an LVN. To do so, respondent had to overcome CalPERS' evidence to the contrary.

30. The medical evidence CalPERS presented established that respondent's orthopedic condition did not render him incapable of performing his usual LVN functions and duties. Dr. Williams was thorough, capable, and persuasive in reaching his opinion that respondent was not substantially and permanently incapacitated from performing the usual duties of an LVN. Dr. Williams credibly explained how respondent's orthopedic conditions impacted his job duties, and he repeatedly noted that the evidence indicated respondent could physically perform most of those duties, albeit sometimes with pain. While both Drs. Capell and Williams offered varying opinions about what LVN job duties respondent could or could not perform based on his conditions, Dr. Williams spent substantially more time demonstrating that the medical records did not provide objective evidence to support respondent's claims of incapacity from performance of his job duties. Because Dr. Williams' opinions found greater support from the records, they were afforded greater weight.

31. In contrast, Dr. Capell's opinions were not as well-founded by the records. For instance, his testimony that respondent could not perform his job duties due to respondent's difficulty walking was not consistently supported by Dr. Capell's own written evaluations. While his December 2019 evaluation of respondent's ability to walk underscored his opinions at hearing, his prior report from his July 10, 2018 evaluation – performed significantly closer in time to respondent's September 2016 fall at work – described respondent's walk as follows:

His gait is normal. There is no Trendelenburg lurch³ nor genu recurvatum. His stride is equal bilaterally. Heel and toe

³ A Trendelenburg lurch or gait is an abnormal gait caused by weakness of the abductor muscles.

walking are accomplished normally but mildly uncoordinated.

By this description, respondent was walking significantly better in July 2018 than he was in December 2019. Dr. Capell offered no opinion on whether respondent's ability to walk was deteriorating, or why, or whether it was connected to his original work injury. Dr. Capell's most recent report also noted respondent had gained approximately 60 pounds since the time of his fall at work. Similarly, Dr. Capell offered no opinion as to how that weight gain, or other conditions, may have contributed to respondent's current increased difficulty with walking. Ultimately, these opinions did not properly address the issue of whether *at the time of filing his application*, respondent was substantially incapacitated from the performance of his usual and customary LVN duties.

32. Respondent's other evidence was not compelling enough to overcome CalPERS' evidence. The QME reports by Dr. Deshmukh, admitted as administrative hearsay,⁴ did not support a finding that respondent is substantially and permanently incapacitated from performing the usual duties of an LVN. To the extent the physician who authored the report applied evaluation standards applicable in workers' compensation cases, his opinion can be given little weight in this proceeding. The standards in disability retirement cases are different from those in workers' compensation. (*Bianchi v. City of San Diego* (1989) 214 Cal.App.3d 563, 567;

⁴ Government Code section 11513, subdivision (d), states, in relevant part: "Hearsay evidence may be used for the purpose of supplementing or explaining other evidence but over timely objection shall not be sufficient in itself to support a finding unless it would be admissible over objection in civil actions"

Kimbrough v. Police & Fire Retirement System (1984) 161 Cal.App.3d 1143, 1152-1153; *Summerford v. Board of Retirement* (1977) 72 Cal.App.3d 128, 132 [a workers' compensation ruling is not binding on the issue of eligibility for disability retirement because the focus of the issues and the parties are different].) Thus, the recommended work restrictions in Dr. Deshmukh's QME reports were insufficient to support that respondent is substantially and permanently incapacitated from performing the usual duties of an LVN.

33. Respondent further relied on the Physician's Report on Disability by Dr. Foxley, also admitted as administrative hearsay, but this report was a mere two-page form containing scant information. For instance, the question whether respondent was substantially incapacitated from performance of his usual job duties was indicated by a checked "Yes" box. Beneath the "Yes" box are directions that "If yes, you must describe specific job duties/work activities that the member is unable to perform due to incapacity," followed by four blank lines to be filled with such descriptions. Dr. Foxley left this segment of the form completely blank. Because Dr. Foxley did not testify, this report could only be considered to explain or supplement other reliable evidence. But the report provided so little information, it was of no significant value.

34. By contrast, Dr. Williams employed the standards applicable in these types of disability retirement proceedings. His opinion that respondent's orthopedic condition was not adequately supported by objective medical evidence was more persuasive and consistent with the available medical records than was Dr. Capell's opinion.

35. In sum, when all the evidence is considered, respondent failed to establish that, at the time he applied for disability retirement, he was substantially and

permanently incapacitated from performing the usual duties of an LVN. Consequently, his industrial disability retirement application must be denied.

LEGAL CONCLUSIONS

- 1. By virtue of his employment, respondent is a state safety member of CalPERS, pursuant to Government Code section 21151.**
- 2. To qualify for disability retirement, respondent had to prove that, at the time he applied, he was "incapacitated physically or mentally for the performance of [her] duties in the state service." (Gov. Code, § 21156.) As defined in Government Code section 20026:**

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

- 3. Evidence Code section 500 provides:**

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 he is asserting.
- 4. Evidence Code section 115 provides in relevant part, that "burden of proof" means the obligation of a party to establish by evidence a requisite degree of belief concerning a fact in the mind of the trier of fact or the court. The party assuming the affirmative at an administrative hearing has the burden of proof, including the**

initial burden of going forward and the burden of persuasion by a preponderance of the evidence. (*McCoy v. Board of Retirement* (1986) 183 Cal.App.3d 1044, 1051.)

Respondent has not met his burden.

5. The determination of whether respondent is substantially incapacitated must be based on an evaluation of whether, at the time he applied for disability retirement, he was able to perform the usual duties of a Licensed Vocational Nurse. (*California Department of Justice v. Board of Administration of California Public Employees' Retirement System (Resendez)* (2015) 242 Cal.App.4th 133, 139.)

6. 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.)

7. The court in *Hosford v. Board of Administration* (1978) 77 Cal.App.3d 855 (*Hosford*), reached a similar conclusion with respect to a state traffic sergeant employed by the CHP. In *Hosford*, the sergeant argued that his condition increased his chances for further injury. The court rejected this argument, explaining that "this assertion does little more than demonstrate that his claimed disability is only prospective (and speculative), not presently existing." (*Hosford, supra*, 77 Cal.App.3d at p. 863.) As the court explained, prophylactic restrictions that are imposed to prevent the risk of future injury or harm are not sufficient to support a finding of disability; a disability must be currently existing and not prospective in nature. (*Ibid*.)

8. When all the evidence in this matter is considered in light of the courts' holdings in *Resendez*, *Mansperger*, and *Hosford*, respondent did not establish that his

disability retirement application should be granted. Despite his credibly-stated complaints of pain, there was insufficient objective evidence based upon competent medical opinion that he was permanently and substantially incapacitated from performing the usual duties of a Licensed Vocational Nurse due to orthopedic conditions at the time he submitted his application. Consequently, his disability retirement application must be denied.

ORDER

The application of respondent Jack F. Howard for Service Pending Industrial Disability Retirement is DENIED.

DATE: March 23, 2020

DocuSigned by:
John DeCure
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JOHN E. DeCURE

Administrative Law Judge

Office of Administrative Hearings