

**ATTACHMENT A**

**THE PROPOSED DECISION**



would not provide adequate privacy protection. In order to prevent the disclosure of confidential information, concurrent with the issuance of this Proposed Decision the ALJ issued a Protective Order providing that the Exhibits 8, 11, and A through W shall be placed under seal following their use in preparation of the Proposed Decision. These exhibits shall remain under seal and shall not be opened, except by order of the CalPERS Board of Administration, by OAH, or by a reviewing court. A reviewing court, parties to this matter, their attorneys, or a government agency decision maker or designee under Government Code section 11517 may review the documents subject to this order provided that such documents are protected from release to the public.

Testimony and documentary evidence was received. The record was left open to allow the parties to submit simultaneous closing briefs (due April 3, 2020) and simultaneous reply briefs (due May 1, 2020). As discussed on the record on March 6, 2020, the parties expected to order copies of the hearing transcript for citation in their briefs.

On April 1, 2020, Respondent filed with OAH a joint motion requesting to extend the time for filing closing briefs because there was a delay in obtaining the transcript of the hearing. Given the late receipt of the transcript, the time for submission of closing briefs was extended to April 17, 2020. The date for submission of simultaneous reply briefs remained the same (May 1, 2020).

CalPERS and Respondent timely filed their closing briefs which were marked as Exhibits 12 and Z, respectively, and lodged. The parties timely filed their reply briefs which were marked as Exhibits 13 and AA and lodged. The record was closed, and the matter was submitted for decision on May 1, 2020.

## **FACTUAL FINDINGS**

### **Procedural Background**

1. Keith Riddle, Chief of the Disability and Survivor Benefits Division of CalPERS, filed the Statement of Issues while acting in his official capacity.
2. Respondent was previously employed by the City's police department as a Public Safety Dispatcher. By virtue of her employment, Respondent was a local miscellaneous member of CalPERS.
3. On May 9, 2019, Respondent signed and subsequently filed an application for disability retirement based on a psychological condition, specifically Post-Traumatic Stress Disorder (PTSD).
4. By letter dated July 17, 2019, Complainant denied Respondent's application. The letter noted that CalPERS had determined that Respondent's psychological condition is not disabling and that Respondent was not incapacitated for performance of her duties as a Public Safety Dispatcher.
5. By letter dated August 9, 2019, Respondent appealed CalPERS's determination, and this hearing ensued.
6. The parties agreed that the issue on appeal is limited to whether Respondent was substantially incapacitated from the performance of her duties as a Public Safety Dispatcher for the City based on a psychological condition (i.e., PTSD) when she applied for disability retirement.

## Respondent's Job Duties and Work History

7A. According to the City's job description, a Public Safety Dispatcher's duties include the following:

[R]eceives, screens and responds to incoming emergency and non-emergency calls for assistance. Dispatches appropriate units and maintains necessary communication with units during their response to calls. [¶] . . . [¶] Exercises considerable judgment in dispatching deployed units emergency. [¶] . . . [¶] Coordinates emergency calls and relays information and assistance requests involving other law enforcement and firefighting agencies. Provides field personnel with information relating to subjects, vehicles, and property so that they can determine appropriate action to be taken."

(Exhibit 10, pp. 1-2.)

7B. A Public Safety Dispatcher must have the ability to "work under pressure, handle multiple tasks and priorities simultaneously, adjust to changing situations and operations as they occur, exercise good judgment, remain calm, and make sound decisions in emergency situations . . . ." (Exhibit 10, p. 2.) The job description notes that the job environment includes working "under pressure and in potentially stressful conditions" and that the dispatcher must have the ability to "work in highly emotional or emergency situations." (*Id.* at p. 3.)

8. Respondent started working as a Public Safety Dispatcher for the City on January 3, 2006. She worked 10-hour shifts, four days per week.

9. At the administrative hearing, Respondent calmly described her many job duties, and she recalled "dealing with life or death constantly." She was trained to take calls from distraught people, and she would periodically receive phone calls from suicidal individuals. Respondent noted it was "distressing dealing with emergency situations on the phone."

10. Respondent did not begin to develop psychological symptoms until after 2014. At that time, she began to suffer from anxiety and hyper-awareness, which she described as, "if a pin dropped on the floor, [she] turned quickly." In 2016, Respondent took one week off work due to "anxiety panic attacks." (Respondent's testimony.) At the administrative hearing, Respondent tearfully testified that her 2016 panic attacks were triggered by doing her "very stressful" job. When asked what was stressful about her job, she was unable to respond through her weeping.

11. Respondent recalled that her 2016 treatment consisted of "one phone conversation" with a doctor. Thereafter, Respondent returned to regular duties, and continued to experience the same symptoms. However, she testified that, "it all came to a head with [the July 28, 2017 events]."

### **Events of July 28, 2017, and Aftermath**

12. Respondent recounted the events of July 28, 2017 calmly and without crying or appearing anxious.

13. On July 28, 2017, Respondent was working with several other dispatchers when, A.D.,<sup>1</sup> a police officer co-worker with whom she was acquainted, "sent a suicide

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<sup>1</sup> Initials are used for privacy protection.

email to the entire department, and [she] was the first one to read it." The email did not specify the suicide method A.D. planned to employ. However, after reading the email, Respondent believed A.D. was going to kill himself, and she said, "Oh my God where's [D.]?" This emergency was different from the others she had handled because "it was a co-worker, in our home, in our station." Thereafter, the phone rang with personnel calling from the police officers' locker room on the floor below the dispatch station. Respondent was told they had "an accidental discharge," and they requested medics be dispatched. Respondent knew the accident involved A.D., and the personnel were "trying to protect" the dispatchers. Emergency vehicles arrived at their location, and Respondent was later informed that the emergency call involved A.D., that he was still alive after attempting to shoot himself, and that the bullet from the gun he placed under his chin had exited the side of his face. A.D. never returned to work.

14. On the day of the incident, Respondent and the other dispatchers were relieved of their duties early, and the City immediately arranged a peer support group. However, Respondent recalled that they "were just zombies and not much help to each other."

15. Respondent returned to work performing her regular duties, but she suffered from increased symptoms including anxiety, shaking, nausea, irritability, nightmares and night terrors, sleeplessness, startling and panic from loud noises, fear of large crowds, and anxiety when seeing a man resembling A.D.

16. Respondent eventually informed the City she could not perform her job, and the City referred her to a doctor who "took her off work." (Respondent's testimony.)

17. Respondent's last day of work was September 30, 2017.

18. At the administrative hearing, Respondent testified that she stopped working because she "could not do [her] job anymore." Respondent also testified that she could not "go back into [the City] building anymore" or even "go near that building." She has not returned to the City since her last day of work.

19. Respondent has continued to experience symptoms with varying severity and unpredictable triggers that include the sound of multiple phone lines ringing or sirens from emergency vehicles.

20. Respondent tearfully lamented, "I cannot do my job anymore. I can't. I loved it! . . . I still do. I cry for it!" She stated that, despite working for a few weeks after the incident, her symptoms grew to be "greater than [her] love of the job." She maintains that she cannot answer emergency lines, deal with suicidal callers, or "work the radio," because "it is all real time . . . and [she] can hear everything that the officers are saying and background noise, [including] officer involved shootings."

21. If offered an alternative position for the City, Respondent asserts she "could not work there" because being close to the City "sets off [her] symptoms." Respondent no longer lives in the City. She moved to Boise, Idaho in June 2019, and her symptoms have decreased.

22. Since October 2019, Respondent has been working as a driver's license clerk at a county office in Idaho.

## **Treatment and Evaluations re: Respondent's Condition**

### **RESPONDENT'S TREATMENT WITH DR. RYLES AND DR. THOMAS<sup>2</sup>**

23. In October 2017, Respondent began treating with Clinical Psychologist, Bryan Scott Ryles, Ph.D., who diagnosed her with PTSD. She attended therapy with Dr. Ryles once per week, tapering to once every two weeks before moving to Idaho. She now speaks to Dr. Ryles telephonically, every two weeks, for about 45 minutes to one hour.

24. In January 2018, Respondent began treating with Lucille C. Thomas, M.D. At the first appointment on January 31, 2018, Dr. Thomas performed a history and physical and ordered laboratory blood work. At that first appointment, Respondent reported that she suffered from escalating stress and anxiety stemming from the incident. She reported that the counseling with Dr. Ryles was not improving her symptoms and that she had continued sleep disruption and persistent anxiety and depression. Respondent informed Dr. Thomas that she was "very cautious regarding

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<sup>2</sup> The reports of Dr. Ryles and Dr. Thomas were admitted as administrative hearsay, pursuant to Government Code section 11513, subdivision (d), which allows otherwise inadmissible hearsay evidence to be used to supplement or explain other evidence but not, by itself, to support a factual finding. Administrative hearsay evidence may be combined with other evidence to provide substantial evidence sufficient to support a finding. (*Komizu v. Gourley* (2002) 103 Cal.App.4th 1001, 1006-1007.)

[selective serotonin reuptake inhibitor (SSRI)]<sup>3</sup> medications as she was prescribed these in 2009 . . . and felt very flat on them.” (Exhibit S, p. 42.) Dr. Thomas gave Respondent a preliminary diagnosis of “Adjustment disorder with anxious mood.” (*Id.* at p. 43.)

25. On February 22, 2018, Respondent had a follow-up appointment with Dr. Thomas. Respondent reported that she continued to struggle with anxiety and insomnia and that she was unable to leave her home or find pleasure in usual activities due to her anxiety. Dr. Thomas reiterated her diagnosis of “Adjustment disorder with anxious mood” (Exhibit R, p. 39), and she prescribed a trial of Zoloft 25 mg with continued counseling.

26. On March 20, 2018, Respondent had a follow-up appointment with Dr. Thomas, and she reported some improvement in her symptoms. Dr. Thomas reiterated her diagnosis of “Adjustment disorder with anxious mood” (Exhibit Q, p. 36), and she prescribed continued use of Zoloft 25 mg.

27. On May 1, 2018, Respondent had a follow-up appointment with Dr. Thomas. She reported significantly diminished anxiety and improved sleep. She was able to go on outings including a fishing trip, and she was planning a trip to Alaska with her husband. Dr. Thomas also noted, “[Respondent] continues to have traumatic dreams typically related to receiving mail or news regarding her pending case. She [has] recently been evaluated by [a] medical examiner and has ongoing litigation. . . . [S]he would like to return to work on a limited basis.” (Exhibit P, p. 34.) Dr. Thomas

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<sup>3</sup> SSRIs are commonly prescribed antidepressants such as Zoloft, the brand name for generic sertraline.

reiterated her diagnoses of "Adjustment disorder with anxious mood," but added a diagnosis of "PTSD." (*Id.* at p. 35.) Dr. Thomas' PTSD diagnosis was added at the same time a PTSD diagnosis was made by a Qualified Medical Evaluator in Respondent's employment litigation. (See Factual Finding 33A.) Dr. Thomas prescribed continued use of Zoloft 25 mg.

28. On May 29, 2018, Respondent had a follow-up appointment with Dr. Thomas. She reported significant reduction in anxiety and improved mood. Dr. Thomas noted Respondent "is doing well[,] is able to get out [and] socialize[, and] has recently returned from a cruise to Alaska which she enjoyed." (Exhibit O, p. 32.) Nevertheless, Respondent reported, she "does not believe she will be able to return to her job as her job caused too much trauma." (*Ibid.*) Dr. Thomas reiterated her diagnoses of "Adjustment disorder with anxious mood," and "PTSD." (*Id.* at p. 33.) Dr. Thomas prescribed continued use of Zoloft 25 mg.

29. On July 30, 2018, Respondent had a follow-up appointment with Dr. Thomas. She reported improvement in anxiety and PTSD symptoms. Dr. Thomas noted, "she has been able to travel with her husband on airplanes even in adverse weather conditions without any difficulty[.] [S]he has no complaints [and] overall sleeps well unless there is something triggering in her environment[.]" (Exhibit N, p. 30.) Dr. Thomas reiterated her diagnoses of "Adjustment disorder with anxious mood," and "PTSD." (*Ibid.*) Dr. Thomas prescribed continued use of Zoloft 25 mg.

30. On October 29, 2018, Respondent had a follow-up appointment with Dr. Thomas. She reported that her father had been hospitalized in an intensive care unit for complications related to a fall and withdrawal from hydrocodone. Respondent informed Dr. Thomas that she was feeling stable, was sleeping well, and was able to handle the stress of her father's hospitalization without difficulty. Dr. Thomas noted,

"she has occasional traumatic dreams but they are rare." (Exhibit M, p. 28.) Dr. Thomas reiterated her diagnoses of "Adjustment disorder with anxious mood," and "PTSD." (*Ibid.*) Dr. Thomas prescribed continued use of Zoloft 25 mg.

31. On February 11, 2019, Respondent had a follow-up appointment with Dr. Thomas. She reported that her father-in-law passed away after Thanksgiving which caused increased stress. She also reported that she was "feeling great" and that she "sleeps better and feels better when she does get regular exercise." (Exhibit L, p. 26.) Respondent informed Dr. Thomas that she "does not plan to return to work." (*Ibid.*) Dr. Thomas reiterated her diagnoses of "Adjustment disorder with anxious mood," and "PTSD." (*Id.* at pp. 26-27.) Dr. Thomas prescribed continued use of Zoloft 25 mg.

32. With therapy and medication over the past few years, Respondent's symptoms have significantly improved but not dissipated completely. She is continuing to take Zoloft as prescribed and monitored by Dr. Thomas.

#### **QUALIFIED MEDICAL EVALUATIONS BY DR. ZARRIN<sup>4</sup>**

33A. In April 2018, Yassi Zarrin, Psy.D. conducted a Qualified Medical Evaluation (QME) of Respondent in Respondent's workers' compensation case. In her May 8, 2018 QME report, Dr. Zarrin diagnosed Respondent with PTSD. (Exhibit W.)

33B. In October 2018, Dr. Zarrin conducted a supplemental QME. During the October 2018 re-evaluation, Respondent acknowledged her emotional symptoms had improved but not entirely resolved. Dr. Zarrin diagnosed Respondent with Major Depressive Disorder. (Exhibit V.) In a January 16, 2019 QME supplemental report, Dr.

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<sup>4</sup> The reports of Dr. Zarrin were admitted as administrative hearsay. (See fn. 2.)

Zarrin opined that "it is medically expected that [Respondent] will be able to return to work in her usual and customary assignment as a public safety dispatcher from a psychological perspective." (*Id.*, at p. 126.) Dr. Zarrin noted Respondent "has acknowledged that through time and through further mental health treatment, her emotional symptomatology and condition has improved. . . . [I]t is anticipated that with even further time and further mental health treatment she should have a good prognosis and there is anticipated further improvement in her emotional condition. As such it would be expected that [Respondent] would be able to handle and maintain her duties and responsibilities as a public safety dispatcher." (*Ibid.*) Dr. Zarrin recommended that, when Respondent returned to work, she should be given a reduced workload with a shorter work schedule and breaks throughout her shift "to process previous phone calls and her emotions. This would negate any feelings of being overwhelmed or emotionally exhausted." (*Ibid.*)

33C. In March 2019, Dr. Zarrin conducted another QME of Respondent. At that re-evaluation, Respondent stated that she realized she cannot, and did not want to, return to work as police dispatcher due to the emotional impact of that job. Respondent reported that, when she thought about returning to work, it made her extremely anxious. Dr. Zarrin diagnosed Respondent with Depressive Disorder, Not Otherwise Specified. (Exhibit U.) In an April 2, 2019 QME re-evaluation report, Dr. Zarrin explained her changing diagnoses as follows:

[A]t the time of my initial evaluation, I opined that [Respondent] met criteria for [PTSD]. This was related to feelings of trauma, flashbacks and visions of the incident and constant fear that something bad or dreadful was going to happen. Through the course of time, feelings of

trauma have improved. [Respondent] then reported symptoms of depression, anxiety, and despondency. At the time of my re-evaluation in October 2018, I opine[d] that [Respondent] met criteria for Major Depressive Disorder. . . . During today's re-evaluation, I opine that [Respondent's] symptomology has continued to improve. I no longer feel that her emotional symptoms would meet the severity of a Major Depressive Disorder. At this juncture, I opine that [Respondent] meets criteria for a Depressive Disorder, Not Otherwise Specified. [¶] . . . [¶]

I find [Respondent's] symptomatology and level of functioning fall within the mild range.

(*Id.* at p. 114.)

### **INDEPENDENT MEDICAL EXAMINATION BY DR. WARRICK**

34. On June 20, 2019, Lawrence H. Warick, M.D., PhD. conducted an independent medical evaluation (IME) of Respondent at CalPERS's request.

35. On June 26, 2019, Dr. Warick issued his Independent Medical Report in Psychiatry following his evaluation of Respondent. In his report, Dr. Warick noted Respondent's reported history of injury that included the following:

The job was stressful. There were constant crises, life and death situations. . . . She recalls an episode in 2016 when she developed symptoms of anxiety because of overwork. She spoke with the department psychologist, who referred

her to a psychologist. . . . She did miss time from work and was taken off work for about a week. . . . In addition to her anxiety at that time, she had rapid heartbeat, shortness of breath, hyper-awareness, and feeling jittery. She was told by her physician in 2016 that her anxiety was due to work. She did not file a workers' compensation claim at that time. She did decide to file a claim, however in October 2017 after she left work in September, because her symptoms increased, and she felt she had "had enough. I couldn't live like that. [¶] . . . [¶]

[After her co-worker's suicide attempt, Respondent] developed panic attacks in addition to her anxiety. . . . She was haunted, visually and emotionally by the suicide attempt. [¶] . . . [¶]

[Respondent] proclaims, "Even though I loved my job and I miss it, I could never continue working in that field again."

(Exhibit 8, p. 2.)

36. Dr. Warick's psychological testing of Respondent included the Millon Clinical Multiaxial Inventory –IV (MCMI-IV) and the Structured Inventory of Malingered Symptomology (SIMS). Dr. Warick noted that the SIMS "indicated no evidence of exaggeration or malingering." (Exhibit 8, p. 7.) He also noted that the MCMI-IV indicated:

On Axis II, her personality is listed as compulsive, turbulent, and histrionic. Histrionic individuals can be dramatic,

interpersonally attention-seeking, temperamentally fickle. Turbulent people can be expressively impetuous, interpersonally high spirited, and having an exalted self-image. On Axis I, she endorses primarily anxiety, which is consistent with my clinical impression. On Axis I, there is no evidence from the testing of any indications of [PTSD] or even clinical depression. It shows primarily anxiety.

(Exhibit 8, p. 7.)

37. Dr. Warick concluded that, "as a result of a stressful work situation and the attempted suicide of a colleague, as well as personal issues," Respondent developed "Adjustment Disorder with Mixed Features, mild." (Exhibit 8, p.10.) In his report, Dr. Warick explained his diagnosis of adjustment disorder, and his ruling out of PTSD, as follows:

An acute adjustment disorder involves a disturbance lasting less than six months, with development of emotional and behavioral symptoms in response to an identifiable stressor occurring within three months of the onset of the stressor. Symptoms that are clinically significant are evidenced by distress that is in excess of what would be expected from exposure to the stressor with some possible impairment in social or occupational or academic functioning. If associated with depressed mood, manifestations are symptoms of depressed mood, tearfulness, or feeling of hopelessness. If associated with anxiety, predominant manifestations are nervousness, worry, jitteriness. [¶] . . . [¶]

The client has some symptomatology of a mild adjustment disorder with mixed features that is responding to low doses of Zoloft, but no evidence at present time of any symptoms of PTSD that would arise to a level of substantial incapacity.

A [PTSD] involves re-experiencing recurrent intrusive recollections, images, thoughts, and perceptions of the event both in waking states as well as in nightmares, physiological reactivity at exposure to internal or external cues that symbolize or resemble aspects of the traumatic event, persistent avoidance of stimuli associated with the trauma, and numbing of general responsiveness, as indicated by avoiding activities, places or people that arouse recollections of the trauma, inability to recall aspects of the trauma, diminished interest or participation in significant activities, and feelings of detachment and estrangement. There may be difficulty falling and staying asleep, irritability, outbursts of anger, difficulty concentrating, hypervigilance, and an exaggerated startle response.

(Exhibit 8, pp. 10-11.)

38. In his report, Dr. Warick did not explain why he diagnosed Respondent with adjustment disorder, when that diagnosis "involves a disturbance lasting less than six months," but Respondent's symptoms had been ongoing for years.

39A. Dr. Warick opined that Respondent was not substantially incapacitated from performance of her usual job duties. He explained how he arrived at that conclusion as follows:

She is currently living a perfectly normal life, and she and her husband are moving to Boise, Idaho, for career changes and relocation, as well as possibly economic reasons, not in any way related to her employment as a dispatcher at the [City]. She has some mild symptoms of anxiety and depression, which may require some ongoing treatment in Idaho with medication and counseling,

I should also note that in addition to her claims of work-related stress, as well as her reaction to the suicide attempt of her colleague, one should note that some important events happened in her life outside of her work situation. Her father, who has a chronic history of depression and treatment for it, also developed a blood clot and subdural hematoma with craniotomy, paralysis, and organic brain symptoms. The client is quite close to her father. She is also dealing with a brother who has MS and a mother who is diabetic, as well as the recent death of her father-in-law, with whom she was close. She also had prior similar symptoms in 2016, for which she was seen by a psychologist but not given any medication.

39B. In his report, Dr. Warick did not address how Respondent's symptoms (Respondent's moving to Idaho, her ability to carry on a "normal life" outside of work,

and her other noted stressors (family illnesses and prior anxiety in 2016) rendered her capable of carrying out her usual job duties.

40. Dr. Warick opined in his report that, "with proper treatment over a short period of time, possibly three to six months, with medication and psychotherapy [Respondent] can perform the essential duties of a dispatcher." (Exhibit 8, p. 12.) Dr. Warick did not specify what types of medication would be included in Respondent's "proper treatment."

### **Experts' Testimony at Hearing**

41A. At the administrative hearing, Dr. Warick and Dr. Thomas testified for CalPERS and Respondent respectively, to establish Respondent's diagnosis and to opine regarding whether she was substantially incapacitated for performance of her duties as a Public Safety Dispatcher.

41B. Dr. Warick is certified by the American Board of Psychiatry and Neurology. He operates a private practice in psychiatry, and he is an Associate Professor of Clinical Psychiatry at the UCLA School of Medicine. Dr. Warick has seen hundreds of PTSD patients in his practice.

41C. Dr. Thomas operates a practice specializing in family and addiction medicine. She is certified by the American Board of Family Medicine and has subspecialty certification in Addiction Medicine. Her addiction medicine certification includes the ability to provide mental health treatment, and she has provided psychiatric treatment to patients who have suffered from adjustment disorders and PTSD. Those patients included individuals working in safety jobs such as police or fire

personnel. Dr. Thomas is familiar with the Diagnostic and Statistical Manual of Mental Disorders.<sup>5</sup>

41D. Dr. Warick and Dr. Thomas were equally qualified to testify as experts in this case. Any additional weight given to one expert's testimony over the other's was based on the content of their testimonies and bases for their opinions, as set forth more fully below.

42A. Dr. Warick's testimony generally mirrored the findings in his report, with some added details. In relating Respondent's history of injury, Dr. Warick noted that "she was overworked, stressed and had issues with coworkers," she "developed symptoms of anxiety because of overwork," and she was affected by her co-worker's attempted suicide and "developed panic in addition to anxiety. . . . Cumulative stuff, not a particular incident." Dr. Warick recalled during the mental status examination that Respondent was friendly, cooperative, articulate, coherent, alert, and showed no signs of clinical depression and no evidence of overt anxiety such as shaking or fidgeting. She was not distracted or preoccupied, and she did not display psychotic symptoms. She did not demonstrate exaggeration or malingering, which was confirmed with the SIMS testing.

42B. Dr. Warick did not observe any physical or mental traits of PTSD during Respondent's mental status exam, and he confirmed his clinical observations with the

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<sup>5</sup> The ALJ took official notice of the Diagnostic and Statistical Manual of Mental Disorders, 5th Ed. (DSM-5) as a generally accepted tool for diagnosing mental disorders.

MCMI-IV testing which showed no evidence of PTSD. Dr. Warick explained that with PTSD, "there's a whole constellation of things which cripples an individual and actually requires very intense treatment." With a PTSD patient, there are typically physical and mental/emotional symptoms observable during a mental status examination. Physically, the patient may demonstrate agitation, nervousness, aggressiveness, or fear. Their eyes may wander, they may pace, or they may be shaking. Mental symptoms may include recurrent thoughts, flashbacks, nightmares, or avoidance of places that remind the patient of the trauma. Dr. Warick also noted that PTSD patients "require about three or four different drugs to handle the PTSD" and that Respondent was taking "a low dose of Zoloft, which is good for anxiety and mild depression."

42C. Dr. Warick observed that, although Respondent claimed she had anxiety, when he evaluated her, "she was calm and relaxed" with no symptoms of overt anxiety. He conceded that a patient may have mild anxiety which he would be unable to see in an interview. He acknowledged that she was a credible historian, that SIS testing was negative for malingering, and that Respondent said she was unable to perform her job duties. However, he maintained that Respondent was not substantially incapacitated from performance of her usual job duties because she was able to perform her job duties well "with her mental issues."

42D. Dr. Warick noted that some patients with acute PTSD can experience symptoms for six months to one year, and others can suffer for 30 years. According to Dr. Warick, a "majority [of PTSD patients] with proper treatment" can return to the scene of the trauma and "their symptoms disappear." He asserted, "I don't consider her treatment of 25 milligrams of Zoloft as a proper treatment for whatever diagnosis she has," and he opined that, if Respondent was given the proper treatment, she could return to her job. Dr. Warick did not specify the proper treatment for Respondent.

43. In explaining his diagnosis of adjustment disorder Dr. Warick's testimony was vague. Although he acknowledged that adjustment disorder usually lasts only three to six months, and rarely becomes chronic, he did not explain how Respondent could suffer from adjustment disorder several years following the incidents giving rise to her symptoms.

44A. In explaining how he ruled out a diagnosis of PTSD, Dr. Warick's testimony was circuitous and argumentative. Dr. Warick evasively refused to concede that certain symptoms could be included in a PTSD diagnosis, and he steadfastly answered such inquiries by circling back to his insistence that Respondent did not have PTSD. Dr. Warick's tenacious defense of his diagnosis included prolonged arguments to maintain his position well after answering the specific questions posed. The following exchanges are examples:

(1). When asked about Respondent's rapid heartbeat, shortness of breath, hyperawareness and feeling jittery, Dr. Warick testified that these could be related to panic attacks. He noted that "hyperawareness can be normal if you are in a dangerous neighborhood," despite there being no evidence that Respondent was in a dangerous neighborhood when experiencing this symptom. Dr. Warick insisted that Respondent's symptoms are "part of the loaf, not the whole loaf" and that a patient must meet "a list of criteria [set forth] in the DSM-5" in order to be diagnosed with PTSD. However, Dr. Warick did not specify what criteria were listed in the DSM-5 for a diagnosis of PTSD and which of the criteria Respondent failed to meet.

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(2). Similarly, when asked if Respondent's anxiety, shaking, nausea and sleeplessness could be related to either an adjustment disorder or PTSD, Dr. Warick responded as follows:

A. Adjustment disorder, yes.

Q. And not post-traumatic stress?

A. No.

Q. Why would those not be possible

A. Well, again, it's a piece of bread rather than a full loaf.

(Hearing Transcript, p. 85, lines 24-25, p. 86, lines 1-7.)

(3). While Dr. Warick agreed that some people may develop PTSD following the attempted suicide of a co-worker, he maintained that "a grief reaction is a more normal reaction" and that he found no evidence in Respondent's history that she had PTSD. He did not adequately explain why Respondent's symptoms were merely "a grief reaction" and not indicative of PTSD.

(4). When Dr. Warick was questioned about Respondent's avoidance of the place where the trauma occurred, this exchange occurred:

Q. When you testified regarding post-traumatic stress, you said one of the common themes is people cannot be near whatever the trauma was that triggered their condition; correct?

A [by Dr. Warick]. If they have post-traumatic stress.

Q. So if she did have post-traumatic stress, this would seem to be something you would expect; correct?

A. But she didn't tell me that.

Q. I'm not asking you that. I'm asking whether this is something that you would expect from somebody with post- -- if they have post-traumatic stress. It's a hypothetical.

A. No. I can't answer hypothetically because she doesn't have post-traumatic stress.

(Hearing transcript, p. 61, lines 21-25; p. 62, lines 1-10.)

44B. In his unyielding defense of his diagnosis, Dr. Warick contended that Respondent did not have PTSD because she did not use the word "trauma" to describe the triggering event. Specifically, he testified:

A. [by Dr. Warick] . . . looking at the form that she filled out, there's no mention in her form of trauma. Okay. There's no mention. She filled out his form. There's no mention of trauma.

Q. When you talked to her, did she not discuss with you the incident where the individual attempted suicide?

A. But she didn't use the word "trauma." [¶] . . . [¶]

Q. Does every person who suffers [PTSD] come to you and say, "I have trauma"?

A. Yes.

Q. Really?

A. Yes. [11] . . . [11]

Q. So I want to make sure I understand what you're saying. You're saying that in all cases, an individual uses the word "trauma" if they have [PTSD]?

A. Yes.

(Hearing Transcript, p. 73, lines 11-25, p. 74, lines 1-20.)

44C. Additionally, when Dr. Warick was asked if he reviewed the records of Dr. Thomas, he instead pointed out that Dr. Thomas was a family practitioner, not a psychiatrist in an unprovoked attack on Dr. Thomas' credentials. Dr. Warick contended that PTSD is a much misused diagnosis, pointing out that Dr. Zarrin changed Respondent's diagnosis three times. He insisted that Dr. Thomas and Dr. Zarrin were "both confused about PTSD."

44D. Given the foregoing, Dr. Warick's testimony often took on the tenor of an advocate, rather than an impartial witness, and this diminished his general credibility as an expert.

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45A. Dr. Thomas confirmed her findings in Respondent's treatment records with some added details. Her testimony was generally credible, except where noted below.

45B. When Dr. Thomas first examined Respondent, her working diagnosis was adjustment disorder with anxiety. However, Dr. Thomas' diagnosis of Respondent's condition changed over time, when "it became clear" that Respondent was not suffering solely from adjustment disorder, as Respondent displayed significantly persistent symptoms of PTSD unresolved with treatment.

45C. Dr. Thomas testified that she was initially cautious about making a PTSD diagnosis because she did not want anything in her medical notes that could negatively impact Respondent. Dr. Thomas had previously diagnosed a police officer with PTSD, and that diagnosis resulted in the patient's involuntary employment termination. This purported reason for withholding a potential differential diagnosis lessened the reliability of Dr. Thomas' medical records and her documented diagnoses, since the purpose of medical recordkeeping is to document accurate findings and a physician's unbiased assessment of those findings, including differential diagnoses. If Dr. Thomas had suspected possible PTSD, she should have included it in her records. However, she did not add the PTSD diagnosis until Respondent's fourth visit, after being informed about the QME in Respondent's employment litigation.

46. Dr. Thomas credibly noted that PTSD requires a precipitating trauma resulting in symptoms of more than a month in duration causing clinically significant impairment not attributable to another condition. Dr. Thomas disagreed with Dr. Warick's assertion that a patient must use the word "trauma" in order to be diagnosed with PTSD. Dr. Thomas credibly explained that a patient must provide a history of

something that the clinician would evaluate to be a "trauma," but the patient is not responsible for classifying it as a "trauma."

47. In this case Respondent had recurrent symptoms, including nightmares, anxiety, and irritability. Dr. Thomas recognized that these "are classic symptoms of PTSD." Respondent also felt anxious if she traveled near the City since the site was "triggering" for her. Respondent initially did not want to leave her home. However, she later improved and was able to take a trip to Alaska. Dr. Thomas noted that, while away from the triggering location, a patient may experience improvement in their day-to-day symptomatology, but this does not mean the PTSD has resolved.

48. Dr. Thomas described PTSD as "a waxing and waning condition," and she opined that it was not realistic to expect complete remission of true PTSD. Nevertheless, symptoms can be reduced over time depending on the trauma and the patient. Additionally, if a PTSD patient avoids triggers, this may provide relief from symptoms, but does not mean the PTSD is gone. During the time Dr. Thomas treated Respondent, her symptoms improved but continued. With distance from the City, Respondent had lessening symptomatology, as Dr. Thomas expected.

49. Dr. Thomas testified that she sought to treat Respondent's symptoms and was not as concerned about the specificity of the diagnosis. She noted that PTSD treatment is "palliative care" involving treatment and management of symptoms and minimizing exposure to triggers. In Respondent's case, Dr. Thomas prescribed medication for her anxiety and depression and advised her to take over-the-counter melatonin to improve her sleep. Respondent derived some benefit from the medication. Additionally, therapy is typically employed to help a patient learn behavioral techniques for minimizing PTSD symptoms. Respondent received this therapy through Dr. Ryles.

50. Dr. Thomas asserted that Respondent no longer has adjustment disorder since that typically resolved about six months after the trauma and it was unlikely for an adjustment disorder to last so long. Dr. Thomas opined that Respondent still suffers from PTSD because it is "highly unlikely for PTSD to go away."

51. Dr. Thomas predicted that, if Respondent was exposed to triggering events, her symptoms would return. Dr. Thomas opined that Respondent cannot substantially perform her job duties as a Public Safety Dispatcher. Dr. Thomas asserted that Respondent's inability to work for the City is "an actual restriction" and "not a prophylactic restriction" because Respondent "cannot work [at the City] with her current condition."

52. Dr. Ryles submitted a December 25, 2019 letter<sup>6</sup> in which he agreed with Dr. Thomas' PTSD diagnosis and likewise opined that Respondent's PTSD comprised an "impairment that arises to the level of substantial incapacity to perform [her] usual job duties." (Exhibit A, p. 4.) Dr. Ryles agreed with Dr. Thomas' opinion that, although Respondent's symptoms have improved with treatment, medication and the removal of occupational exposure, "her symptoms would present in full reemergence upon [Respondent's] return to work in the capacity of a public safety dispatcher or in the environs of the [City]." (*Ibid.*)

53A. The preponderance of the evidence established that Respondent suffered from symptoms in 2017 through 2018 which were likely attributable to PTSD, as defined by the DSM-5. In 2019, Respondent's most likely diagnosis remained PTSD, as diagnosed by Dr. Thomas. Dr. Warick's diagnosis of adjustment disorder, by definition,

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<sup>6</sup> Dr. Ryles' letter was admitted as administrative hearsay.

was inappropriate, given that such a disorder should have resolved within six months after the July 2017 trauma. Dr. Zarrin's diagnosis of Depressive Disorder, Not Otherwise Specified, was admitted as administrative hearsay, and cannot be used as direct evidence to establish Respondent's appropriate diagnosis.

53B. The preponderance of the evidence did not establish that Respondent continues to suffer from PTSD. Dr. Thomas did not testify that Respondent continues to exhibit symptoms which meet the criteria for a PTSD diagnosis. Instead, she merely opined that Respondent continues to suffer from PTSD because it is "highly unlikely for PTSD to go away."

54. Regardless of Respondent's diagnosis, all of Respondent's doctors and evaluators noted that, with therapy and medication, her symptoms decreased significantly over time. By 2019: Dr. Thomas noted that Respondent reported "feeling great" and sleeping better; Dr. Zarrin noted that Respondent's symptoms had improved such that they no longer met the severity of a major depressive disorder; and Dr. Warick noted during Respondent's mental status examination that she showed no signs of clinical depression and no evidence of overt anxiety.

## **LEGAL CONCLUSIONS**

1. Government Code section 21150 provides, in pertinent part: "Any member incapacitated for the performance of duty shall be retired for disability, pursuant to this chapter if he or she is credited with five years of state service, regardless of age. . . ."

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2. Government Code section 20026, states, in pertinent part:

“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. “Incapacitated for the performance of duty,” means the “substantial inability of the applicant to perform his usual duties,” as opposed to mere discomfort or difficulty. (*Mansperger v. Public Employees’ Retirement System* (1970) 6 Cal.App.3d 873, 877; *Hosford v. Board of Administration* (1978) 77 Cal.App.3d 854.) The increased risk of further injury is not sufficient to establish current incapacity; the disability must exist presently. Restrictions which are imposed only because of a risk of future injury are insufficient to support a finding of disability. (*Hosford, supra*, 77 Cal.App.3d 854, 862 -863.)

4A. Respondent did not establish with medical certainty that, if she returned to work as a Public Safety Dispatcher, she would sustain psychological injury such that she would be incapacitated from her usual and customary duties. Dr. Thomas opined that Respondent cannot return to work because her symptoms would recur and prevent her from performing her duties as a Public Safety Dispatcher. Dr. Thomas’ conclusion is questionable because it does not sufficiently account for Respondent’s subsiding symptoms with medication and therapy. Additionally, the potential for exacerbation or escalation of Respondent’s psychiatric symptoms when placed in her former position is a prospective possibility, not a medical certainty, and is insufficient to support a finding of Respondent’s inability to perform her usual and customary duties. As noted in *Hosford, supra*, a disability cannot be premised on a risk of further injury, and the fact that someone may feel discomfort is insufficient to grant industrial

disability retirement. Respondent must be unable to perform her usual and customary duties. Dr. Thomas arrived at her opinion based on Respondent's trepidation about returning to work, but she did not sufficiently establish that Respondent's aversion to the discomfort of returning to the stress of her job prevented her from performing her usual duties as a Public Safety Dispatcher.

4B. Although Respondent asserts that the July 2017 trauma renders her currently incapable of handling the stressful duties of a Public Safety Dispatcher, her assertion was not borne out by the evidence. Respondent is greatly apprehensive about her return to work and the discomfort it may cause her. While Respondent may experience emotional reactions to triggers she associates with her job and the 2017 trauma, these responses in themselves do not establish that she would be unable to perform her duties and re-adapt to the stress of her position if she returned. Following the July 2017 incident, when Respondent last worked as a Public Safety Dispatcher, she was able to perform her usual duties, although she was uncomfortable doing so. After she discontinued work in September 2017, Respondent received treatment, and her symptoms decreased significantly. By 2019, her symptoms were considered mild, and she showed no signs of clinical depression and no evidence of overt anxiety during her mental status examination. Respondent has never attempted to return to work following her treatment and her decreased symptomology, and thus, she cannot establish that she is currently incapable of handling the duties of a Public Safety Dispatcher with continued medication and treatment.

5. Given the foregoing, the evidence did not establish that at the time of her application for industrial disability retirement, Respondent was substantially incapacitated from the performance of her usual and customary duties as a public safety dispatcher.

## ORDER

The appeal of Respondent Kimberly A. O'Donnell, seeking retirement for disability as a local miscellaneous member of CalPERS, is denied.

DATE: May 22, 2020

DocuSigned by:  
  
JULIE CABOS-OWEN

Administrative Law Judge

Office of Administrative Hearings