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 Disability Retirement of: JESUS ESCANUELA, Respondent, and CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION (AVENAL STATE PRISON), Respondent.	Case No. 2012-0364 OAH No. 2012061020

PROPOSED DECISION

Administrative Law Judge Catherine B. Frink, State of California, Office of Administrative Hearings, heard this matter in Fresno, California on January 10, 2013.

Rory J. Coffey, Senior Staff Counsel, represented the California Public Employees' Retirement System (CalPERS).

Jesus Escanuela (respondent) was present and represented himself.

There was no appearance by or on behalf of the California Department of Corrections and Rehabilitation (CDCR), Avenal State Prison.[1]

The record was closed and the matter was submitted on January 10, 2013.

[1] CDCR did not appear at hearing, despite having been properly served with the pleadings and notice of hearing; therefore, the matter proceeded as a default against CDCR, pursuant to Government Code section 11520.

PUBLIC EMPLOYEES RETIREMENT SYSTEM
FILED January 31 2013

ISSUE

Whether respondent is permanently disabled or incapacitated from performance of his duties as a Correctional Officer with CDCR on the basis of psychological, neurological (headaches), and cardiac (heart, high blood pressure) conditions.

FACTUAL FINDINGS

Procedural History

1. CalPERS, by Mary Lynn Fisher, Chief, Benefit Services Division, filed the Statement of Issues in its official capacity on June 13, 2012.

2. At the time respondent filed his application for industrial disability retirement, he was employed by CDCR at Avenal State Prison (Avenal) as a Correctional Officer. By virtue of this employment, respondent is a state safety member of CalPERS subject to Government Code section 21151.[2]

3. On July 20, 2011, respondent signed an application for industrial disability retirement.[3] In his application, respondent described his specific disability as follows:

> (Stress, high blood pressure and heart)
> As as a result of cumulative trauma due to the stress associated to my job as a correctional officer with the California Department of Corrections and Rehabilitation (CDCR) at Avenal State Prison (ASP), I have developed the above mentioned conditions. I filed these claims on 7/1/10 because I began to experience severe headaches and elevated blood pressure. Additionally in October of 2010, I experienced

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[2] All statutory references are to the California Government Code, unless otherwise specified. Section 21151, subdivision (a), states: "Any patrol, state safety, state industrial, state peace officer/firefighter, or local safety member incapacitated for the performance of duty as the result of industrial disability shall be retired for disability, pursuant to this chapter, regardless of age or amount of service."

[3] Section 21166 provides in pertinent part:

> If a member is entitled to a different disability retirement allowance according to whether the disability is industrial or nonindustrial and the member claims that the disability as found by the board...is industrial and the claim is disputed by the board...the Workers' Compensation Appeals Board, using the same procedure as in workers' compensation hearings, shall determine whether the disability is industrial....

elevated blood pressure and medical staff at ASP became concerned that I could experience a stroke.

Respondent described the following limitations/preclusions due to his injury or illness: "No inmate contact, working in a correctional environment and avoid excessive stress." Respondent stated that, "[d]ue to my physical condition and doctors restrictions, I am no longer able to perform the essential functions of my job." He also stated: "It should also be noted that on two other occasions I was transported by ambulance from ASP to the hospital due to extremely high blood pressure. I have been advised by my Cardiologist Dr. Plenys, that my high blood pressure has lead [*sic*] me to developing complications with my heart. At this point, he has concerns about my ability to return to work in my usual and customary capacity as a Correctional Officer due to my condition."

4. CalPERS obtained or received medical reports concerning respondent's psychological, neurological (headaches), and cardiac (heart, high blood pressure) conditions from competent medical professionals. After review of those documents, CalPERS determined that respondent was not permanently disabled or incapacitated from performance of his duties as a Correctional Officer at the time the application for disability retirement was filed.

5. Respondent was notified of CalPERS' determination and advised of his appeal rights by a letter dated February 24, 2012.

6. Respondent filed a timely appeal from the denial of disability retirement by letter dated March 5, 2012, and requested a hearing. The matter was set for an evidentiary hearing before an Administrative Law Judge of the Office of Administrative Hearings, an independent adjudicative agency of the State of California, pursuant to Government Code section 11500 et seq.

State Employment and Job Duties

7. Respondent became employed by CDCR at Soledad State Prison (Soledad) in the fall of 2001. In 2004, he transferred to Avenal. Soledad is a high security facility, and inmates were confined to cells. At Avenal, inmates are housed in groups, in open dormitories. Respondent stated that, because the inmates at Avenal had more freedom of movement, it was necessary to be in a state of constant awareness, "by just being in the presence of 200 inmates, with just one partner [correctional officer]." He stated that the correctional officers did not take breaks or lunch during their eight-hour shifts, and they were often required to work double shifts (16 hours). Respondent stated that correctional officers could not turn down overtime assignments.

8. CDCR has identified 37 "Essential Functions" for the position of correctional officer, including the following:

- Must be able to work in both minimum and maximum security institutions as well as male and female institutions
- Must be able to perform the duties of all the various posts
- Must be able to work overtime. Overtime is mandatory and could be 8 hours at one time, and on very rare occasions up to 16 hours in a situation such as a riot
- Must range qualify with departmentally approved weapons, keep a firearm in good condition, fire weapon in combat/emergency situation
- Must be able to swing baton with force to strike an inmate
- Disarm, subdue and apply restraints to an inmate
- Defend self against an inmate armed with a weapon
- Inspect inmates for contraband, conduct body searches
- Occasionally, lift and carry an inmate and physically restrain the inmate including wrestling an inmate the floor, track/carry an inmate out of the cell, perform lifting/carrying activities while working in very cramped space
- Must have mental capacity to be aware/alert in their observation/identification of security risks. Correctional Officers are at risk to [*sic*] a variety of inmate behaviors, including but not limited to aggressive or violent inmates, psychological manipulation, or verbal abuse/harassment. Correctional officers must also have mental capacity for exposure to very unpleasant situations including inmates who have attempted or committed suicide by hanging themselves in their cell or slashing their wrists, or inmates who throw bodily fluids at them
- Must have the mental capacity to judge an emergency situation, determine the appropriate use of force, and carry out that use of force. Use of force can range from advising an inmate to cease an activity to firing a lethal weapon at an inmate when another life is threatened with great bodily harm or death

Other essential functions include the ability to walk occasionally to continuously; run occasionally while responding to alarms or serious incidents; climb occasionally to frequently; ascend or descend stairs or ladders; crawled and crouched occasionally; stand occasionally to continuously; sit occasionally to continuously; stoop and bend occasionally to frequently; lift and carry continuously to frequently (20 to 50 pounds) and occasionally up to 100 pounds; continuously where equipment belt weighing 15 pounds; pushing and pulling occasionally to frequently; reaching occasionally to continuously, reach overhead while performing cell or body searches, etc.; head and neck movement frequently to continuously throughout the workday; arms movement occasionally to continuously; hand and wrist movement frequently to continuously; and twisting of the body frequently to continuously.

Respondent's Testimony and Evidence

9. Respondent is 42 years old. He stated that he experienced stress on the job from the time he was first employed at Soledad, but that his stress increased after he transferred to Avenal, where inmates were "not locked up," thereby requiring a heightened level of vigilance while at work. In 2005 or 2006, he began to experience anxiety, and noticed that his blood pressure was elevated. He also developed headaches, which he associated with his high blood pressure. He began to experience "panic attacks" at work. On one occasion, he was on his way to Avenal in a CDCR van, and he became claustrophobic; he felt he had to "get out," and had the driver of the van pull over. On his last day of work, respondent felt like he was having a stroke. He went to the infirmary, and the nurse took his blood pressure, which was very high. He took off his bullet-proof vest and sat in front of a fan, but his blood pressure did not go down. The nurse recommended that he "go home and see a doctor, so [he] wouldn't have a stroke." Respondent visited his primary care physician the next day, and she took him off work. Respondent's last day of work was in late October 2010, on an exact date not established by the evidence.

10. Respondent acknowledged that being a correctional officer is an inherently stressful and dangerous job. While employed at CDCR, he was not harassed by peers or supervisors, and he was not assaulted, "gassed"[4] or physically injured on the job. He reported that, in the two years since he has been off work, he has "gotten better with anxiety." When he was going to work, he would "get physically sick," and experienced cold sweats. He felt "overwhelmed" dealing with inmate issues in the housing unit. He stated that inmates made death threats against him and his family. He was prescribed anti-anxiety and high blood pressure medications, which he felt impaired his decision-making. His current prescriptions include atenolol (to slow his heart rate); lisinopril and amlodipine (for high blood pressure); and Xanax (for anxiety, as needed).

11. In October of 2010, respondent's primary care physician was Irma Castro, M.D. Dr. Castro saw respondent on October 20, 2010, with a complaint of stress at work. Dr. Castro had prescribed Xanax for anxiety, which respondent claimed made him feel groggy. At the October 20, 2010 appointment, Dr. Castro prescribed Lexapro, and told respondent to return in two weeks. Dr. Castro also told respondent to seek counseling to assist him with the underlying causes of his anxiety. Respondent did not return to Dr. Castro until December 14, 2010. At that appointment, respondent informed Dr. Castro that he had not gone to counseling, and had stopped taking Lexapro after about a week and a half, but did not inform Dr. Castro.

[4] "Gassed" refers to inmates throwing urine or feces at staff.

12. Dr. Castro prepared a report dated December 14, 2010, which was received in evidence and considered to the extent permitted under Government Code section 11513, subdivision (d).[5] The report stated, in pertinent part:

> WHEN ASKED WHY HE DIDN'T COME BACK, NO REAL ANSWER EXCEPT HE WAS DOING GOOD BY HIMSELF AND ON HIS OWN. WHEN TOLD HE NEEDED COUNSELING HE MENTIONED HIS LAWYER WAS GOING TO GET HIM SOMEONE WHO DEALS WITH THIS WORKMAN'S COMP ISSUE AND WOULD HELP HIM. NATURALLY, SINCE I DO NOT DEAL WITH WORKERS COMP I TOLD PATIENT THAT I ADVISE HIM TO CONTINUE TAKING CARE OF THIS ISSUE WITH WHOMEVER HIS LAWYER GETS HIM AS I WOULD NO LONGER TAKE CARE OF THIS ISSUE FOR HIM. IN MY OPINION THE PATIENT WHO DOES NOT DO ANYTHING TO GET BETTER AND IS NON-COMPLIANT WITH TREATMENT PLAN IS JUST EQUIVALENT TO SOMEONE WHO TAKES A PAID VACATION. I AGREED TO HIM [*sic*] ONE MONTH OFF FOR NOW BUT THIS WILL BE THE LAST VISIT.
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> (Capitalization in original.)

13. Respondent ceased treatment with Dr. Castro in December of 2010, and Diego Allende, D.O., became his primary treating physician as of January 6, 2011.

14. Respondent acknowledged that he has not had any professional counseling to deal with anxiety issues. He has not received therapy to deal with stress, i.e., how to deal with stress, what triggers stress, or how to cope with stress, in anticipation of a possible return to work. He reported that he was "going to church and talking to church people regarding stuff [he] was going through." The individuals at church "allow him to vent and talk about what goes on in the prison setting." None of these individuals are licensed therapists.

Medical Reports

15. Respondent did not call any medical practitioners to testify at the administrative hearing. Respondents submitted letters and/or reports from three physicians,

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[5] Government Code section 11513, subdivision (d), states in pertinent 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. ..."

which were received in evidence and considered to the extent permitted under Government Code section 11513, subdivision (d).

16. **Dr. Meth**. Respondent submitted three reports from Robert F. Meth, M.D. Dr. Meth is board-certified in internal medicine, allergy and immunology, and pulmonary disease. Dr. Meth evaluated respondent as an agreed medical examiner (AME) for worker's compensation. Dr. Meth examined respondent on October 31, 2011. He noted that respondent was claiming heart, hypertension, stress and anxiety as industrially-related conditions.

Dr. Meth took a history from respondent. Respondent reported experiencing headaches on an almost daily basis beginning in 2005. The headaches would occur on his way to work and last for his entire shift. Respondent was seen by his primary care physician at the time, Dr. Depry, and it was determined that his blood pressure was elevated. After being placed on blood pressure medication, his headaches became less frequent and less severe. In 2007, Dr. Depry took respondent off the blood pressure medication, and his headaches returned. Respondent resumed taking medication for high blood pressure. His blood pressure remained high despite the medication. Respondent reported experiencing anxiety in 2007, and his then-treating physician, Dr. Castro, placed him on anti-anxiety and antidepressant medication, which made respondent feel sleepy. In the summer of 2010, respondent reportedly experienced an increase in the frequency and severity of headaches. On his last day at work, he experienced a painful headache that lasted two hours, and when he went to the infirmary, his blood pressure was 184/81. He was sent home from work, and was taken off work by Dr. Castro the next day. He thereafter began treatment with Dr. Diego Allende. After several months, Dr. Allende cleared respondent to return to work, but he developed anxiety and headache with inability to sleep and heart palpitations. Respondent did not return to work.

Respondent also reported to Dr. Meth that, in approximately 2004, he noted pressure-like discomfort in his chest along with rapid heartbeat which would go on for three to five minutes. He was diagnosed with SVT,[6] and was referred to a cardiologist, Dr. Plenys, who performed an ablation. Thereafter, the episodes became less frequent, but did not completely resolve.

Dr. Meth performed a physical examination and conducted various tests. His diagnostic impressions were: "1. Complaint of perceived stress and anxiety; 2. Hypertension; [and] 3. History of arrhythmia." Dr. Meth attributed respondent's elevated blood pressure and cardiac arrhythmia to stress from his job. For purposes of worker's compensation, Dr. Meth found respondent was "in stage 2 hypertension on three antihypertensive medications," and "should be considered as having a 34% impairment of the whole person." With respect to respondent's arrhythmia, he characterized respondent's condition as "asymptomatic during ordinary activities...documented by EKG, and moderate

[6] Supraventricular tachycardia, i.e., fast heartbeat for reasons other than exercise, high fever, or stress.

dietary adjustment and use of drugs are required to prevent symptoms," with a "19% impairment of the whole person." Dr. Meth did not express an opinion about whether respondent was permanently incapacitated for the performance of his duties as a correctional officer.

17. Dr. Meth submitted two follow-up reports, dated March 20, 2012, and April 16, 2012, which summarized his review of various medical records. Dr. Meth's review of records did not change his impairment ratings or other opinions expressed in his AME report of October 31, 2011, except that in his April 16, 2012 report, Dr. Meth concluded that respondent's hypertension was impacted by nonindustrial stressors (divorce, and obesity), which affected his assessment of apportionment between industrial and nonindustrial factors.

18. **Dr. Reiss**. Respondent submitted two medical reports from David M. Reiss, M.D., a psychiatrist. Dr. Reiss evaluated respondent as an AME for worker's compensation. Dr. Reiss conducted a psychiatric examination of respondent on August 11, 2011. Dr. Reiss also performed a review of medical-legal records. Dr. Reiss described his "very complex" evaluation of respondent "who has a complicated history of anxiety reportedly related to basic job duties as a Correctional Officer but who also describes what appear to be significant cardiological/cardiovascular disease that may or may not be deemed industrially-related... from appropriate specialists. Thus, there are issues of 'job burnout,' 'job dissatisfaction' as well as apparently realistic concern and anxiety regarding a possibly industrially-related physical illness. Additionally, the applicant exhibits ongoing, ineffectively treated psychiatric symptomatology and he has a history of significant personal, family and relationship problems in the remote past, the recent past, and continuing to the current time."

Dr. Reiss performed a mental status examination, and noted "a mildly elevated level of anxiety, especially when speaking about his employment with the Department of Corrections. However, [respondent's] anxiety never interfered with his ability to communicate in a clear, polite, cogent manner – albeit with a subtle underlying tone of neediness. [Respondent's] mood was mildly subdued, appropriate to the circumstances, but he subjectively denied being depressed and there were no objective indications of clinical depression." Dr. Reiss opined that respondent's concern and worry about his cardiovascular/cardiological pathology was contributing to his anxiety.

Dr. Reiss diagnosed respondent with "Anxiety disorder, not otherwise specified," and "Probable Psychological Factors Affecting Physical Condition: 'Stress' possibly contributing to, causing or exacerbating cardiovascular/cardiological pathology." Dr. Reiss stated that respondent's "current vulnerability to anxiety would interfere with the safe and effective functioning as a Correctional Officer." However, Dr. Reiss noted that respondent "had not yet received appropriate mental health treatment." He recommended that respondent "could benefit from a comprehensive mental health treatment approach, which includes supportive, cognitive-behavioral psychotherapy addressing [respondent's] anxiety and as possible [his] rigid defenses." Dr. Reiss also recommended, "within the context of a supportive psychotherapeutic relationship, that [respondent] should be administered judicious

psychopharmacological intervention (with appropriate cardiologic consultation), to address [respondent's] manifest symptoms of anxiety (and mild underlying dysphoria)." He also concluded that mental health treatment should be administered by a psychiatrist.

19. Dr. Reiss wrote a supplemental report, dated May 15, 2012, after he reviewed additional medical records from Dr. Meth. He wrote: "The additional medical records do not change my opinion regarding the indicated mental health treatment (with the recommended psychopharmacological intervention to be cleared by, and coordinated with, [respondent's] cardiologist)."

20. **Dr. Allende**. Respondent submitted a letter from Dr. Allende, his primary treating physician, dated October 30, 2012. Dr. Allende's medical practice involves family and occupational medicine. He stated that respondent "has been off of work as a Correctional Officer due to his anxiety/stress disorder and is unable to perform any type of duties that may put [him] into a stressful situation." He opined that respondent was "unable to return to work as a Correctional Officer due to his stress and anxiety disorder and would not be able to perform any type of security work due to his condition." Dr. Allende did not comment on the fact that respondent had not received psychiatric treatment or therapy to deal with his anxiety issues.

Neurology Evaluation – Dr. McIntire

21. Respondent was evaluated by Steven L. McIntire, M.D., on December 15, 2011. Dr. McIntire is a specialist in neurology. He is a consulting associate professor of medicine with the Stanford University Medical Center, and he is board-certified by the American Board of Psychiatry and Neurology. Dr. McIntire prepared an independent medical examination report dated December 15, 2011, in which he summarized his neurology findings and review of medical records. Dr. McIntire also testified at the administrative hearing.

22. Dr. McIntire examined respondent with regard to his complaint of headaches due to hypertension. Respondent reported that he was being treated for hypertension and heart disease, including supraventricular tachycardia. Respondent stated that "the hypertension causes headaches." Respondent noted that "he still gets headaches now that he is on blood pressure medication, but the headaches occur less often." Respondent claimed that he experienced headaches one to two times per week, lasting one to three hours. Respondent takes ibuprofen for the headaches, and the medication completely resolves the headaches about 50 percent of the time. Respondent noted that his headaches sometimes occurred when he forgets to take his lisinopril (antihypertensive medication) on time.

23. Dr. McIntire concluded that, from a neurological perspective, respondent was not substantially incapacitated for the performance of his duties as a Correctional Officer due to headaches. He found that the headaches were "avoidable simply by adequate dosing of his blood pressure medication." He concluded that, "[f]rom a neurological perspective, this is a

benign headache disorder. It is also one that is treatable." Dr. McIntire's testimony at hearing was consistent with his report.

Cardiology Evaluation – Dr. Chann

24. Respondent was evaluated by Harcharn S. Chann, M.D. on December 8, 2011. Dr. Chann is a cardiologist in private practice. He is board certified by the American Board of Internal Medicine, with a subspecialty of cardiovascular disease. He is a Fellow of the American College of Cardiology and the American College of Chest Physicians. He is currently an associate clinical professor at the University of California, San Francisco School of Medicine – Fresno Medical Education Program. Dr. Chan prepared an independent medical examination report dated December 8, 2011, in which he summarized the results of his cardiac evaluation. He also testified at the administrative hearing.

25. Dr. Chann obtained respondent's medical history and conducted a physical examination. He also reviewed respondent's medical records. Respondent reported that his main difficulties were related to uncontrolled high blood pressure, and he "would get very nervous sometimes associated with nausea feeling [*sic*]." Dr. Chann noted that respondent had not suffered a heart attack, although he had been taken to the emergency room on at least two occasions for chest discomfort. Respondent "did have cardiac dysrhythmia in the past for which he has seen several cardiologists, and he had undergone radiofrequency ablation for his arrhythmia by Dr. John Tellis. Presently, he states that just the thought of going to work makes him very anxious." Respondent reported that he was taking medications for depression and anxiety, as well as antihypertensive medications (lisinopril and amlodipine).

26. Dr. Chann's diagnoses were: "1. Essential hypertension with labile hypertension, which has been complicated by somewhat limited compliance to medication and anxiety; [and] 2. Anxiety disorder." Dr. Chann noted that respondent had a history of supraventricular tachycardia which was treated successfully by radiofrequency ablation, without repeated episodes thereafter. Dr. Chann concluded that, "there is nothing in the record which indicates that with proper medical treatment and control of his blood pressure, he cannot perform his job duties." He did not find that respondent was substantially incapacitated for the performance of his usual duties as a Correctional Officer.

27. Dr. Chann's hearing testimony was consistent with his report. He noted that respondent did not have a heart murmur at the time of his examination in December 2011. He noted that Dr. Meth's finding of a "grade 2/6 systolic ejection murmur at the left sternal border radiating to the apex" was a "functional murmur," which did not have "valvular pathology," and was not uncommon in individuals with high blood pressure. He further stated that radiofrequency ablation "cures the problem" of supraventricular tachycardia in "98 to 99 percent of the cases." Respondent's electrocardiogram results were consistent with those of an individual with high blood pressure, and were not suggestive of any particular pathology. In Dr. Chann's opinion, respondent's high blood pressure can be treated successfully with medication, diet, exercise, and weight loss.

Psychiatric Evaluation – Dr. Callahan

28. Respondent was evaluated by Thomas Callahan, M.D. on December 5, 2011. Dr. Callahan is a psychiatrist. He is a Diplomate of the American Board of Psychiatry and Neurology. He is in private practice, and has hospital affiliations with ST. Agnes Medical Center and Community Regional Medical Center, both in Fresno. Dr. Callahan prepared an independent medical examination report dated December 8, 2011, in which he summarized his psychiatric findings and review of medical records. He also testified at the administrative hearing.

29. Dr. Callahan noted in his review of medical records that some of the reports stated that "anxiety may possibly be the cause of [respondent's] intermittent elevated blood pressure," and that respondent "has anxiety due to work which causes hypertension." In his history of present illness, Dr. Callahan noted that respondent "attributed his stopping work to hypertension, which in turn made his headaches worse." Respondent "reported having had difficulty with his blood pressure associated with headaches and nausea since 2005," and despite treatment with various cardiac medications, "the condition has never been fully resolved. [Respondent] attributes part of his blood pressure difficulties to the pressure of his job." Respondent also reported continuing difficulties with anxiety, even after he ceased work, stating that "he recently has been often unable to leave his apartment."

30. Dr. Callahan conducted a mental status examination, which was unremarkable. He noted that respondent "presents with a certain degree of physical symptoms" but he found "no evidence of an ongoing psychiatric disorder." His diagnosis was "Psychological Factors Associated with General Medical Condition." He concluded that respondent was not presently substantially incapacitated from the performance of his usual duties as a result of any mental condition.

31. At hearing, Dr. Callahan's testimony was consistent with his report. He reviewed the reports of Dr. Reiss, which did not change his diagnosis or opinion concerning respondent's ability to perform his usual job duties. He found it significant that respondent had not been referred for any formal consultation or counseling or psychiatric intervention. Dr. Callahan concluded that respondent "has not approached anxiety as a psychological problem needing psychological attention." Rather, respondent's anxious feelings related to physical problems, i.e., his hypertension was causing headaches, which in turn was causing respondent to feel anxiety. Dr. Callahan noted that there was no triggering event that could be tied to an anxiety disorder. Rather, respondent appeared to have an overall sense of anxiety that was tied to his physical condition; thus, Dr. Callahan concluded that physical factors precipitated feelings of anxiety which, in his opinion, were not disabling.

Discussion

32. Respondent has the burden of proving entitlement to disability retirement. It was incumbent upon him to present competent medical evidence and opinion that he is disabled and incapacitated from performance of his duties as a Correctional Officer

Respondent submitted medical reports and evaluations of Dr. Reiss, Dr. Meth, and Dr. Allende. However, these reports are hearsay documents and in the absence of direct testimony by these physicians cannot be the basis for making disability findings in this case. (Gov. Code, § 11513, subd. (d).)

33. Even if the medical reports submitted by respondent could be considered as direct evidence, they would not be sufficient to establish respondent's eligibility for disability retirement. As was noted in Findings 16 and 17, Dr. Meth did not express an opinion about whether respondent was permanently incapacitated for the performance of his duties as a correctional officer. Dr. Allende expressed the conclusory opinion that respondent was unable to work as a Correctional Officer due to his stress and anxiety disorder, but did not identify the medical evidence which formed the basis of his opinion. While Dr. Reiss concluded that respondent's anxiety issues would interfere with his functioning as a Correctional Officer, he noted that respondent had not received appropriate mental health treatment to address his anxiety issues (Findings 18 and 19). The issue of treatment for stress and anxiety was not addressed in Dr. Allende's letter (Finding 20). Thus, based upon the record, it was not established that respondent has received appropriate and consistent psychotherapeutic treatment for his stress and anxiety conditions. (See, *Reynolds v. City of San Carlos* (1981) 126 Cal.App.3d 208, 216, in which the court determined that the requirement to comply with medical treatment that reasonably could be expected to affect a cure is implicit in the common law rule requiring mitigation of damages, and is properly applied in determining eligibility for disability retirement). Thus respondent's medical evidence failed to establish that he is "permanently incapacitated" from performing the normal duties of his position as a Correctional Officer.

34. The medical opinions of Dr. McIntire, Dr. Callahan, and Dr. Chann are the only competent (i.e. non-hearsay) evidence in the record relating to his claimed disability. They do not support respondent's application for disability retirement, uniformly opining that he is not substantially incapacitated for the performance of his usual duties. Respondent has not otherwise presented persuasive medical evidence to establish that he has a psychological, neurological or cardiac disability that incapacitated him from performing his usual duties at the time he applied for disability retirement in 2011.

LEGAL CONCLUSIONS

Applicable Statutes

1. Government Code section 20026 provides in pertinent part that:

> "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.

2. Government Code section 21156 provided in pertinent part that:

> If the medical examination and other available information show to the satisfaction of the board ... that the member is incapacitated physically or mentally for the performance of his or her duties in the state service and is eligible to retire for disability, the board shall immediately retire him or her for disability....

Burden of Proof and Legal Standards for Determining Disability

3. Respondent has the burden of proof to establish by a preponderance of evidence that he is "incapacitated for the performance of duty,"[7] which courts have interpreted to mean "the substantial inability of the applicant to perform his usual duties." (*Mansperger v. Public Employees' Retirement System* (1970) 6 Cal.App.3d 873, 877.) Discomfort, which may make it difficult to perform ones 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* (1978) 77 Cal.App.3d 854, 862.) Furthermore, an increased risk of further injury is insufficient to constitute a present disability, and prophylactic restrictions on work duties cannot form the basis of a disability retirement. (*Hosford v. Board of Administration*, *supra*, 77 Cal.App.3d. at p. 863.)

Conclusion Re: Eligibility for Disability Retirement

4. The matters set forth in Findings 7 through 34 were considered. It was not established through competent medical evidence that respondent is permanently disabled or incapacitated from performance of his duties as a Correctional Officer with CDCR on the basis of psychological, neurological (headaches) and/or cardiac (heart, high blood pressure) conditions.

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[7] Although no court construing CalPERS law has ruled on this issue, courts applying the County Employees' Retirement Law have held that the applicant has the burden of proof. (*Harmon v. Board of Retirement of San Mateo County* (1976) 62 Cal.App.3d 689, 691.) CalPERS may rely on decisions affecting other pension plans when the laws are similar. (*Bowman v. Board of Pension Commissioners for the City of Los Angeles* (1984) 155 Cal.App.3d 937, 947.) In this case, Government Code section 31724 (County Employees' Retirement Law) is similar to Government Code section 21151 (California Public Employees' Retirement Law), and the rule concerning the burden of proof is therefore applicable. Furthermore, Evidence Code section 664 creates the general presumption that a public agency has performed its official duty. Here, CalPERS has fulfilled its duty to determine respondent's eligibility for disability retirement, and the burden falls on respondent to rebut the presumption of Evidence Code section 664 by proving incapacitating disability.

ORDER

The application of Jesus Escanuela for disability retirement benefits is DENIED.

Dated: January 28, 2013

CATHERINE B. FRINK
Administrative Law Judge
Office of Administrative Hearings