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:	Case No. 9773
ANNETTE L. NORTON,	OAH No. 2011010079
Respondent,	
and	
COUNTY OF SHASTA,	
Respondent.	

PROPOSED DECISION AFTER REMAND

This matter was heard before Dian M. Vorters, Administrative Law Judge (ALJ), Office of Administrative Hearings, State of California.

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

Annette L. Norton (respondent) was present and represented herself.

Adam M. Pressman, Senior Deputy County Counsel, represented Shasta County (County).[1]

This matter was originally heard on December 8, 2011, and March 6 and 12, 2012. A proposed decision was issued on April 16, 2012. On June 13, 2012, the Board of Administration remanded the matter, and requested that the ALJ take additional evidence, specifically on "how competent medical opinion establishes that the member is actually and substantially incapable of performing her usual and customary job duties." Respondent presented additional argument based on the record and the matter was again submitted for decision. Because no new evidence was submitted, no changes have been made in the original proposed decision.

[1] Adam M. Pressman, Senior Deputy County Counsel, Shasta County Counsel's Office, 1450 Court Street, Room 332, Redding, California 96001-1675.

ISSUE

Is respondent permanently disabled or incapacitated from performance of her duties as an Employment and Training Worker II, for the County, based upon an orthopedic condition (carpel tunnel syndrome, pronater teres syndrome, problems of the neck, right arm, and right shoulder)?

As no new evidence was presented, the proposed decision and order remain the same. Based on competent medical evidence, respondent met her burden to establish that she was and is permanently disabled for the performance of her duties as an ETW III for the County. Consequently, her application for disability retirement should be granted.

FACTUAL FINDINGS

Respondent's Employment History

1. Respondent has worked for the County for approximately ten years ending in November 2008. Her last five years was with the Department of Social Services as an Employment and Training Worker (ETW) II. Since approximately 2003, she received treatment for pain and numbness in her hands, upper right extremity, and neck. After a course of treatment including pain management, physical therapy, and chiropractic, numerous medical leaves, and unsuccessful accommodations by her employer, she stopped working in November 2008. She states that she is physically unable to perform her normal office duties. Her contention is supported by her treating physicians.

Duties of an Employment and Training Worker II

2. As set forth in the County job description for ETW I and II, respondent provided employment services to applicants of local social service agencies. Typical duties included interviewing program participants to evaluate employability, administering vocational measurement tests, assessing educational and employment histories, conducting orientation workshops, operating a computer and office equipment, maintaining regular client contact, documenting client compliance, and performing a variety of clerical duties.

3. *Physical Requirements of Position/Occupational Title.* In January 2009, respondent and her supervisor signed a form that itemized the physical requirements of the ETW position. The form identified the frequency with which various physical activities were expected.

In the "constantly" (over six hours) category, an ETW was expected to sit, bend at the neck, perform fine manipulation and simple grasping, use hands repetitively, and use the keyboard and mouse. In the "occasionally" (up to three hours) category, an ETW was expected to stand, walk, bend at the waist, twist at the neck and waist, reach above and below the shoulder, push and pull objects, lift up to ten pounds, walk on uneven ground, and drive.

An ETW is "never" required to run, crawl, kneel, climb, squat, power grasp, lift over 10 pounds, work with heavy equipment, tolerate exposure to excessive noise, temperature, dust, gas, chemicals, work at heights, operate tools with repetitive movement, or use special visual/auditory protective equipment.

Respondent's Disability Retirement Application

4. On or about January 20, 2009, respondent filed a Disability Retirement Election Application with CalPERS. Her last day of work was November 2, 2008. At that time she was under the care of Lance Lollar, D.C.

a. Respondent described her specific disability as, "Bi-lateral carpul [sic] tunnel syndrome, pronater teres syndrome in R. arm, compensable consequence injury to R. shoulder and neck. Cumulative injury resulted from repetitive motions starting in 2003."

b. Respondent described her limitations/preclusions as follows:

> Can't do any fine manipulation with hands/fingers for extended periods of time. Hands go numb + [sic] I get pain in upper extremities.

c. Respondent stated that her condition affects her ability to perform her job in that she is "unable to type, write, file, or manipulate case files for extended periods of time." She is not currently working in any capacity.

d. Respondent also provided that her injuries have caused difficulty with certain daily activities such as holding a fork to eat, brushing her teeth, and washing her hair.

5. CalPERS arranged an appointment with Baer I. Rambach, M.D., an Independent Medical Examiner (IME), for an evaluation of respondent's orthopedic complaint. Dr. Rambach is a board certified orthopedic surgeon. On May 7, 2009, he performed an evaluation of respondent and prepared a report of his findings. (Factual Findings 9-17.)

6. By letter dated June 25, 2009, the Benefit Services Division of CalPERS notified respondent that, based upon review of the IME report and patient records, it had determined that her orthopedic conditions were not disabling and that she was not substantially incapacitated from performing her duties as an ETW II. CalPERS based this determination on medical reports of Bryan Meredith, D.C., Lance Lollar, D.C., and Baer Rambach, M.D. Respondent's options were to resume work as an ETW II, transfer to a different job within the County or to another agency covered under CalPERS, discontinue CalPERS employment and maintain accumulated contributions in the Retirement Fund or

withdraw such contributions. The letter notified respondent of her right to appeal the decision within 30 days of the date of the denial letter. (Cal. Code Regs., tit. 2, §§555-555.4)

7. *Letters of Appeal.* Respondent timely filed an appeal from the denial, by letter received by CalPERS on July 28, 2009. She recapped her history of illness since 2003 when she was diagnosed with carpal tunnel syndrome (CTS). She described her symptoms as numbness and tingling in her hands. She received treatment through her primary care physician, Dr. Malotky. She stated that her right arm turned blue and narcotics did not relieve the pain which prevented her from dressing without assistance. She developed "atrophy in [her right] arm. She reported that Dr. Malotky diagnosed her with reflex sympathetic dystrophy (RSD) also called complex regional pain syndrome (CRPS). She reported several absences from work due to "conditions flaring up." She was also diagnosed with pronator teres syndrome (PTS).

Respondent receives "stellate ganglion blocks to control the pain." She stated that she was referred to two to three orthopedists who told her that "surgery was not an option" due to her "history of RSD." "These orthopedists" referred her back to her primary care physician because there was "nothing they could do" for her. After a period of physical therapy, her physician referred her to a chiropractor after he had "exhausted all possible options." The chiropractor treated her with "cold laser therapy, massage therapy, and manipulations" to alleviate symptoms. After being off work for eight months, her symptoms "severely flare up" with overuse of her hands. Symptoms are numbness, tingling in hands and fingers, pain radiating up through the wrist, forearm, elbow area, upper arm, and into her shoulder and neck. Headaches and sleeplessness sometimes result. Bathing and toileting are impeded.

Her symptoms impair her ability to perform office duties. She had difficulty typing. Accommodations including "Dragon Speak" dictation software, were not effective. Her QME physician took her off work and a second QME physician agreed that all treatment options had been exhausted. Respondent was critical of the quality and duration of the IME performed by Dr. Rambach.

8. The County filed a separate letter of appeal dated July 28, 2009. The County asserted that respondent is substantially unable to perform the usual duties of an ETW II and requested that her disability retirement application be granted.

IME Report – Baer I. Rambach, M.D.

9. On May 7, 2009, Dr. Rambach conducted an examination of respondent pursuant to IME protocol. Dr. Rambach interviewed respondent, conducted a physical examination, reviewed the job duty and physical requirements descriptions, and reviewed medical records. He prepared initial and supplemental reports of his findings and testified at hearing.

10. Respondent provided Dr. Rambach with a history of her present illness and treatment. She relayed her inability to perform normal household chores such as vacuuming, washing floors, and kitchen activities. She previously enjoyed camping, fishing, racquetball,

and in-line hockey; but no longer, due to pain. Symptoms in her hand include numbness, and pins and needles sensations in her fingers, especially on the right. She reiterated her diagnosis with pronator teres syndrome of the right forearm but stated her "reflex sympathetic dystrophy [was] partially under control." She was taking ibuprofen and Ultracet for pain.

11. The physical examination found full range of motion of the cervical spine, biceps and triceps muscle strength was good, no pathologic reflexes were elicited. Respondent's grip strength measurements of the upper extremities were average. Her right and left shoulder examinations revealed no atrophy of the deltoid musculature. There was "some tenderness over the spine of the scapula." Her shoulder joint examination showed a full range of motion with no abnormalities. Right shoulder abduction was 170 degrees and forward flexion was 180 degrees. Left shoulder abduction was 180 degrees and forward flexion was 180 degrees. Dr. Rambach found right elbow "tenderness over the lateral epicondyle and also over the attachment of the extensor musculature about the proximal forearm and epicondylar region." Range of motion of the right elbow was "good," but maximum pronation caused complaint of pain. Examination of the right wrist and hand revealed tenderness over the proximal flexion creases of the wrist. He noted good range of motion in both hands and no evidence of atrophy of the musculature of the right hand. Left hand and wrist examination was within normal limits.

12. *Medical Records Review.* Dr. Rambach reviewed medical records from January 2004 forward as provided by CalPERS. He noted respondent's first report of occupational injury in January 2004. She was diagnosed with bilateral CTS and given a cortisone shot and wrist braces. She was released to return to work in April 2004, with instructions to avoid heavy strenuous lifting. She received physical therapy. On April 28, 2004, respondent was seen in the emergency room (ER) with a swollen arm. Deep venous thrombosis (DVT) was ruled out; impression was lateral epicondylitis. Dr. Matlotky subsequently provided a diagnosis of "reflex sympathetic dystrophy (RSD) of the right forearm."

An MRI of the cervical spine in May 2004 showed "mild annular degeneration at the C6-C7 and minimal circumferential bulging." It appears respondent was off work in May, June and July 2004 with a confirmed diagnosis of CPS and "mild right pronator teres syndrome." Conservative treatment was recommended. In August 2004, she began seeing Dr. Lollar, D.C. In September 2004, Dr. Malotky determined that despite his numerous efforts to improve respondent's symptomology, he was unable to effect any change or get her back to work. He referred her to Richard D. Tortosa, M.D. In October 2004, Dr. Tortosa recommended a trial return to work but it is not clear from the record that respondent was able. Respondent participated in physical therapy throughout 2004 and 2005 with several notes of being off work for ongoing chronic right forearm pain and CTS.

She participated in a QME with Bryan Meredith, D.C. in January 2006. He diagnosed respondent with CTS, right PTS, left ulnar neuropathy, myofascial pain syndrome (all chronic). Dr. Lollar recommended work restrictions to include that she only perform data entry 15 minutes every one to two hours and no repeated use of the hands during the rest. He

suggested that she dictated her work. A follow up QME in February 2007 by Dr. Meredith, recommended continued work restrictions.

In May 2007, Dr. Lollar recommended that respondent return to work with restrictions and employer accommodations. In August 2007, Dr. Lollar noted that respondent was showing improved functioning and decreased pain. Cold laser therapy was added to increase blood flow. In October and November 2007, Dr. Lollar noted, "Going good, modified duty going well, neck pain and upper back pain and occasional increased tightness." In September 2008, Dr. Lollar noted that respondent could return to full duty on September 24, 2008, with "no limitations or restrictions." On November 19, 2008, Dr. Lollar noted "total temporary disability through December 19, 2008. Dr. Meredith's QME report in December 2008 indicated respondent's condition had deteriorated and she would not be able to continue in her current employment.

13. Based on his physical examination and review of respondent's records, Dr. Rambach made the following diagnoses:

1. Chronic bilateral carpal tunnel syndrome, right greater than left
2. History of pronator teres syndrome, right forearm
3. Chronic lateral epicondylitis, right elbow, mild
4. Complex regional pain syndrome, right upper extremity (forearm, wrist, and hand), resolved
5. Chronic cervical spine strain, mild, superimposed on early degenerative changes

14. Dr. Rambach further opined that respondent has a chronic epicondylitis of the right elbow which is "minor in nature." He could detect no indication of a pronator teres syndrome of the right proximal forearm at the time of the IME. He believes that if she did have the problem in the past, it has resolved. She has some degree of bilateral CTS, a little worse on the right than on the left, but he did not believe it to be significant enough to prevent her from performing her normal duties as an ETW II.

15. In response to specific questions posited by CalPERS regarding respondent's condition, Dr. Rambach provided his professional opinion that there are no specific job duties respondent is unable to perform because of a physical condition involving her upper extremities including her right shoulder and neck at the time of this examination. He does not believe respondent is substantially incapacitated for performance of her usual duties. She was cooperative during the IME and appeared to put forth her best effort with possibly some minor exaggeration of her complaints. She is mentally able and competent to handle her financial and legal affairs.

16. *Supplemental Report.* At the request of CalPERS, Dr. Rambach reviewed additional medical and imaging records dated April 2010 through January 2011. Records included a cervical MRI report dated April 27, 2010, that showed multiple bulging discs at the C2-C3, C3-C4, and C4-C5, described as "mild relative right neuroforaminal narrowing." At the C5-C6 there is a "posterior herniated disc with posterior annular tear, mild bilateral

neuroforanimal narrowing. At the C6-C7 there is a "posterior annular tear with mild right neuroforanimal narrowing and moderate left neuroforaminal narrowing and at C7-T1 minimal posterior bulging discs." The radiologist's impressions were: "bulging and herniated disc at multiple levels which are greatest at C5/C6 and C6/C7."

A brain MRI also dated April 27, 2010, noted "subtle abnormality in the posterior left frontal white matter with a history of peripheral neuropathy..." A follow-up MRI was performed on January 5, 2011, showed no new abnormalities.

A cervical spine x-ray report dated April 13, 2012, consisting of five views provided an impression of "mild cervical spondylosis" which is relatively greatest at C6-C7, slight right C4-C5, and C5-C6 neuroforaminal narrowing.

A record of Fazad H. Sabet, M.D. dated November 11, 2010, described a procedure whereby he injected respondent at multiple trigger points for pain relief and prescribed Lynca 50 mg and Valium. He recommended physical therapy for myofascial release.

17. Dr. Rambach issued a Supplemental Report dated March 10, 2011. His opinion after reviewing the additional records remained unchanged. He noted the results of the brain and cervical MRIs. From an orthopedic standpoint, he did not see documents to support a finding consistent with nerve-root irritation emanating from the cervical spine area.

Respondent's History of Injury and Evaluations

18. Respondent is currently 42 years of age. Her last date of employment for the County was in November 2008. Her QME reports date the onset of her carpal tunnel complaint to December 2003. She filed an industrial disability claim for work related injury stemming from repetitive typing, 10-key operations, writing, computer use, flipping through files, and heavy phone use. She had multiple follow-up QMEs performed by Dr. Meredith. She reported being in at least two motor vehicle accidents, one in February 2003 and another in January 2004. She related that the accidents cause injury to her neck, thoracic, and lumbar spine. She was treated conservatively by Dr. Lollar, a chiropractor and her primary care provider. Dr. Meredith stated that none of the accidents "apparently changed her subjective or objective findings with regard to her industrial injuries."

19. On March 8, 2011, Farzad Sabet, M.D. referred respondent to undergo a "Work Capacity Evaluation." The purpose of the WCE was to determine respondent's physical abilities and limitations in order to determine if she was able to return to her "pre-injury job" as an ETW II. She reported "cumulative trauma in her hands and neck beginning approximately one year prior to reporting date of December 12, 2003." The WCE was conducted by Tim L. Thomas, PT, CWCE. Mr. Thomas is the owner and clinical administrator of Redding Physical Therapy, in Redding. His report and recommendations were that respondent "currently does not meet the critical physical demands of her pre-injury occupation as an ETW II for Shasta County based on objective findings of the Work/Functional Capacity Evaluation."

20. Lance Lollar, D.C. wrote a declaration signed December 2, 2011, under penalty of perjury. He summarized respondent's condition as "chronic neck and bilateral upper extremity pain and numbness." He described her treatment as "a multidisciplinary approach involving chiropractic, massage and pain management specialists." He stated that attempts at modified work duties had failed and that she must give great consideration to how much she used her upper extremities for domestic chores in an attempt to minimize exacerbation. He stated that it would be extremely difficult for her to perform most tasks in the open labor market or maintain regular work hours in that when her symptoms flared, it required a significant amount of convalescence. He shared that she had seen multiple providers and "is currently not a surgical candidate." He did not state the basis for his opinion regarding surgical intervention.

Respondent's Treating Physician Farzad Sabet, M.D.

21. Farzad Sabet, M.D. has provided ongoing treatment to respondent since May 2010. He is board certified in physical medicine and rehabilitation. His subspecialty is treatment of the spine. His training is in non-surgical treatment of the spine. Respondent currently sees Dr. Sabet every 60 to 90 days. He testified at hearing.

22. In Dr. Sabet's consultation notes dated May 7, 2012, respondent complained of neck pain, numbness, and tingling in bilateral hands and feet. The onset of symptoms was noted to be since 2004. Pain decreased with medication and increased with activity and when sitting. Symptoms were gradually worsening. The quality of the pain was "a constant achy sensation ... pins and needles." Pain was frequent, gradually worsening, and consisted 80 percent on the right upper extremity. Respondent was taking Neurontin. Dr. Sabet found her upper extremity (UE) Motor Examination to be within normal limits, equal bilaterally. Her UE Sensibility and Dermatomes were within normal limits bilaterally. Her cervical spine exam found "severe tenderness to palpation over the taut band in the paraspinals and periscapular area with radiating symptoms." An MRI study showed "bulging and herniated disc at multiple levels which are greatest at C5-6 and C6-7."

23. Dr. Sabet was asked his opinion of a 2006 EMG nerve conduction study performed by Harvinder S. Birk, M.D., in Redding. Dr. Birk is a Diplomate of the American Board of Psychiatry and Neurology, and is Certified in Neurology and Clinical Neurophysiology. On January 6, 2006, he physically examined respondent and administered a series of Nerve Conduction Velocity (NCV) Studies including anti-sensory, ortho sensory, motor, F-Waive, electromyogram (EMG), and paraspinal EMG tests. He prepared a report of the test measurements and his impressions. He concluded that respondent's study was "abnormal." He stated that the electrodiagnostic study revealed electrophysiologic evidence of:

1. Mild right carpal tunnel syndrome (median nerve entrapment at wrist) affecting sensory components.

2. There is no electrodiagnostic evidence of any other brachial plexopathy cervical radiculopathy focal nerve entrapment generalized peripheral neuropathy.

24. Other significant imaging studies included:

a.. A cervical spine MRI was obtained on February 17, 2007. Respondent's complaint was neck pain with radiculopathy. Findings at the C4-5, C5-6, and C6-7 showed disc bulges. Impressions were: "1-3 mm broad-based posterior disc bulges between the levels of C4-5 through C6-7, most pronounced at the latter level. ...Cord compression is not apparent."

b. A C-spine series (X-rays, five view) was obtained on April 13, 2010. Findings were: "No loss of vertebral body height or subluxations are present. Disc space narrowing and end plate osteophytes are present at C6-C7. A reversed normal cervical curvature is present and is centered at C4-C5 and C5-C6 causing slight neuroforaminal narrowing. The left neural foramina are widely patent. No prevertebral soft tissue swelling is present."

c. A cervical spine MRI was obtained on April 27, 2010. Findings were: "The size and signal intensity of the spinal cord is normal. No loss of vertebral body height, subluxations, or significant bone marrow signal abnormalities are present. Mild relative loss of disc space height is prenset at C6-7. Disc desiccation is relatively greater at this level. No paraspinal soft tissue abnormalities are seen."

25. Though none of the studies showed a nerve root impingement, Dr. Sabet disagreed with the NCV report findings. He stated that CTS is overly diagnosed and that respondent's neck is the main source of her problems. He referenced the 2010 MRI that showed progression of degenerative discs in the neck, however, none of the tests showed significant pinched nerves in the neck. In spite of the MRI findings, Dr. Sabet believes that respondent has a pinched nerve in her cervical spine. Dr. Sabet diagnosed respondent with degenerative disc disease with significant annular tears at the C5, C6, and C7, and with neuropathic pain (also known a radiculitis). He stated that her condition is difficult to diagnose and that sometimes electro-diagnostic studies do not show any significant signal of nerves from the neck coming down from the arms.

26. Respondent's treatment consists of trigger point injections, heat, deep tissue massage, and stress reduction techniques. She had not as of the hearing date been referred for an evaluation by a neurosurgeon. Dr. Sabet stated, "I feel comfortable keeping her away from the surgeons." He recommended against a two-level fusion in respondent's neck because of her relatively young age and the possibility of adjacent level degeneration above and below the fused discs. He believes it is in respondent's best interest to stay off work and go on disability. He stated that a return to her regular duties including consistent typing and flexion of the neck will make her problem worse.

27. Respondent's husband, Steven Taylor, testified at hearing. They met in early 2006. When the met, respondent was employed at CalWORKS and enjoyed working. Mr. Taylor testified that they used to enjoy golf and snow boarding. He is in the military and was deployed for six months. Upon his return he witnessed respondent's symptoms become progressively worse. She is unable to perform household chores such as vacuuming. He observed crying and depression in response to reported pain symptoms. She complains of numbness in her hands when holding utensils and blow drying her hair. At these times, Mr. Taylor must assist her with basic toileting. Mr. Taylor stated that respondent will awake at night to shake out her hands and put on "hockey-things" (hand braces). He stated that she employs home remedies including "lots of massages, shaking of hands trying to get feeling back into them, hands going numb, holding them up in the air." He typed and assembled her hearing exhibit binder because she was unable.

28. Respondent testified that she has always been a hard worker and felt a sense of accomplishment in her job. She recalled being in two separate car accidents prior to 2003, including a rear end collision in 2002. She believes that her work activities accelerated her disc degeneration. In 2003, she first noticed pain including numbness and tingling in her fingertips. Her chiropractor told her that she might have carpal tunnel syndrome and suggested she file a worker's compensation claim. Respondent stated that Dr. Malotky began giving respondent steroid injections in the spring of 2004 after diagnosing her with CTS. It is noted that on September 3, 2004, John A. Dorsett, M.D. performed electrodiagnostic testing (a nerve conduction study). Respondent's symptomology was "hypersensitivity in the right forearm, which increases with increased activity, ... some decreased strength in her right hand." Dr. Dorsett's findings were:

1. Evidence of mild right-sided carpal tunnel syndrome by sensory criteria only.
2. No evidence of median nerve slowing in the forearm, across the pronator teres muscle, therefore no evidence of pronator teres syndrome.
3. No evidence of right-sided cubital tunnel syndrome.
4. No evidence of peripheral neuropathy.

29. Respondent described her current symptoms as pain, numbness, and tingling starting from her fingertips and hands. The sensations interfere with toileting, eating (holding utensils), using a computer keyboard/mouse. She will often need to stop and shake her hands out. She also feels upper arm achiness, pain in the upper shoulder (under the scapula), neck (usually on the right side going down the center). She stated that she was in pain during the hearing and felt like it was "on fire." She experiences headaches lasted two to ten days that are so debilitating that she cannot get out of bed. In his September 2004 Report, David Hankin, M.D. recommended a carpal tunnel release. This has not been attempted because of respondent's history of "complex regional pain syndrome which may flare up with surgical intervention." Respondent's testimony regarding her symptoms and history of complaint was credible. There is no report of malingering in the record.

30. The County has placed respondent on periods of disability leave and in February 2007 arranged an ergonomic evaluation by Cresswell Physical Therapy. Various equipment and workstation accommodations have been attempted to no avail. Reduced case

loads and reassignment to other jobs have not resulted in maintained service to the County. Dr. Malotky referred respondent to numerous pain specialists, orthopedics, radiologists, physical therapy, and chiropractic, with no sustain improvement noted. On November 19, 2008, Dr. Lollar took respondent off work with a diagnosis of CTS, wrist (median nerve), cervical segmental dysfunction or somatic dysfunction, and thoracic segmental dysfunction or somatic dysfunction. She did not return to County employment after that date. She was deemed permanent and stationary as of January 8, 2009.

31. In consideration of the Factual Finding in their entirety, respondent has established that she was permanently disabled from the performance of her duties as an ETW II for the County when she applied for disability retirement on or about January 20, 2009.

LEGAL CONCLUSIONS

1. By reason of her employment, respondent is a local miscellaneous member of CalPERS and eligible for disability retirement under Government Code section 21150.

2. To qualify for disability retirement, respondent must prove that, at the time she applied for disability retirement, she 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, or in the case of a local safety member by the governing body of the contracting agency employing the member, on the basis of competent medical opinion.

3. The burden is on respondent to present competent medical evidence to show that, as of the date she applied for disability retirement, she was substantially unable to perform the usual duties of a ETW II. (*Harmon v. Bd. of Retirement of San Mateo County, supra,* 62 Cal.App.3d at p. 691.) She has met her burden.

4. Respondent has made a showing of substantial disability. She was diagnosed with carpal tunnel syndrome, degenerative disc syndrome, and pronater teres syndrome. Numerous medical reports from 2004 to present support chronic symptoms including neck pain, numbness, and tingling in the bilateral hands which impair her ability to perform basic household and work related tasks. Her pain increases with activity associated with her duties as an ETW II. A variety of treatments, interventions, and accommodations have been tried with no lasting improvement.

5. There is competent medical evidence that respondent was or is permanently disabled for the performance of her duties as an ETW II for the County. Consequently, her application for disability retirement should be granted.

ORDER

The application of respondent Annette L. Norton for disability retirement is GRANTED.

DATED: April 16, 2012

DIAN M. VORTERS
Administrative Law Judge
Office of Administrative Hearings