ATTACHMENT A

THE PROPOSED DECISION

BOARD OF ADMINISTRATION
CALIFORNIA PUBLIC EMPLOYEES' RETIREMENT SYSTEM
STATE OF CALIFORNIA

In the Matter of the Application for Disability Retirement of: MIKE W. SCHMIDKE, Respondent. DEPARTMENT OF CORRECTIONS AND REHABILITATION, CALIFORNIA REHABILITATION CENTER, Respondent.	Case No. 9014 OAH No. 2011080091

PROPOSED DECISION

Administrative Law Judge Vallera J. Johnson, State of California, Office of Administrative Hearings, heard this matter in Orange, California on July 14, 2014.

Preet Kaur, Staff Attorney, represented Mary Lynn Fisher, Chief, Benefit Services Division, California Public Employees' Retirement System.

John M. Kielbasa, Esq., represented Mike W. Schmidke.

There was no appearance by or on behalf of Department of Corrections and Rehabilitation, California Rehabilitation Center.

The matter was submitted on July 22, 2014.[1]

FACTUAL FINDINGS

1. Mary Lynn Fisher filed Statement of Issues, Case No. 9014, against Mike W. Schmidke and the Department of Corrections and Rehabilitation, California Rehabilitation

[1] The record remained open for receipt for page two of Michael Bloom, M.D.'s report (Exhibit 19). The document was filed on July 15, 2014. Without objection from Respondent Schmidke, on July 22, 2014, the record was closed, and the matter was submitted.

Center, in her official capacity as Chief of the Benefit Services Division, California Public Employees' Retirement System, and not otherwise.

2. On March 20, 2007, Respondent Schmidke signed an application for service pending industrial disability retirement. In filing the application, disability was claimed on the basis of a cardiovascular (atrial fibrillation) condition.

Effective March 17, 2007, Respondent Schmidke retired for service and has been receiving his retirement allowance from that date.

3. On the date that Respondent Schmidke filed his application for retirement, Respondent DCR employed Respondent Schmidke as a Correctional Officer. By virtue of his employment, Respondent Schmidke was a state safety member of CalPERS subject to Government Code section 21151.

4. CalPERS obtained or received medical reports concerning Respondent Schmidke's cardiovascular condition from competent medical professionals. After review of the reports, CalPERS determined that Respondent Schmidke was not permanently disabled or substantially incapacitated from performance of his duties as a Correctional Officer at the time the application for disability retirement was filed.

5. By letter, dated April 22, 2008, CalPERS notified Respondent Schmidke of its determination and advised of his appeal rights.

6. By letter, dated April 30, 2008, Respondent Schmidke filed a timely appeal and requested a hearing.

7. This appeal is limited to the issue of whether, on the basis of cardiovascular (atrial fibrillation) condition, Respondent Schmidke is permanently disabled or incapacitated from performance of his duties as a Correctional Officer for Respondent Department of Corrections and Rehabilitation, California Rehabilitation Center. If disability is found to exist, any dispute as to whether the disability is industrial or nonindustrial will be resolved pursuant to Government Code section 21166.

Duties and Physical Requirements of Correctional Officer - Assigned to California Rehabilitation Center

8. Correctional Officers may be rotated to different assignments on a scheduled basis and are on call 24 hours a day, seven days a week, if needed to assist in emergency situations, such as riots and disturbances. They are subject to being ordered to work overtime and to provide coverage whenever and wherever needed.

Correctional Officers must be alert at all times while on duty, and they must be physically and mentally able to perform any assignment at all times.

Typical assignments include the control and discipline of inmates in all activities, such as work assignments, recreation and leisure time activities, meals, showers and housing units. In addition to close supervision of inmates, Correctional Officers may be assigned to an armed tower, control rooms, gates, etc.

9. The varied assignments of the Correctional Officer at Respondent DCR required different types of physical ability, such as climbing stairs and ladders, bending, stooping to search under buildings, standing or sitting for long periods of time, chasing inmates, if necessary, climbing a fence or driving a vehicle.

Specifically, the job duty description requires that, among other things, a Correctional Officer:

- Must be able to wear protection clothing and breathing apparatus to prevent blood/air borne pathogens;
- Must range qualify (with a handgun, rifle and shotgun), keep firearm in good condition, fire weapon in combat/emergency situation;
- Defend self against an inmate armed with a weapon;
- Inspect inmates for contraband; conduct body searches;
- Walk occasionally to continuously;
- Run occasionally; run in an all-out effort while responding to alarms or serious incidents; distances vary from a few yards up to 400 yards; running may take place over varying surfaces including uneven grass, dirt areas, pavement, cement, etc. running can include stairs or several flights of stairs maneuvering up or down;
- Climb occasionally to frequently; ascent/descent or climb a series of steps/stairs, several tiers of stairs or ladders as well as climb onto bunks/beds while involved in cell searches; must be able to carry items while climbing stairs;
- Crawl and crouch occasionally; crawl or crouch under an inmate's bed or restroom facility while involved in cell searches; crouch while firing a weapon or while involved in property searches;
- Stand occasionally to continuously; stand continuously depending on assignment;
- Sit occasionally to continuously; sit while performing record keeping or report writing activities, observing designated areas, and driving activities;
- Stoop and bend occasionally to frequently; stoop and bend while inspecting cells, physically searching inmates from head to toe, and while performing janitorial work;
- Lift and carry continuously to frequently, lift and carry in the light (20 pound maximum) to medium (50 pound maximum) range frequently throughout the workday and in the very heavy lifting range (over 100 pounds) occasionally; lift and carry an inmate and physically restrain the inmate, including wrestling an inmate to the floor; drag/carry an inmate out

of cell; perform lifting/carrying activities while working in very cramped space; and
- Continuously wear equipment belt weighing 15 pounds.

Medical Evidence

10. Subsequent to the filing of his application, the medical evidence included the following.

- Reports of Prakash Jay, M.D., dated February 12, 2007, and May 25, 2010;
- Reports of Malcolm S. Pond, M.D., dated February 25, 2008, August 19, 2010, and October 29, 2010; and
- Reports of Robert B. Weber, M.D., dated October 29, 2010 and October 29, 2012.

11. With the exception of Dr. Jay, each physician performed an evaluation of Respondent Schmidke that included, among other things, taking a history, performing a physical examination, ordering and interpreting diagnostic studies, reviewing medical records, and the duties, essential functions, and physical requirements of the position of Correctional Officer. Prior to issuing his report, dated February 12, 2007, Dr. Jay followed the foregoing procedure but did not review the duties, essential functions, and physical requirements of the position of Correctional Officer.

Doctor Jay is an internist, and Doctors Pond and Weber are cardiologists.

12. Based on the evaluation by Dr. Weber, by letter, dated February 25, 2013, Respondent Schmidke requested to amend his application to include, diabetes mellitus, sleep apnea, high blood pressure, hyperthyroidism, hypotestosteronism, hypercholesterolemia, hyperlipidemia and morbid obesity.

13. Following Respondent Schmidke's request, CalPERS obtained or received additional medical reports concerning Respondent Schmidke's additional medical conditions. The additional reports included: a supplemental medical report from Dr. Weber, dated October 16, 2013, and a report from Michael Bloom, M.D., dated March 13, 2014.

Dr. Bloom is an internist who performed an independent medical evaluation of Respondent Schmidke and issued his report. In order to do so, he followed the procedure followed by the other physicians, with the exception of Dr. Jay.

14. After review of the additional reports, again, CalPERS determined that Respondent Schmidke was not permanently disabled or substantially incapacitated from performance of his duties as a Correctional Officer at the time that he filed the application for disability retirement.

15. CalPERS provided Doctors Pond, Weber and Bloom with CalPERS' criteria to determine whether Respondent Schmidke qualified for a disability retirement. Prior to Dr. Jay's evaluation in 2010, Respondent Schmidke's attorney provided Dr. Jay with the same information.

Medical History

16. In 2004, Respondent Schmidke was diagnosed with hypertension for which he was treated with medication. On February 20, 2006, during a physical examination, he was found to have heart problems, immediately transferred to an emergency room, hospitalized for seven days, and confirmed to have atrial fibrillation. He was started on Warfarin and antiarrhythemic medications. In July 2006, he was hospitalized for four days with atrial fibrillation with a fast heart rate; medications were added and readjusted. In November 2006, Respondent Schmidke was hospitalized for four days with atrial fibrillation.

In 2006, he was diagnosed with type II diabetes mellitus. Other medical conditions noted in his medical records include obesity and probable sleep apnea.

Physician Evaluations

17. The qualifications, reports and testimony of the physicians have been evaluated. Doctors Weber and Bloom testified as witnesses in this proceeding.

18. Dr. Jay performed an agreed medical evaluation in internal medicine of Respondent Schmidke on January 19, 2007 and issued a report, dated February 12, 2007. He concluded that Respondent Schmidke had hypertension, hypertensive heart disease and recurrent atrial fibrillation and imposed job restrictions to avoid injury in the future.

Dr. Jay's AME was for Respondent Schmidke's Workers Compensation case, utilizing the Workers Compensation criteria rather than the CalPERS criteria. He did not review the job duties, essential functions or physical requirements of the Correctional Officer position. As such, Dr. Jay's opinion had minimal significance to this proceeding.

19. In response to a request from CalPERS, Dr. Pond performed an independent medical examination of Respondent Schmidke regarding his cardiac condition on February 25, 2008, and issued a report on the same date.

In addition to the evaluation described in Finding 11, Dr. Pond reviewed medical records (from 2006 and 2007), and Dr. Jay's AME report, dated February 2007; in addition, he ordered and interpreted an echocardiogram.

Dr. Pond commented on Dr. Jay's findings:

> A laboratory study from January 20th, 2007 showed a total cholesterol of 220. triglyceride 320. HDL 29. and LDL of 127

> Blood sugar was 123 The echocardiogram done January 19th, 2007 at Dr. Jay's office showed left ventricular diastolic dimension of 6 1 cm, ejection fraction 64%. which is normal The septal and posterior wall thickness were 1 2 cm respectively. consistent with left ventricular hypertrophy The left atrial dimension was 5 2 cm, which is elevated An electrocardiogram showed sinus rhythm[2]

Respondent Schmidke told Dr. Pond that he had been aware of palpitations from time to time; but he denied shortness of breath, lightheadedness, chest pain or other specific cardiac limitations. He had had a problem with significant weight gain, hyperlipidemia and hypertension. Dr. Pond noted the medications that Respondent Schmidke was taking at the time.[3]

On physical examination, among other things, Respondent Schmidke's weight was 343 pounds, blood pressure 140/86, pulse 64, irregular.

The EKG, performed during Dr. Pond's evaluation, demonstrated atrial fibrillation with a ventricular rate of 98 QRS; morphology was normal – nonspecific ST-T wave changes were present.

Dr. Pond summarized Respondent Schmidke's medical conditions as follows: (1) persistent atrial fibrillation (atrial fibrillation first diagnosed in February 2006, but sinus rhythm has been described since then, and is confirmed on EKG performed at the time of Dr. Jay's examination on January 19, 2007); (2) obesity; (3) type II diabetes mellitus; (4) hyperlipidemia; (5) obstructive sleep apnea (for which he recently started CPAP therapy); (6) no demonstration of ischemic heart disease or previous myocardial infarction, based on the records available for review at this time); and (7) metabolic syndrome (based on combination of obesity, hypertension, hyperlipidemia and diabetes mellitus).

In response to questions posed by CalPERS, Dr. Pond stated, in part:

> ... there are no specific job duties that he is unable to perform based on physical or mental conditions. Clearly he is overweight and in poor physical condition. but this has no direct bearing on his atrial fibrillation As a Correctional

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[2] The punctuation is as indicated in this and subsequent reports by Dr. Pond.

[3] Digoxin 125 mg. qd, Levothyroid 25 mcg. qd, Glypizide 5 mg. twice a day, Lisinopril 10 mg. twice a day, Warfin 7.5 mg. a day, Lovastatin 20 mg. a day, Diltiazem 240 mg. three times a day, Metoprolol 50 mg. three times a day, Potassium twice a day, and Omeprazole 20 mg. daily. Dr. Pond reported that Respondent Schmidke was taking Metformin 500 twice a day on the date of his evaluation but did not clearly identify whether it was mg. or mcg.

Officer, he is at risk for injuries on the job, and he is specifically worried about the possibility of being "shanked" by one of the prisoners, but this concern by itself it not an adequate reason to prevent him from performing his duties

.... in my opinion he is not substantially incapacitated for the performance of his usual duties I reviewed the duty statement, job description and physical requirements and the atrial fibrillation per se does not cause "substantial incapacitation" Atrial fibrillation can be managed with medications for rate control and prophylactic anticoagulants to reduce the risk of thromboembolic complications Alternatively it can be managed by catheter ablation techniques in attempts to cure it Nevertheless the atrial fibrillation by itself is not grounds for substantial incapacitation

.... I do not believe he is substantially incapacitated He has had episodes of partial incapacitation. for which reason he has been treated at St Mary's Hospital in Apple Valley and at Kaiser Hospital in Fontana His temporary incapacitation resolved at the time he was released from the hospital. but his physicians have not pursued all options available to return him to a normal healthy productive life In particular I think he is a candidate for an electrophysiologic study and possible pulmonary vein isolation procedure to cure his atrial fibrillation If such a procedure was successful. then there would be no basis for temporary or even permanent incapacitation ...

20. By letter, dated February 4, 2010, Respondent Schmidke's attorney asked Dr. Jay to indicate whether Respondent Schmidke was substantially incapacitated because of his internal medicine conditions. He provided Dr. Jay with certain documents as well as the CalPERS criteria to determine whether Respondent Schmidke is substantially incapacitated. In order to respond to this question, Dr. Jay reviewed the Correctional Officer Essential Functions, Correctional Officer Job Analysis, California Rehabilitation Duty Statement for Correctional Officer, and Specifications for Correctional Officer as per the California State Personnel Board. In addition, he reviewed the CalPERS criteria to determine whether Respondent Schmidke is substantially incapacitated and his prior reports, dated February 22, 2006, and February 12, 2007. Thereafter, Dr. Jay issued a supplemental report, dated May 25, 2010.

Dr. Jay stated that Respondent Schmidke cannot perform the shift work and cannot work overtime. He cannot be involved in firing weapons in combat/emergency situations. He should not be involved in swinging a baton with force or striking because of his ongoing use of Coumadin therapy. He cannot disarm, subdue, or apply restraints to inmates, and he cannot defend himself against an inmate armed with a weapon. He cannot run in an all out

effort in responding to alarms or serious incidents, including running on uneven surfaces or grass, pavement, or fights. He cannot perform the activity of frequent climbing or descending of stairs. He cannot crawl or crouch. He cannot lift or carry weight continuously or frequently ranging from 20 pounds to 50 pounds, and he cannot lift and carry 100 pounds. He cannot work in emotional stressful situations.

In Dr. Jay's opinion, Respondent Schmidke cannot be involved and should not be involved in performing many of essential functions of a Correctional Officer; therefore, he is substantially incapacitated in the performing the job of Correctional Officer.

21. Thereafter, CalPERS requested that Dr. Pond review additional documents; he did so and issued a supplemental report, dated August 19, 2010. The documents included records previously reviewed by Dr. Pond, the job description for the Correctional Officer, essential functions, and previous physician reports on disability (including the report from Dr. Jay, dated May 25, 2010) and additional records from St. Mary's Hospital (dated September 26, 2008, October 27, 2007, December 4, 2006, June 30, 2006 and March 22, 2006). In addition to the foregoing, Dr. Pond reviewed his prior correspondence to CalPERS and referred to relevant portions in his supplemental report.

Finally, Dr. Pond stated, in part:

> The records that you have submitted to me do not change my opinion as to the fact that he is not permanently incapacitated To the contrary, new information that you provided shows that he has not been taking his digoxin on a regular basis, as evidenced by low or non existent digoxin serum levels Likewise he has not been managing his diabetes well, as indicated by the frequent episodes of hyperglycemia in the range of 350 or more He has not been "treated with multiple medications (antiarrhythmic agents). including Amiodarone" as alleged by Dr. Jay. in fact there is no evidence in these records that he has been maintained consistently on a beta blocker, digoxin, Amiodarone, or any other antiarrhythmic Likewise there is no documentation that he sought the assistance of an electrophysiologist for consideration of definitive treatment and management of his atrial fibrillation[4]

22. In response to a third request from CalPERS, Dr. Pond reviewed additional records and issued a second supplemental report, dated October 29, 2010. Previously, Dr. Pond had reviewed the documents related to Respondent Schmidke's job duties and physical requirements of the position and the physician's disability report dated March 27, 2007. The new medical records were from various dates in 2009. Dr. Pond summarized as follows:

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[4] The punctuation is as indicated in Dr. Pond's report.

> ... He was tried on Dofetilide for control of atrial fibrillation, but developed QT prolongation and this medication was discontinued He therefore continues to take Diltiazem for rate control, and Warfarin therapy The note from August 21st, 2009 alleges that he had undergone pulmonary vein ablation, but this is not corroborated by any other records. and he allegedly was referred to an electrophysiologist for consideration of ablation and pacemaker. however, none of this information is addressed in the records in my possession
>
> In summary, the additional records which you have asked me to review from Kaiser indicate that he has been tried on Dofetilide therapy unsuccessfully, he remains on digoxin, Diltiazem, Metoprolol. and Coumadin, in addition to his diabetes medications There was reference to referral to an electrophysiologist, but the current records do no provide any additional information for my review Therefore, I see no reason to change or modify my original assessment of Mr. Schmidke and again maintain that he is not "permanently and substantially incapacitated"

23. At the request of CalPERS, on October 29, 2012, Dr. Weber performed an Independent Medical Examination of Respondent Schmidke's atrial fibrillation, hypertension and heart disease and issued a report on the same date. In his testimony at the hearing, Dr. Weber explained medical concepts, explained his findings and identified information in other reports that supported his conclusions.

Dr. Weber reviewed records from: (1) CalPERS (March 18, 2003 – October 29, 2010), (2) St. Mary's Medical Center (February 22, 2006 – September 25, 2008), Kaiser (July 12, 2007 – March 23, 2012), and Desert Valley Hospital (June 30, 2006). In addition, he reviewed a CalPERS physician report on disability, dated March 26, 2007 and the IME by Dr. Pond. Dr. Weber noted that Dr. Pond reviewed medical history through 2008, and Dr. Pond referred to the AME performed by Dr. Jay, dated January 19, 2007.

Respondent Schmidke reported that he monitored his heart rate periodically "when it gets crazy" almost nightly; his heart rate was usually 100 to 110 beats per minute. He stated that he felt dizzy much of the time regardless of his heart rate. Upon Dr. Weber's specific questioning, Respondent Schmidke stated he believed it was due to his medications. Usually, his heart rate was in the 70s to 90s bpm; although the most recent time it became rapid, it went up to 140 bpm. Respondent Schmidke stated that he was aware of his heart beating irregularly. His blood pressure was usually 130/80 but sometimes went up to 140/90. He experienced exterional dyspnea when he walked less than one-quarter block.

Respondent Schmidke reported the medications that he was taking at the time for treatment of his medical conditions.[5]

On physical examination, Respondent Schmidke's heart rate 112 (irregularly regular), blood pressure left arm with thigh cuff 204/104, right arm 202/98, respirations 16, and weight 317 pounds.

Dr. Weber's diagnoses were: (1) atrial fibrillation, initially paroxysmal and now chronic, historically his ventricular response rate per patient report in adequate range; (2) hypertension per patient self-report) had been well controlled; acutely elevated at time of Dr. Weber's examination, presumably due to anxiety; (3) obstructive sleep apnea; (4) diabetes mellitus type II; (5) history of hypothyroidism, may be receiving suboptimal dose of thyroid replacement medicine; (6) history of hypotestosteronism; (7) history of dyslipidemia[6]; and (8) morbid obesity.

CalPERS asked Dr. Weber to address certain questions. In response to the question regarding whether there are specific job duties that Dr. Weber felt that Respondent Schmidke was unable to perform because of a physical or mental condition, Dr. Weber stated, in part:

> The job duties of a corrections officer require running, crawling, kneeling, climbing squatting, bending in addition to occasionally/frequently carrying weights up to 50 pounds and occasionally lifting/carrying weights of 75, 100, and above pounds for a distance up to 200 yards I reviewed the physical requirements of the job description and job analysis with Mr. Schmidke and he himself states that he is unable to perform these duties It is my opinion that given the multiplicity of medical problems that Mr. Schmidke is unable to perform a substantial number of his job duties. I will now enumerate them. Mr. Schmidke is unable to run, craw [sic], kneel, climb, squat, bend, carry weights up to 50 pounds or lift/carry weights up to 50 pounds for a distance of 100 yards.
>
> As a cardiologist I will begin by stating that his atrial fibrillation per se cannot be considered the cause of his inability to perform these duties as limitations owing description and by review of his medical records It is clear that his heart rate is generally in a

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[5] K-tab 10 meq. daily, Warfarin 5 mg. 2 daily, Digoxin 0.25 mg. daily, an additional Digoxin 1.25 mg. daily (totaling 1.5 mg.), Metoprolol 100 mg. one tablet twice a day, Furosemide 10 mg. 2 daily, Metformin 1000 mg. twice a day, Glipizide 2 mg. twice a day, Losartan 100 mg. daily, Pantoprazole 40 mg. twice a day, Atorvastatin 80 mg. q.h.s., Levothroid 25 mcg. daily, and Lantus insulin 46 units subcutaneously each morning.

[6] Another term for dyslipidemia is elevated cholesterol and/or triglycerides.

normal range and, in fact, at the time of my examination during which he had a situational reason to be anxious his heart rate was 112, a rate not considered excessive particularly in atrial[7] fibrillation, however his hypertension, which according to his own report based on home blood pressure monitoring as well as review of medical records, is generally quite controlled and should also not be the cause of his inability to perform his job duties

The conditions that singly and in combination I believe are likely responsible for his inability to perform his job duties are morbid obesity which by definition would make it extremely unlikely that he could perform the above described job duties and certainly at the higher level of physical exertion This combined with cardiovascular deconditioning, as he has not been engaged in regular physical exercise He has obstructive sleep apnea which is known to cause lack of restfulness and contributes to fatigue Furthermore his history of hypotestosteronism and the fact that he is not taking testosterone supplementation and this is well known that low levels of male sex hormone testosterone can contribute to muscle weakness and a lower than optimal energy level In addition, he has a history of hypothyroidism and it is quite possible that his current modest dose of Levothroid at 25 mcg daily may be inadequate I have not seen recent laboratory values to evaluate function tests Mr. Schmidke himself stated that he becomes dyspneic when walking less than one quarter of a block and this is without carrying any weight other than himself

Dr. Weber concluded that, based on the CalPERS medical qualifications for disability retirement, Respondent Schmidke is substantially incapacitated for the performance of from the performance of his usual duties based on the medical conditions cited above.

24. CalPERS requested that Dr. Bloom perform an IME in internal medicine (hypertension, hypertensive heart disease, obstructive sleep apnea, diabetes, hypothyroidism, dyslipidemia, morbid obesity, cardiovascular deconditioning and hypertesosteronism) of Respondent Schmidke. In addition to the evaluation described in Finding 11, Dr. Bloom ordered and interpreted an EKG. He performed his IME on March 14, 2014 and issued a report on the same date. In his testimony at this hearing, Dr. Bloom explained medical concepts and explained the findings and opinions in his report.

Dr. Bloom reviewed and commented on medical records, dated February 2006 through March 21, 2013.

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[7] The punctuation is as indicated in Dr. Weber's report.

Dr. Bloom identified Respondent Schmidke's current medications.[8]

On physical examination, Dr. Bloom noted "Right radial pulse 96 per minute – irregular – Right brachial blood pressure 170/102 and left brachial blood pressure 170/100 – sitting – via a thigh cuff Oxygen saturation 97% (room air) He stands 71 inches and weighs 303-1/2 pounds (without shoes)"

Dr. Bloom's diagnoses were:

- Hypertensive cardiovascular disease in atrial fibrillation
- Metabollic problems (Hypertension – uncontrolled, Diabetes mellitus – adult onset, Hyperlipidemia, Hypothyroid, Obesity)
- Obstructive sleep apnea

In Dr. Bloom's opinion, Respondent Schmidke is not incapacitated for the performance of his job duties.[9]

25. Among the physicians, Doctors Pond and Weber are most credible regarding Respondent Schmidke's atrial fibrillation. Their reports are well reasoned and supported by the objective medical evidence. Each reviewed the job duties, essential functions and physical requirements of Correctional Officer and relied on the CalPERS criteria for disability retirement. Dr. Pond distinguished his medical findings from Dr. Jay's. Doctors Pond and Weber's opinions regarding atrial fibrillation are consistent.

There is no dispute that Respondent Schmidke has the medical conditions of diabetes mellitus, sleep apnea, high blood pressure, hyperthyroidism, hypotestosteronism, hypercholesterolemia, hyperlipidemia and morbid obesity. Doctors Weber and Bloom commented on whether any or all of these medical conditions incapacitated Respondent Schmidke for the performance of his usual duties. Doctor Weber's evaluation is more thorough, well reasoned and supported by the medical evidence; in addition, he reviewed and discussed the duties, physical requirements and essential functions of the position and the CalPERS criteria for disability retirement. Though Dr. Weber specializes in cardiology, there is no evidence that he is not qualified to render an opinion regarding these medical conditions.

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[8] Losartan 100 mg. a day, Digoxin 0.25 mg. and 0.125 mg once a day, Metoprolol 100 mg. twice a day, Furosemide 20 mg. a day, Pantoprazole 40 mg. a day, Warfarin 5 mg. a day, Levothyroxine 25 mcg. a day, Amlodipine 2.5 mg. a day, Lipitor 40 mg. a day, Metformin 500 mg. twice a day, Nortriptyline 10 mg. at bedtime, Zolpidem 5 mg. at bedtime, Potassium 10 mEq. twice a day, and Humulin N injections twice a day.

[9] Dr. Bloom reported that Respondent Schmidke had limited ability to run on even ground because of his exertional shortness of breath. However, Dr. Bloom stated that this was not one of Respondent Schmidke's duties.

In Dr. Weber's opinion, Respondent Schmidke is unable to run, crawl, kneel, climb, squat, bend, or carry weights up to 50 pounds for a distance of 100 yards.

In Dr. Weber's opinion, Respondent Schmidke is not substantially incapacitated from his usual duties due to a cardiovascular condition or hypertension. Respondent Schmidke was in atrial fibrillation with a controlled heart rate. His hypertension (or high blood pressure) is well controlled.

In Dr. Weber's opinion the conditions that singly and in combination are responsible for his inability to perform his job duties are morbid obesity, cardiovascular deconditioning, sleep apnea, hypotestosteronism and hypothyroidism.

26. Considering the duties and physical requirements of the position of Correctional Officer and the competent medical evidence, Respondent Schmidke is substantially incapacitated for the performance of his duties, singly and in combination, on the bases of morbid obesity, cardiovascular deconditioning, sleep apnea, hypotestosteronism and hypothyroidism.

27. After Dr. Jay told Respondent Schmidke that he could not return to work as a Correctional Officer, his employer did not offer Respondent Schmidke another position or a modified position. Respondent DOCR did not file an application for disability retirement on Respondent Schmidke's behalf. Instead, Respondent Schmidke's employer told him to do so.

LEGAL CONCLUSIONS

1. Respondent Schmidke, is a safety member of CalPERS, seeks disability retirement pursuant to Government Code sections 20026 and 21151.[10]

2. Section 20026 states, in part:

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

3. 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 an industrial disability shall

[10] Hereinafter all reference is to Government Code.

be retired for disability, pursuant to this chapter, regardless of age or amount of service . . .

4. Section 21152 states, in part:

Application to the board for retirement of a member for disability may be made by:

[¶] . . . [¶]

(c)The governing body, or an official designated by the governing body, of the contracting agency, if the member is an employee of a contracting agency.

(d)The member or any person in his or her behalf.

5. In 1970, the Court of Appeal held that to be "incapacitated for the performance of duty" within Government Code section 21022 (now section 21151) means "the substantial inability of the applicant to perform his usual duties." (*Mansperger v. Public Employees' Retirement System* (1970) 6 Cal.App.3d 873, 877.)

In *Mansperger*, the appellate court found that while a game warden's disability incapacitated him from lifting or carrying heavy objects, which was sometimes a remote occurrence, the game warden was not entitled to a disability retirement because he could *substantially* perform most of his *usual* duties. (*Ibid.*, at pp. 876-877.) The appellate court drew a crucial distinction between a person who suffers some impairment that does not impact his performance of his customary and usual duties, and one who suffers the substantial impairment that prevents him from performing those duties.

6. Neither risk of injury nor risk of aggravation of an injury is sufficient basis to award a disability pension. Many injuries or medical conditions create an increased risk that the person will suffer a further injury or aggravation at a later time. For example, a person with a back injury or a heart problem is sometimes advised by doctors to avoid heavy in order to prevent further injury. Although the person is presently capable of performing a certain task, the task should be avoided on a prophylactic basis.

In *Hosford v. Board of Administration* (1978), 77 Cal.App.3d 854, the disability applicant argued that his back injuries created increased risk of further injury. The Court rejected his contention that the increased risked constituted a present disability and stated that Hosford's assertion did "little more than demonstrate his claimed disability is only prospective (and speculative), not presently in existence." (*Id.* at p. 863.)

7. Respondent Schmidke has the burden of proving entitlement to disability retirement by a preponderance of the evidence. (*McCoy v. Board of Retirement* (1986) 183

Cal.App.3d 1044, 1051, fn. 5; *Glover v. Board of Retirement* (1989) 214 Cal.App.3d 1327, 1332.)

8. It is determined that the conditions that singly and in combination are responsible for Respondent Schmidke's inability to perform his the usual and customary duties of a Correctional Officer employed by Respondent DCR are morbid obesity, cardiovascular deconditioning, sleep apnea, hypotestosteronism and hypothyroidism.

9. Respondent Schmidke is substantially incapacitated from performing his usual and customary duties as a Correctional Officer employed by Respondent DCR on the bases of morbid obesity, cardiovascular deconditioning, sleep apnea, hypotestosteronism and hypothyroidism, singly and in combination.

10. Section 21153 states:

> Notwithstanding any other provision of law, an employer may not separate because of disability a member otherwise eligible to retire for disability but shall apply for disability retirement of any member believed to be disabled, unless the member waives the right to retire for disability and elects to withdraw contributions or to permit contributions to remain in the fund with rights to service retirement as provided in Section 20731.

11. Respondent Schmidke contends that Respondent DCR did not perform its mandated duty to file for an industrial disability retirement on his behalf as required by Section 21153, and therefore he is entitled to recover certain remedies and identified the remedies that he seeks.

The statute requires the employer to file the application for disability retirement if the employer believes that the employee is disabled. The criteria for determining disability in Workers Compensation cases is different that the criteria in CalPERS case. As such, though Respondent DCR believed that Respondent Schmidke was disabled under the Workers Compensation criteria, Respondent Schmidke was required to establish that Respondent DCR believed that he was disabled in accordance with the CalPERS criteria. Respondent did not offer such evidence. Therefore his argument regarding this issue is rejected.

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ORDER

The application for disability retirement of Mike W. Schmidke is granted.

DATED: December 17, 2014

VALLERA J. JOHNSON
Administrative Law Judge
Office of Administrative Hearings