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: EDITH Z. DAVENPORT, and WEST CITIES POLICE COMMUNICATIONS, Respondents.	Agency Case No. 2015-0037 OAH No. 2015031184

PROPOSED DECISION

Administrative Law Judge Thomas Y. Lucero heard this matter on December 9, 2015, in Glendale, California.

Elizabeth Yelland, Senior Staff Attorney, represented the California Public Employees' Retirement System (CalPERS).

Thomas J. Wicke, Attorney at Law, represented Edith Z. Davenport (respondent).

No appearance was made on behalf of respondent, West Cities Police Communications.

Oral and documentary evidence was received. The record was left open for submission of briefs on or before January 8, 2016.

Briefs were timely submitted. "CalPERS' Closing Brief in Support of Determination" was marked for identification as Exhibit 11. Respondent's "Post-Hearing Closing Brief" was marked for identification as Exhibit E.

The record was deemed closed and the matter was submitted for decision on January 8, 2016.

FACTUAL FINDINGS

1. Acting in her official capacity, Diane Alsup, Interim Chief of the Benefits Services Division of CalPERS, filed the statement of issues.

2. As indicated in Exhibit 3, on February 14, 2014, respondent, who worked as a police dispatcher, signed, and later filed, an application for disability retirement (application).

A. She claimed disability on the basis of a psychological condition. She stated the psychological condition includes: (i) posttraumatic stress disorder (PTSD); (ii) panic attacks; (iii) anxiety caused by triggering events; (iv) depression; (v) loss of concentration; (vi) loss of memory; and (vii) inability to communicate.

B. The application stated that respondent's psychological condition was associated with: (i) nausea; (ii) vomiting; (iii) sweating; (iv) shaking; and (v) migraines.

C. The application stated that respondent's disability arose on October 12, 2011, when she answered an emergency telephone call from a person who was witnessing shootings and mass murder at a retail establishment in Seal Beach, California. As a result, respondent stated she is disabled from continuing as a police dispatcher who can safely handle emergency and routine calls to the police and related radio traffic.

3. At the time she filed her application, respondent had been employed by West Cities Police Communications and had the minimum service credit necessary to qualify for retirement. By virtue of her employment, respondent is a "local miscellaneous member" of CalPERS.

4. After it reviewed medical reports that respondent submitted in support of the application, CalPERS determined that respondent was not substantially incapacitated for performance of her duties as a police dispatcher with West Cities Police Communications at the time the application was filed.

5. In an October 20, 2014 letter, CalPERS notified respondent of its determination and informed her that her application was denied. (Exhibit 4.)

6. In an October 29, 2014 letter, respondent timely appealed the denial. (Exhibit 5.)

7. The issue on appeal is whether respondent is substantially incapacitated for performance of her duties as a police dispatcher with West Cities Police Communications on the basis of a psychological condition, the result of mental and emotional disorders that are associated with physical illnesses and symptoms.

Respondent's Job

8. Respondent first worked as a police dispatcher for the City of Garden Grove, California, when she was 23 years old. She worked there from May 2003 until September 2005.

9. Respondent considered the police dispatcher job with West Cities Police Communications a better opportunity. She began working there in late 2005, in an office in Seal Beach with about 18 dispatchers. They averaged 40 hours per week, working 12-hour shifts three days per week with an extra shift every fourth week. There was no time off for meals, which were provided at dispatchers' desks. As dispatchers answered telephone calls in the order the office received them, they sat before several computer monitors showing: (i) calls waiting to be answered, (ii) where police officers were located, (iii) information about where a land line call originated, and (iv) notes the dispatcher wrote to transmit to a radio operator who was in communication with officers in the field.

10. Some calls were about nuisances like barking dogs and other non-emergency matters. Other calls concerned emergencies reported to the 911 emergency number. Dispatchers took about five to ten calls per hour. They dealt with many difficulties and crises. They had to decide a course of action quickly, whether, for instance, to have an officer drive to the caller. They had to decide what to tell the officer about the situation, such as possible danger from weapons or other hazards. Often the first difficulty was keeping a caller focused in order to obtain information. The dispatcher had to obtain the caller's location and a description of the emergency, accident, or other circumstances. This could be difficult when, as frequently happened, callers were scared or injured or otherwise under stress.

11. Because of her experience and good work record, respondent was sometimes asked to fill in for a supervisor. She would then be responsible for the information radioed to officers and might advise the dispatcher who took a call on how best to proceed.

History of Injuries

12. Respondent answered a call from a woman who reported shootings in Seal Beach in the early afternoon on October 12, 2011 (incident). A gunman killed eight people in the incident. Respondent was on the call for 15 to 20 minutes. She heard the caller's panicked voice and gunshots and chaos in the background. The experience traumatized her, but respondent was able to finish her shift, working until 6:00 p.m.

13. Respondent returned to work the day after the incident. She had trouble concentrating and was sent home. She was off work until October 19, 2011, but the time off did not seem to help. After returning to work, she was fearful and continued to have trouble with many tasks.

14. Respondent continued to work for about 14 months after the incident. Many calls reminded respondent of the incident, causing her growing anxiety. On December 5, 2012, she participated in training required by her employer. Training materials included recordings of reported violence and how police personnel should respond. The training upset respondent and made her anxious. She felt she was reliving the incident. As a result, she did not complete the training and left work. Since then she has not returned to work and has felt unable to do so.

15. Respondent experienced several events affecting her psychological condition before the psychological trauma of the incident.

A. When respondent was five years old, her 19-year-old brother was shot by a stranger. He spent a few days in a hospital, where he died.

B. Respondent had an abortion in 1998.

C. Respondent became a single mother in 1999. She felt abandoned by the child's father and scared about raising a child alone.

D. Respondent was unhappily married from 2003 through 2008. This first husband was unfaithful and left her in 2006.

E. Respondent is affected by endometriosis. In 2003 respondent had an ectopic pregnancy. It caused internal bleeding, which required emergency surgery. Respondent was scared because she could easily have died from her condition or from the surgery.

F. Respondent remarried in 2010. That year she gave birth to twin daughters. However, in April 2011, she had a second ectopic pregnancy. She underwent an oophrosalpingectomy (removal of the ovaries and fallopian tubes). She was saddened and depressed by this abnormal pregnancy.

G. In the course of treatment for the 2011 ectopic pregnancy, respondent was found to have a goiter and hyperthyroidism. Her thyroid was surgically removed in April 2011 and found to have cancer. She must take medications to compensate for the lack of a thyroid.

H. As indicated below, respondent was shocked by the suicide of a psychologist intern who had counseled her weekly for about a year regarding the incident.

16. Respondent testified, slowly, at times tearfully, that, since the incident, she suffers from depression and anxiety and feelings of guilt that she is not stronger mentally and emotionally. Her testimony was consistent with that of a person struggling with depression. She no longer participates in many activities of daily life, such as preparing meals, daily care of her children, paying household bills, and doing other household chores. All such activities

she leaves to her 16-year-old daughter and husband. Respondent's mother, who lives near her, also helps out occasionally.

Treatment for Injuries

(a) Treatment by Psychologists

17. A few days after the incident, respondent began weekly sessions with Tom Richards, M.A. He was a psychologist intern at Psychological Consulting Associates, Inc., which specializes in counseling and treating first responders. Respondent's last session with him was two days before his suicide in February 2013. The suicide was a shock that saddened and depressed respondent.

18. Respondent continued with psychological therapy, as indicated in Exhibit B, described below. On April 8 and 23, 2013, and again on June 19, 2013, she had sessions at Psychological Consulting Associates, Inc. with licensed clinical psychologist, Gina L. Gallivan, Ph.D., A.B.P.P. Following these sessions, Dr. Gallivan's objective findings were:

> Tearful, blunted affect, hypervigilance, dysphoric and anxious mood, difficulty concentrating, psychomotor agitation, excessive worry and fear that harm will come to her family, negative thought rumination and avoidance behavior

Dr. Gallivan's diagnoses were:

Post Traumatic Stress Disorder, chronic	ICD-9 309.81[1]
Major Depressive Disorder, Moderate	ICD-9 296.22

19. Respondent continued in therapy about twice a month in 2013, except that, according to Dr. Gallivan's notes, she did not attend sessions in September or December. Following sessions in 2014 on January 20, February 10, and April 8, Dr. Gallivan submitted a progress report to the Division of Workers' Compensation indicating no change in objective findings or diagnoses. Dr. Gallivan also wrote a letter to the workers' compensation carrier advising that respondent's condition was permanent and stationary. (Exhibit B.)

20. Dr. Gallivan's observations of respondent, as indicated in Exhibit B, are similar to those of respondent's psychiatrist, Dr. Gudipati, noted below in Finding 26. Dr. Gallivan's notes dated June 19, 2013 stated:

> Cl. [Client] has been out of tx [therapy] since 4-23-13. She stated that she stopped taking psych. medication & going to therapy because she was "trying to get better on my own . . . but it didn't work." Cl. stated she resumed

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[1] ICD-9 refers to the International Statistical Classification of Diseases and Related Health Problems and its system of codes for various disorders and diseases.

medication & made app[ointment]t for counseling last week. Mood was dysphoric. She was tearful. She denied suicidal ideation. . . .

(b) Treatment by Psychiatrist and Current Treatment

21. As indicated in Exhibit A, respondent first visited a psychiatrist, Sandhya R. Gudipati, M.D., M.B.A., on January 3, 2012.

A. Dr. Gudipati noted respondent's eight-month history of depression following the incident, as well as her brother's death, her first ectopic pregnancy, and oophrosalpingectomy in 2011. Dr. Gudipati's report included this history of respondent's illness:

> [Respondent] [n]oticed next morning [following the incident] severe anxiety, feelings of sadness, negative ruminations, inability to go to work for more than a week, nightmares of visualization of the incident while on the phone, inability to sleep well. Started seeing a therapist, saw him 6 times for crisis management, but in December could not see him due to work pressures and overtime she had to put in. Noticed increased depressive symptoms, sadness, hopelessness, crying spells, irritability, negative ruminations, increased memories of brother's death in a drive shooting [*sic*] when he was 18 and client was 5. Never grieved his death. Insomnia, lethargy, constant tiredness, inability to focus, concentrate at work, inability to have any interest in pleasurable activities noted. No suicidal thoughts or psychotic symptoms.

B. Dr. Gudipati's report of a mental status exam (MSE) of respondent stated:

> Alert, oriented, disheveled, female appears extremely depressed with mood, affect is tearful and constricted. Speech is clear, coherent, answers appropriately to the questions. TP/TC [thought process/thought content] - extremely depressed, sadness+, hopelessness+, lack of self worth+, negative ruminations+, anhedonia+, sense of impeding [*sic*] doom and gloom+, no SI [suicidal ideation], no psychotic symptoms noted. Insight and judgment is fair. Cognitive functions grossly intact.

C. Dr. Gudipati's diagnoses were:

> ICD-9 Codes:
> 1) 30981; POSTTRAUMATIC STRESS DISORDER
> 2) 29631; MAJOR DEPRESSIVE DISORDER, RECURRENT EPISODE, MILD

D. Dr. Gudipati prescribed Wellbutrin, an antidepressant, which respondent was to take once a day.

22. Respondent returned to Dr. Gudipati on January 31, 2012. There was no change in diagnoses. Dr. Gudipati noted that respondent was having sleep problems and

constant worry about the future. But she also observed that respondent was "[s]miling a little more." Respondent was tolerating medications well, Wellbutrin and Ativan, for treatment of her anxiety disorders. Dr. Gudipati prescribed in addition Celexa, an antidepressant.

23. At respondent's next appointment with Dr. Gudipati on February 27, 2012, the assessments noted were:

> Smiling spontaneously, mood improved with addition of Celexa, sleeping better on current dose of Ativan and Melatonin. Feels rested, anxiety much improved. No acute anxiety or depressive symptoms. No side effects to meds.

24. Starting on May 18, 2012, respondent saw Dr. Gudipati every three months or more, as needed. There was little change in her condition in 2012. Dr. Gudipati's assessments on January 9, 2013 stated:

> Apparently was placed on medical leave in December due to insomnia, increased memories of the phone call she took about the shooting incident in Seal Beach. Very tearful, lethargic, unable to function due to stress and anxiety. No side effects to meds.

25. Among Dr. Gudipati's assessments on October 28, 2013 is that, "Client is currently stable with symptoms on current dose of medications, no acute mood or anxiety symptoms . . . ." The doctor's assessments on January 16, 2014 start with the same statement.

26. A change in the assessments occurs with Dr. Gudipati's report dated July 7, 2014:

> Seen after 6 months, decided to try without medications in the last 2 months, noticed increased lethargy, crying spells, emotional lability, irritability, stress with retirement benefits not being paid yet despite work releasing her from her position upon recommendation of worker's comp lawyer and 2 other doctors certifying her for retirement. Back on medications in the last two weeks, started school with one class with good grade. Wants to move on but feels anxious about the retirement issues. . . .

27. Dr. Gudipati's last assessment in evidence is dated February 27, 2015:

> Seen after 9 months. Apparently was in school to finish her medical assistance program. Decided to go off medications, notices emotional outbursts, sadness, irritability, anxiety, and inability to care for the children. Looking at being employed soon, no behavior issues. Requested to restart medications. No suicidal thoughts.

28. Respondent currently sees Jessica Tucker, D.O., who prescribed Paxil, which respondent takes nightly to help her sleep.

(c) Agreed Medical Examination

29. On November 20, 2013, an agreed medical examination (AME) in psychiatry was performed by Robert A. Faguet, M.D., Ph.D., Diplomate, American Board of Psychiatry and Neurology. (Exhibit D.) The AME was to help assess respondent's workers' compensation claim. Dr. Faguet reviewed respondent's medical records, including her treatment with Mr. Richards, Dr. Gallivan, and Dr. Gudipati. Dr. Faguet observed:

> Emotionally, she is anxious and short tempered. She cries easily. She has lost about five pounds. Her memory and concentration are poor. She is not interested sexually. She sleeps poorly. She has nightmares two or three times a week about the shooting, and has flashbacks once a week of the incident. She did not have any future plans, but feels better knowing that she doesn't have to go back to work. She feels a little more stable.

30. Dr. Faguet gave his diagnoses and recommendation as follows:

> . . . Ms. Davenport did suffer an industrially related Posttraumatic Stress Disorder (DSM IV TR 309.81)/Major Depressive Disorder (DSM IV TR 296.20) and was TD [temporarily disabled] beginning in December 2012. She is P&S [permanent and stationary] at this time with a psychiatric residual as described below. . . . Industrially related psychiatric treatment has been in order and should continue at the current rate into the future. She is a QIW [qualified injured worker] and should not return to dispatching. . . .
>
> The applicant's score on the Global Assessment of Functioning (GAF) Scale is 50[2] . . . which translates into a whole person impairment (WPI) rating of 30.

Dr. Faguet's finding that respondent was QIW means, under the Workers' Compensation system, she was found permanently unable, or likely to be unable, to engage in her usual and customary employment at the position in which she worked at the time of injury, and therefore was entitled to vocational rehabilitation benefits.

(d) Independent Medical Evaluation

31. CalPERS sought an independent medical evaluation (IME). Accordingly on August 14, 2014, respondent underwent a complete psychiatric disability evaluation. The

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[2] As stated in the DSM-IV, 50 on the GAF Scale indicates: "**Serious symptoms** (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) **OR any serious impairment in social, occupational, or school functioning** (e.g., no friends, unable to keep a job)." (Emphasis in original.)

evaluating physician, Lawrence H. Warick, M.D., Ph.D., Diplomate, American Board of Psychiatry and Neurology, prepared an IME report dated August 15, 2014. (Exhibit 7.)

32. Dr. Warick's IME report notes that the source of respondent's job-related stress was "devastating" emergency phone calls "from people at their worst" and communicating with police officers involved in pursuits and other stressful situations. Dr. Warick wrote that respondent enjoyed her job, in that she liked helping people and meeting the challenges the job presented, though she acknowledged that the job was stressful emotionally and psychologically.

33. Respondent reported to Dr. Warick that on the day of the incident she went home "very shaky[,] was hyperventilating[,] had insomnia and was crying." She became more and more withdrawn. She felt embarrassed for not being stronger. Focusing and concentrating were difficult. She was irritable and angry. There was marital tension.

34. Dr. Warick notes respondent's sessions with Mr. Richards and his suicide in February 2013. About a month before, in January 2013, as she reported to Dr. Warick, respondent had had feelings of guilt that led her to suicidal ideation. The feelings were relieved when respondent spoke to Mr. Richards's supervising psychologist, Dr. Gallivan. Dr. Warick notes that Mr. Richards's suicide "devastated" respondent and "revived the feelings of the event of 10/12/11."

35. Dr. Warick reviewed the reports of respondent's sessions with Dr. Gallivan and noted that in April 2014 respondent was considered permanent and stationary. Dr. Warick reviewed Dr. Gudipati's records of her treatment of respondent and the report of the AME performed by Dr. Faguet.

36. In evaluating respondent, Dr. Warick used criteria in the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision (DSM-IV-TR, which was revised by means of a fifth edition in mid-2013, the DSM-5). Dr. Warick's evaluation states his "diagnostic impression according to DSM-IV-[T]R" as follows:

Axis I[3]	PTSD by history
	Major Depressive Disorder by history
Axis II	Diagnosis deferred

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[3] DSM-IV-TR uses five axes pertaining to information as follows: Axis I to clinical disorders; Axis II to personality disorders; Axis III to general medical conditions; Axis IV to psychosocial and environmental problems; Axis V to a Global Assessment of Functioning (GAF). DSM-5 does not use an Axial System or GAF.

Axis III	Thyroidectomy for hyperthyroidism[,] breast augmentation[,] endometriosis[,] abortion[,] IVF pregnancy 2 ectopics[, and] C-section
Axis IV	Occupational problems
Axis V	GAF = 70[4] Whole person impairment = 0%

37. Dr. Warick testified that he observed respondent to have a high level of functioning. She planned to study nursing and had already successfully completed one class in nursing at Santa Ana College.

38. Dr. Warick noted further that "nonindustrial factors" had to be considered in evaluating respondent's psychological makeup. In this regard he lists the murder of her brother and its impact on her unhappy first marriage, her hyperthyroidism and its associated generalized and severe anxiety, her two life-threatening ectopic pregnancies, an abortion, and the suicide of Mr. Richards.

39. Dr. Warick concluded that respondent is not substantially incapacitated in performance of her usual duties, is able to perform her duties as a police dispatcher, but has chosen to change careers. The IME report continued: "Though still somewhat symptomatic she is not disabled and is functioning quite adequately as well as her symptoms being controlled by medication[.] Her symptoms have also diminished."

40. Dr. Warick testified that his conclusions against substantial incapacity are supported by the results of the Millon Clinical Multiaxial Inventory-III (MCMI-III), which he administered to respondent. The MCMI-III is an assessment tool designed to provide information about disorders described in the DSM-IV. Regarding Axis I (concerning clinical disorders), the MCMI-III states:

> The major complaints and behaviors of the patient parallel the following Axis I diagnoses, listed in order of their clinical significance and salience
>
> 296 33 Major Depression (recurrent severe without psychotic features)
> 300 02 Generalized Anxiety Disorder
> 309 81 Posttraumatic Stress Disorder

The results above are preceded by this statement in the MCMI-III:

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[4] As stated in the DSM-IV, 70 on the GAF Scale indicates: "**Some mild symptoms** (e.g., depressed mood and mild insomnia) **OR some difficulty in social, occupational, or school functioning** (e.g., occasional truancy, or theft within the household), **but generally functioning pretty well, has some meaningful interpersonal relationships.**" (Emphasis in original.) The DSM-5 does not use the GAF Scale.

Definitive diagnoses must draw on biographical, observational, and interview data in addition to self report inventories such as the MCMI-III.

41. Dr. Warick stated that the Axis I diagnoses are computer-generated and therefore subject to a physician's revision. The Axis I results of the MCMI-III notwithstanding, Dr. Warick did not agree that respondent had PTSD when he evaluated her. He pointed out that usually a person with PTSD is directly involved in the traumatic event or witnesses it in person. Respondent did neither. She was simply on the phone. Dr. Warick believes that the incident caused respondent to suffer from depression and anxiety, but as indicated above, not such as to incapacitate her.

42. On December 7, 2015, Dr. Warick wrote a supplemental report, Exhibit 7A, in which he noted inconsistency in respondent's discussion of her brother's death. To him she minimized its impact and denied her grieving the loss of her brother, whereas Dr. Gudipati noted that respondent did grieve over the loss and received treatment as a result.

LEGAL CONCLUSIONS

1. Absent a statutory presumption, an applicant for a disability retirement has the burden of proving by a preponderance of the evidence that he or she is entitled to disability retirement. (*Glover v. Board of Retirement* (1989) 214 Cal.App.3d 1327, 1332.)

2. Government Code section 21150, subdivision (a) provides in pertinent part:

A member incapacitated for the performance of duty shall be retired for disability pursuant to this chapter if he or she is credited with five years of state service, regardless of age . . . .

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

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

4. "Incapacity for performance of duty" means "the substantial inability of the applicant to perform his usual duties," as opposed to mere discomfort or difficulty. (*Mansperger v. Public Employees' Retirement System* (1970) 6 Cal.App.3d 873, 876; *Hosford v. Board of Administration* (1978) 77 Cal.App.3d 854, 862.) The increased risk of further injury is not sufficient to establish current incapacity. The disability must exist in the present. Restrictions imposed only because of a risk of future injury are insufficient to support a finding of disability. (*Ibid.*, 77 Cal.App.3d at 862-863.)

5. As indicated in Finding 10, respondent's job required critical thinking under pressure, at times extreme pressure. It required calm while others faced dangers, which could often be life-threatening. Before the incident, respondent did her job well, but after the incident she had difficulty, especially with emergency calls.

6. Respondent's difficulties decreased with treatment, as Dr. Warick found, based on Dr. Gudipati's records in particular. The evidence does not demonstrate that respondent was ever completely unable to fulfill her duties. Perhaps most telling in this regard is that respondent was able to continue doing her job not only on the day of the incident for some hours afterwards, but for over a year after that. (Findings 12 and 14.)

7. Both Dr. Gallivan and Dr. Gudipati noted that respondent's mental and emotional complaints were relieved with medications. Respondent felt well enough to stop taking medications, although after some weeks she found she should continue with them, as Dr. Gudipati noted, and as indicated in Finding 20. Respondent was looking forward to working again, as Dr. Gudipati noted and as indicated in Finding 27.

8. Respondent's testimony was slow and tearful, and generally consistent with a person struggling with depression. However, there is reason to question her credibility. Certain facts seemed unforthcoming, except when prompted by leading questions. According to the records of Dr. Gallivan and Dr. Gudipati, respondent did not have suicidal ideation, yet Dr. Warick records her discussion with him that she had considered suicide. Dr. Warick's December 7, 2015 supplemental report also noted inconsistency in respondent's discussion of her brother's death, as indicated in Finding 42.

9. Respondent is proceeding with work plans. She seeks to be educated and trained as a nurse. That job has similarities to that of police dispatcher. Calm and critical thinking are required of a nurse facing the medical or physical dangers threatening others. Such dangers may be faced by even those nurses who never work in a hospital or directly with patients, and simply manage health from an office.

10. Dr. Faguet determined that respondent was disabled, permanently or likely so, and should not return to her job as a police dispatcher. But his opinion should be given less weight than those of other examiners. Dr. Faguet does not indicate whether respondent's depression is mild, as Dr. Gudipati did, or moderate, as Dr. Gallivan did. His assigning respondent a score of 50 on the GAF scale suggests that his assessment of respondent was not complete inability to work as a police dispatcher. Dr. Gudipati's assessments in October 2013 and January 2014, as indicated in Finding 26, were that respondent's condition had stabilized with "no acute mood or anxiety symptoms." Dr. Warick found that respondent was not incapacitated.

11. The events listed in Finding 16 that preceded the incident did not prevent respondent from working as a police dispatcher for approximately eight years. The other stressful event listed, the suicide of Mr. Richards, negatively affected respondent after the incident, but the evidence does not demonstrate that the events, taken together, have a cumulative force that incapacitates her.

12. Respondent did not meet her burden of showing that at the time of her application for disability retirement, on the basis of mental or emotional disorders (that is, (i) PTSD; (ii) panic attacks; (iii) anxiety caused by triggering events; (iv) depression; (v) loss of concentration; (vi) loss of memory; and (vii) inability to communicate) associated with physical illnesses or symptoms (that is, (i) nausea; (ii) vomiting; (iii) sweating; (iv) shaking; and (v) migraines), she was substantially incapacitated for performance of her duties as a police dispatcher with West Cities Police Communications.

13. The weight of the medical evidence tends to show that respondent is not incapacitated by reason of her psychological condition and its associated physical conditions and is not eligible to retire for disability.

ORDER

The appeal of respondent, Edith Z. Davenport, is denied.

Dated: February 1, 2016

DocuSigned by:
Thomas Lucero
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THOMAS Y. LUCERO
Administrative Law Judge
Office of Administrative Hearings