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: DANIEL M. WHITE, Respondent, and, 21ST DISTRICT AGRICULTURAL ASSOCIATION, BIG FRESNO FAIR, DEPARTMENT OF FOOD AND AGRICULTURE, Respondent.	Case No. 2013-0982 OAH No. 2014080590

PROPOSED DECISION

This matter was heard before Danette C. Brown, Administrative Law Judge, Office of Administrative Hearings, State of California, on February 4, 2016, in Fresno, California.

Kevin Kreutz, Senior Staff Counsel, represented the California Public Employees' Retirement System (CalPERS).

Daniel M. White (respondent) appeared, and was represented by Michael J. DeNiro, Attorney at Law.

No appearance was made by or on behalf of the 21st District Agricultural Association, Big Fresno Fair, Department of Food and Agriculture. Proper service of the Statement of Issues and Notice of Hearing was made. The matter proceeded as a default against respondent 21st District Agricultural Association, Big Fresno Fair, Department of Food and Agriculture, pursuant to Government Code section 11520.

Evidence was received, and the record was held open until February 23, 2016, to allow the parties to submit closing briefs. On February 23, 2016, respondent submitted his

closing brief, which was marked as Exhibit R21.[1] CalPERS did not submit a closing brief. The record was closed, and the matter was submitted for decision on February 23, 2016.

ISSUE

At the time of respondent's application for disability retirement, was respondent permanently disabled or substantially incapacitated from the performance of his duties as a Chief of Racing for respondent 21st District Agricultural Association, Big Fresno Fair, Department of Food and Agriculture (Department), on the basis of a psychological (stress, anxiety, depression) condition?

FACTUAL FINDINGS

Duties of a Chief of Racing for the Department

1. At the time of his application for disability retirement, respondent was employed as a Chief of Racing. The Department's Duty Statement for a Chief of Racing describes the essential duties and responsibilities of the job classification as follows: key member of management team directing overall operations and functions of the live horse racing program and the Fair's two satellite wagering facilities; work on shifts other than 8:00 a.m. to 5:00 p.m. and on weekends and holidays; ensure that rules and regulations of the California Horse Racing Board are properly observed; understand principles of pari-mutuel wagering; assist with audio/visual signals; establish and maintain good public relations; administer personnel supervision relating to daily operation of satellite facility; supervise employees; and serve as Director of Racing for Fair's live race meet.

2. The physical requirements of the job include: frequent (three to six hours) sitting, standing, walking, driving, exposure to extreme temperature, humidity and wetness, working at heights, operation of foot controls and repetitive movement; occasionally (up to three hours) climbing, bending, twisting, reaching, pushing and pulling, fine manipulation, power grasping, simple grasping, repetitive use of hands, keyboard use, mouse use, lifting and carrying, walking on uneven ground, working with heavy equipment, exposure to excessive noise, and working with bio-hazards. The job does not require: running, crawling, kneeling, squatting, lifting over 75 pounds, and use of special visual or auditory protective equipment.

Respondent's Employment History

3. Respondent began working for the Department in the 1990's. At the time respondent filed his application for disability retirement, he was employed as a Chief of

[1] Both parties used numbers for their exhibits. Respondent's exhibits are distinguished from CalPERS' exhibits by using the letter "R" prior to the exhibit number.

Racing. By virtue of his employment, respondent is a state miscellaneous member of CalPERS subject to Government Code section 21150. Respondent retired for service on June 1, 2012.

Respondent's Disability Retirement Application

4. On May 15, 2012, CalPERS received respondent's Disability Retirement Election Application (application). In response to the question on the application about his specific disability, and when and how it occurred, respondent wrote:

> Starting in 2008, my work environment became increasingly hostile resulting in anxiety related [*sic*] mental and physical health issues and increasing hypertensive episodes. A specific interaction on July 14, 2010, resulted in a physical and mental breakdown. I was unable to work and went to a mental health professional. I remain in treatment but the anxiety, nervousness, depression, severe sleep issues and effects of prescribed medication have been difficult, along with physical symptoms of hypertension and headaches.

Respondent stated that his limitations/preclusions due to his injury or illness are as follows:

> Physicians have stated I am unable to work under the supervision of the current CEO or even the location at this time due to recurring anxiety, depression, sleep issues and hypertension.

Respondent explained how his injury or illness affected his ability to perform his job as follows:

> Symptoms of PTSD[2] and depression continue with episodes of inability to sleep due to nightmares, night sweats and panic attacks. Some memory loss. Hand shake with intentional small movement, poor memory for time and dates, decline in ability to calculate math in my head, loss of confidence, anger, sense of "unfairness". [*sic*] Side effects of prescribed medications impact clear thinking at all times.

5. On April 16, 2013, Anthony Suine, Chief of the Benefit Services Division, notified respondent that his application had been denied based upon a determination that his psychological condition was not disabling, and that he was not substantially incapacitated

[2] Post Traumatic Stress Disorder.

from the performance of his job duties as a Chief of Racing for the Department. Respondent timely appealed the denial.

CalPERS Expert and Independent Medical Examiner Thomas R. Callahan, M.D.

6. Thomas R. Callahan, M.D., is a board-certified psychiatrist, and has been in private practice in Fresno, California since 1990. His practice consists of forensic psychiatry, psychopharmacology, medical ethics consultation, and individual and family psychotherapy. From 1969 to 1990, Dr. Callahan served as a senior staff psychiatrist at Kings View Center in Reedley, California, treating a wide variety of psychiatric disorders and physical illnesses. Dr. Callahan has authored numerous publications in the field of psychiatry and ethics.

7. Dr. Callahan conducted an independent medical examination (IME) of respondent at the request of CalPERS on January 31, 2013. He testified credibly at hearing about his IME of respondent, his IME Report dated March 5, 2013, and several supplemental reports. Dr. Callahan's IME of respondent consisted of a review of respondent's job description, an interview of respondent, a review of respondent's medical records, and a mental status examination. Dr. Callahan's interview with respondent revealed the following:

8. Respondent began work at the Department as a security guard on September 16, 1991. He was eventually promoted to Chief of Racing five years before a new Chief Executive Officer (CEO) was hired. A strained relationship existed between respondent and the CEO. On July 20, 2010, during a staff meeting, respondent claimed to have been publicly humiliated by the CEO. The incident impacted respondent to such an extent that he left work and never returned.

9. Since July 20, 2010, respondent has reported multiple symptoms consistent with anxiety such as nightmares, social isolation, daily recall of the incident, fantasizing about physically hurting the CEO, and having his body tattooed with depictions of his hate for the CEO. His weekly psychotherapy sessions sought to modulate his aggressive behavior, even toward the police. Respondent's daughter has so little confidence in respondent's self-control that she will not permit respondent to be alone with her two daughters.

10. Respondent's medications consisted of Diovan for hypertension, Propanolol for respondent's cardiac condition, Remeron for nightmares, Tomazepam for insomnia, Celexa for depression, Adderall XR for attention-deficit disorder, and Xanax on an as-needed basis for anxiety.

11. Respondent claimed that he was unable to return to work because of the many hours it would involve. He also stated that he was not able to work anywhere else because he was too frightened to go outside. Dr. Callahan did not note anything further with regard to these statements made by respondent.

12. Dr. Callahan's review of respondent's medical records noted a July 23, 2012 report by Dr. Matthew House, a psychiatrist. Dr. House diagnosed respondent with attention deficit disorder (ADD), major depressive disorder, and PTSD. Dr. Callahan also found nerve conduction studies performed on June 8, 2012, which showed no evidence of radiculopathy, myopathy and neuropathy. Magnetic resonance imaging (MRI) performed on June 4, 2012 showed degenerative disc disease with neural foraminal narrowing and potential nerve root contact at the L2-3 level.

13. Dr. Callahan conducted a mental status examination. He noted that respondent was well-oriented to time, place and person. Respondent was very difficult to interview, and was frequently vague and manipulative. Respondent tried to control the interview and was often agitated. He feared being evaluated, stating to Dr. Callahan, "My future lies with you." Respondent's powers of concentration seemed adequate. He exhibited paranoid ideation, but denied suicidal ideation. Respondent was not delusional or thought-disordered.

14. Dr. Callahan questioned respondent's credibility related to his reported work limitations, due respondent's "emotional lability and manipulative style." Dr. Callahan requested psychological testing of respondent by Dr. Errol Leifer, a psychiatrist in Fresno. Dr. Callahan noted respondent's potential explosiveness as reflected in the refusal of his daughter to allow respondent to spend time alone with his grandchildren, as well as respondent becoming "obsequious" when challenged by Dr. Callahan to control the interview.

15. Dr. Callahan also questioned respondent's diagnosis of PTSD. He noted that a "fundamental requirement for that diagnosis is that the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others." Respondent's humiliation at work, Dr. Callahan noted, regardless of how distressful, did not meet the requirements of the condition, taken from the diagnostic criteria in the Diagnostic and Statistical Manual of Mental Disorders (DSM)-IV-TR.[3]

16. Dr. Callahan diagnosed respondent as follows:

Axis I: 309.28 Adjustment Disorder with Mixed Anxiety and Depressed Mood, apparently provoked by a humiliating incident at work

Axis II: 301.9 Personality Disorder Not Otherwise Specified, associated with borderline and histrionic features

Axis III: General medical condition – hypertension

[3] The DSM-V was published on May 18, 2013, superceding the DSM-IV-TR. However, the DSM-IV-TR was in effect at the time of respondent's IME by Dr. Callahan. The parties stipulated that the DSM-IV-TR applied to the facts in this case.

Axis IV: Psychosocial and Environmental Problems – Occupational Problems

Axis V: Global Assessment of Functioning (GAF Scale), Current: 60

17. Dr. Callahan concluded that respondent is not substantially incapacitated from the performance of his usual duties. He noted that there is a marked exaggeration by respondent of his complaints.

REVISED IME REPORT OF MARCH 5, 2013/EXAMINATION BY ERROL LEIFER, PH.D.

18. Dr. Callahan issued a Revised IME Report on March 5, 2013, after Errol Leifer, Ph.D., a Fresno neuropsychologist, performed a psychological assessment on respondent per Dr. Callahan's referral. Dr. Callahan testified that he "got Dr. Leifer involved because respondent was concerned about the gravity of the outcome" of Dr. Callahan's conclusions. To eliminate any potential bias, Dr. Callahan referred respondent to Dr. Leifer, who administered the "MMPI", or Minnesota Multiphasic Personality Inventory, which is a test consisting of 500 or more questions to "find out what makes a person tick." The test assesses personality traits and psychopathology. Dr. Callahan's Revised IME Report included Dr. Leifer's entire psychological assessment.

19. During his evaluation, Dr. Leifer observed that respondent presented casually and "somewhat disheveled in his attire." Throughout the interview and assessment, respondent demonstrated notable physical manifestations of anxiety and nervousness, such as shaking of the hands, legs and voice. Respondent was oriented to person, place and time, and he expressed awareness of the purpose of the evaluation, and that Dr. Callahan would be receiving a copy of Dr. Leifer's report.

20. Respondent told Dr. Leifer that he had a long history of psychological and psychiatric treatment, to address many years of alcoholism, depression, generalized anxiety, PTSD, unstable blood pressure, dehydration, transitory ischemic attacks for 14 to 15 years, and impaired motor control of his legs. He also reported numerous hospitalizations in the past 12 years. Respondent stated that he had no military service experience, and that subsequent to his divorce, he raised his children as a single parent.

21. Dr. Leifer noted that respondent's mood was pleasant and he was fully cooperative during the evaluation. He noted no overt manifestations of negativity, resistance, or oppositionalism. There were no indications of physical or emotional impairment that would preclude meaningful engagement of the test materials. Respondent frequently asked questions about the test materials for clarification. The pattern of his responses clearly documented that respondent understood the individual test items, and that he was attentive in his reading and consideration of his responses. For example, Dr. Leifer noted, respondent consistently and accurately matched the item numbers in the test booklet to the corresponding numbers on the answer sheet.

22. In assessing respondent's test results, Dr. Leifer wrote:

> Mr. White had an excessive elevation on two scales noted for the rarity of the affirmation of their items and on a scale sensitive to motivation to emphasize the most bleak negative and exaggerated symptomatic picture of experience and functional disruption. This pattern revealed a notably consistent effort by Mr. White to exaggerate his disturbance. In point of fact, the level of disturbance indicated by his response pattern is not manifested by hospitalized psychotic patients.
>
> Mr. White made markedly excessive atypical and rarely given responses to the test material. A number of empirical possibilities could account for this pattern including deliberate malingering, severe disorganizing psychopathology, acute panic, and extreme plea for assistance or a strong psychological orientation to over emphasize [*sic*] a subjective sense of disability in the context of objective greater competence and functional integrity ... **The most likely general understanding of his response pattern is a clear conscious intention to exaggerate and to look impaired.** (Bold added.)

23. Dr. Callahan considered Dr. Leifer's findings as a "double-check" of his own. He agreed that respondent exaggerated his symptoms, and "had a mission for himself to persuade [Dr. Callahan] that he was [more] distressed than he actually was." Dr. Callahan did not believe that respondent gave a clear representation of his work situation.

SUPPLEMENTAL IME REPORTS BY DR. CALLAHAN

24. Dr. Callahan issued four additional supplemental IME Reports dated May 27, 2013, June 26, 2013, July 24, 2013 and February 20, 2015, after reviewing additional medical records provided to him by CalPERS.

May 27, 2013 Supplemental IME Report

25. In his May 27, 2013 supplemental report, Dr. Callahan noted that he was provided with progress note from Dr. Richard Berquist dated May 4, 2011, related to respondent's hospital visit involving a possible transient ischemic attack versus a stroke. Respondent was advised to cease smoking, and was given medications for hypertension, asthma, anxiety and PTSD. Dr. Callahan also received a series of progress notes by Dr. Sherry Walling of the House Psychiatric Clinic regarding two individual treatment therapy sessions. The notes indicated that respondent was anxious and upset after meeting with an assessment psychiatrist, felt disrespected and mistreated, and that respondent "fought off urges to strike him during the appointment."

26. Dr. Walling also wrote a letter dated April 9, 2013, in support of respondent's disability claim, indicating that she was treating respondent for symptoms of PTSD and depression. She described respondent as highly distractible with difficulty concentrating, having an unstable sleep pattern with frequent nightmares, marked irritability and occasional aggression, difficulty in regulating emotion and managing anger. Respondent's treatment focused on keeping a functional daily life. Dr. Walling did not opine on the cause or diagnosis of respondent's PTSD in her letter.

27. Based upon his review of the additional documents, Dr. Callahan did not alter his diagnoses or responses to the questions posed in his original IME Report of March 5, 2013.

June 26, 2013 Supplemental IME Report

28. In his June 26, 2013 supplemental report, Dr. Callahan reviewed a June 23, 2013 psychiatric report by Dr. Matthew House, and progress notes related to respondent's psychiatric treatment. Dr. Callahan also reviewed notes related to respondent's pulmonary treatment, and a hospital visit to Barton Memorial Hospital on April 9, 2013, related to pain in respondent's head after receiving "some upsetting news regarding his retirement."

29. Dr. Callahan noted that Dr. House's June 23, 2013 report noted respondent's diagnosis of ADD and PTSD. Dr. House wrote, "With continued treatment and treatment compliance, [respondent's] prognosis is guarded." With regard to respondent's symptoms, "His ability to engage in the mental activities necessary in a work environment is significantly impaired." Dr. House's report did not provide any specific details of how he arrived at the diagnoses of ADD and PTSD.

30. Upon careful consideration of the additional documents, Dr. Callahan did not alter his diagnoses or responses to the questions posed in his original IME Report of March 5, 2013.

July 24, 2013 and February 20, 2015 Supplemental IME Reports

31. Dr. Callahan's review of additional medical documentation related to respondent's ongoing psychiatric treatment by Dr. Richard Berquist, and medication monitoring by Dr. William Siegfried, did not alter his diagnoses or responses to the questions posed in his original IME Report of March 5, 2013.

Respondent's Expert Sherry M. Walling, Ph.D.

32. Sherry M. Walling, Ph.D., is a licensed psychologist, and has been the Director of Clinical Training as a Staff Psychologist at the House Psychiatric Clinic in Fresno, California, since 2011. Dr. Walling is currently an Assistant Clinical Professor at the Department of Psychiatry at the University of California, San Francisco, Fresno campus, and serves as adjunct faculty at the California School of Professional Psychology, Fresno, and at

Fresno Pacific University in the Department of Marriage Family Child Counseling. Dr. Walling has an extensive clinical history dating back to September 2003 to present. Most notably, from July 2006 to June 2007, Dr. Walling provided individual and group therapy for veterans suffering from PTSD, depression, anxiety disorders, relational problems, and AXIS II disorders at the Veterans Affairs (VA) Ambulatory Care Center in Los Angeles. From July 2008 to July 2009, as a postdoctoral fellow, Dr. Walling provided individual therapy to female veterans suffering from PTSD, depression, eating disorders and Axis II symptomology at the National Center for PTSD at the National Center for PTSD, VA Boston Healthcare System. Dr. Walling has authored several peer-reviewed publications and has made several peer-reviewed conference presentations related to PTSD.

33. Dr. Walling also testified credibly at hearing. She explained the six criteria for PTSD from the DSM-IV-TR:

a. The person experienced, witnessed, or was confronted with an event or events that involved actual threatened death or serious injury, or a threat to the physical integrity of self or others.

b. The traumatic event is persistently re-experienced in one (or more) of the following ways:

1) Recurrent and intrusive distressing recollections of the event.

2) Recurrent distressing dreams of the event.

3) Acting or feeling as if the traumatic event were recurring.

4) Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

5) Physiological reactivity on exposure to internal or external cures that symbolize or resemble an aspect of the traumatic event.

c. Persistent avoidance of stimuli associated with trauma and numbing of general responsiveness as indicated by three or more of the following:

1) Efforts to avoid thoughts, feelings, or conversations associated with the trauma.

2) Efforts to avoid activities, places, or people that arouse recollections of the trauma.

3) Inability to recall an important aspect of the trauma.

4) Markedly diminished interest or participation in significant activities.

5) Feeling of detachment or estrangement from others.

6) Restricted range of affect.

7) Sense of foreshortened future.

d. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

1) Difficulty falling or staying asleep.

2) Irritability or outbursts of anger.

3) Difficulty concentrating.

4) Hypervigilance.

5) Exaggerated startle response.

e. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than one month.

f. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

34. Dr. Callahan questioned respondent's PTSD diagnosis because Criterion A (Finding 33a) was lacking. He did not believe that respondent "experienced, witnessed, or was confronted with an event or events that involved actual threatened death or serious injury, or a threat to the physical integrity of self or others." Dr. Walling testified that there is some evidence in the research literature that an individual can experience PTSD without satisfying Criterion A. Dr. Walling cited an article from the *European Journal of Work and Organizational Psychology*, 2002, Vol. 11(1), pp. 87 to 111, entitled, "Basic assumptions and symptoms of post-traumatic stress among victims of bullying at work," which states, in part:

> Based on self-report measures, 76% of the victims portrayed symptoms indicating post-traumatic stress disorder. However, although 29% were found to meet all DSM-IV-TR criteria for PTSD, another 47% only failed to fulfil [*sic*] the A1 criterion, i.e., they did not report serious injuries or threats to their physical integrity while being bullied.

35. Dr. Walling opined that an individual can exhibit PTSD symptoms without meeting Criterion A, and that there is some divergence among providers about diagnosing PTSD without meeting Criterion A. However, Dr. Walling ultimately conceded in her testimony that "you cannot make the [PTSD] diagnosis without full Criterion A."

36. Dr. Walling testified that respondent reported that he was threatened persistently, and that he was going to be removed from his job. Respondent reported that his employer did not allow him to visit his daughter when she experienced significant trauma, and that he had been humiliated at work in front of others. Respondent reported that his experiences at work caused him fear. Dr. Walling conceded that these conditions as reported by respondent "probably do not meet [the criteria] for PTSD."

37. Dr. Walling then addressed respondent's elevated scores from the MMPI test, which was administered by Dr. Leifer. (Finding 22.) Dr. Walling opined that an elevated score indicates pathology, and is not a reliable predictor of malingering. In support, Dr. Walling relied on an article entitled, "PTSD Disability Assessment," in the journal *PTSD Research Quarterly*, (2011) Volume 22/No. 4, published by the National Center for PTSD, VA Medical Center, Department of Veterans Affairs. The article addresses concerns about symptom exaggeration and malingering in individuals with military-related PTSD. Early studies used the MMPI to classify veterans into "exaggerators" and "non-exaggerators." The exaggerators exhibited more psychiatric comorbidity and scored higher on other indices of psychopathology. A follow-up study in 1999 found that higher scores were an indicator of exaggerated response, and were also associated with increased (actual) symptomology. In a 2002 study, compensation-seeking veterans with elevated MMPI scores were not purposely exaggerating their symptoms, or attempting to deceive assessors, but rather were experiencing extreme distress. A 2008 study revealed that 53 percent of treatment-seeking veterans exaggerated symptoms or malingered on psychological tests. The authors noted that self-identifying malingerers are extremely rare. They also concluded that more research is needed.

38. Dr. Walling opined that Dr. Callahan should have considered Dr. Siegfried's medical monitoring notes which showed respondent's PTSD symptoms, Dr. House's psychiatric notes indicating that respondent reported abuse at work, the notes of Brook Denni, Marriage and Family Therapist, House Psychiatric Clinic, indicating that respondent reported that "[H]e thought he saw boss. Engaged in fight, flight and froze. Had nightmares next few days."

39. Dr. Walling believes that based upon respondent's medical records, and her own observations of respondent, he meets Criterion A for PTSD. She testified that respondent has consistently, over time, described his workplace to his medical providers as "threatening." Dr. Walling contended that there were numerous instances of respondent's supervisor threatening and humiliating respondent. There was an implicit threat to respondent's well-being. She opined that respondent's supervisor would or could cause very significant harm to respondent if he did not carry out his supervisor's requests. Dr. Walling stated, "In some way this is a judgment call." She concluded that respondent's PTSD was an appropriate diagnosis. Dr. Walling also testified that respondent had been diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) since childhood, and this is noted in his medical records.

Discussion

40. Dr. Callahan persuasively concluded that respondent is not permanently disabled or substantially incapacitated from performing the usual duties of a Chief of Racing for the Department. Respondent did not testify at hearing, but it should be noted that respondent was clearly anxious and agitated. He agreed to leave mid-hearing, in order to allow the parties to present their evidence without disruption. His behavior at hearing supported Dr. Callahan's observation of respondent as "emotionally labile and manipulative." Nonetheless, this case was decided largely upon the expert testimony of two credible medical practitioners. Dr. Callahan's IME determined that respondent exaggerated his complaints, and failed to meet DSM-IV-TR Criterion A for PTSD. As noted previously, respondent's humiliation at work, regardless of how distressful, did not meet Criterion A.

41. Dr. Walling is an expert on PTSD. Despite relying upon compelling evidence to show that a PTSD diagnosis need not satisfy Criterion A, she ultimately conceded that a medical practitioner "cannot make the PTSD diagnosis without full Criterion A."

42. With respect to respondent's elevated scores on the MMPI, which, according to Dr. Callahan, evidenced a clear conscious intention to exaggerate and to look impaired, Dr. Walling opined that an elevated score indicates pathology, and is not a reliable predictor of malingering. Her opinion in this regard was less persuasive, in that she relied upon a published article which addressed symptom exaggeration and malingering in individuals with military-related PTSD, rather than "bully-related" PTSD. The experiences of our brave military personnel in wartime situations is far different than the experiences related by respondent in his workplace. Moreover the elevated MMPI scores showed exaggerated symptoms in all of the studies cited.

43. The above matters having been considered, respondent has not established through competent medical evidence that, at the time of application, he was permanently disabled or incapacitated from performing the usual duties of his position as a Chief of Racing for the Department.

LEGAL CONCLUSIONS

1. Respondent has the burden of proof to establish by a preponderance of evidence that he is "incapacitated for the performance of duty,"[4] which courts have interpreted to mean "the substantial inability of the applicant to perform his usual duties." (*Mansperger v. Public Employees' Retirement System* (1970) 6 Cal.App.3d 873, 877.) Discomfort, which may make it difficult to perform one's duties, is insufficient to establish permanent incapacity from performance of one's position. (*Smith v. City of Napa* (2004) 120 Cal.App.4th 194, 207, citing *Hosford v. Board of Administration* (1978) 77 Cal.App.3d 854, 862.) Furthermore, an increased risk of further injury is insufficient to constitute a present disability, and prophylactic restrictions on work duties cannot form the basis of a disability retirement. (*Hosford, supra*, 77 Cal.App.3d at p. 863.)

2. Pursuant to Government Code section 21150, members incapacitated for the performance of duty shall be retired for disability. Government Code section 20026 provides that "'Disability' and 'incapacity for performance of duty' as a basis of retirement, means disability of permanent or extended and uncertain duration, as determined by the board... on the basis of competent medical opinion." In *Mansperger, supra,* 6 Cal.App.3d at p. 873, the court construed the term "incapacitated for the performance of duties" to mean a substantial inability to perform the employee's usual duties. (*Id.* at p. 876.) As the court explained in *Hosford*, prophylactic restrictions imposed to prevent the risk of future injury or harm are not sufficient to support a finding of disability; a disability must be currently existing and not prospective in nature. (*Hosford, supra*, 77 Cal.App.3d at p. 863.) An applicant for disability retirement must submit competent, objective medical evidence to establish that, at the time of application, he or she was permanently disabled or incapacitated from performing the usual duties of his or her position. (*Harmon v. Board of Retirement* (1976) 62 Cal.App.3d 689, 697 [finding that a deputy sheriff was not permanently incapacitated from the performance of his duties, because "aside from a demonstrable mild degenerative change of the lower lumbar spine at the L-5 level, the diagnosis and prognosis for the [the sheriff's] condition are dependent on his subjective symptoms"].)

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

3. *Mansperger*, *Hosford* and *Harmon* are controlling in this case. The burden was on respondent to present competent medical evidence to show that, as of the date he applied for disability retirement, he was substantially unable to perform the usual duties of an Chief of Racing on the basis of a psychological (stress, anxiety, depression) condition. Respondent did not present any evidence to meet this burden.

4. In sum, respondent failed to show that when he applied for disability retirement, he was permanently and substantially incapacitated from performing the usual and customary duties of a Chief of Racing for the Department. His application for disability retirement must, therefore, be denied.

ORDER

The application for disability retirement filed by respondent Daniel M. White is DENIED.

DATED: March 21, 2016

DocuSigned by:
Danette C. Brown
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DANETTE C. BROWN
Administrative Law Judge
Office of Administrative Hearings