ATTACHMENT E

THE PROPOSED DECISION

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

In the Matter of the Application for Industrial Disability Retirement of: HARRY R. SAGALA, Respondent, and CALIFORNIA DEPARTMENT OF STATE HOSPITALS – PATTON, Respondent.	Case No. 2014-0399 OAH No. 2015060988

PROPOSED DECISION

Administrative Law Judge Vallera J. Johnson, State of California, Office of Administrative Hearings, heard this matter in San Diego, California, on June 13, and September 13, 2016.

Danny T. Polhamus, Esq., Cantrell • Green, a professional corporation, represented Harry Sagala.

There was no appearance by or on behalf of California Department of State Hospitals – Patton.

John Shipley, Senior Staff Attorney, California Public Employees' Retirement System, represented Anthony Suine, Chief, Benefit Services Division, Board of Administration, California Public Employees' Retirement System (CalPERS).

The matter was submitted on October 28, 2016.[1]

[1] The hearing in this matter occurred on June 13, 2016, and September 13, 2016. The record remained open for receipt of written closing argument. On October 6, 2016, respondent filed his Post-Hearing Brief, and it was marked Exhibit D-1. On October 21,

FACTUAL FINDINGS

Jurisdiction

1. Anthony Suine filed Statement of Issues, Case No. 2014-0399, in his official capacity as Chief, Benefit Services Division, Board of Administration, California Public Employees' Retirement System (CalPERS), and not otherwise.

2. Respondent California Department of State Hospitals – Patton (respondent Patton) employed Harry R. Sagala (respondent Sagala) as a registered nurse. Because of his employment, respondent Sagala was a state safety member of CalPERS subject to Government Code section 21151.

3. On December 22, 2011, respondent Sagala signed an application for industrial disability retirement. In filing the application, disability was claimed based on an orthopedic (neck, back, arms, and shoulders) condition.

4. CalPERS obtained medical reports concerning respondent Sagala's orthopedic (neck, back, arms, and shoulders) condition from competent medical professionals. After review of the reports, CalPERS determined that respondent Sagala was not permanently disabled or incapacitated from performance of his duties as a registered nurse at the time that he filed his application for industrial disability retirement.

5. By letter, dated December 31, 2013, CalPERS notified respondent Sagala of the determination and advised of his appeal rights.

By letter, dated January 8, 2014, respondent Sagala filed a timely appeal and requested a hearing in this matter.

Respondent Patton did not file a request for hearing.

6. This appeal is limited to the issue of whether, at the time of the application, based on an orthopedic (neck, back, arms, and shoulders) condition, respondent Sagala was permanently disabled or substantially incapacitated from performance of his usual duties as a registered nurse for respondent Patton.

2016, CalPERS filed its Closing Brief in Support of Determination, and it was marked Exhibit 16. On October 28, 2016, respondent filed his Reply to CalPERS Closing Brief, and it was marked Exhibit D -2.

On October 28, 2016, the record was closed, and the matter was submitted.

Duties and Physical Requirements of Registered Nurse – Assigned to Respondent Patton

7. At the time that he filed his application, respondent Sagala worked on a full-time basis at respondent Patton as a registered nurse – day case manager. He worked with two (sometimes three) other registered nurses and two security guards.

In this capacity, he assessed patients' physical and mental needs, administered medication, drew blood, administered injections, and drafted reports; in addition, he held individual and group counseling sessions with patients and supervised sports activities; finally, he was required to participate in Management of Assaultive Behavior training. When a patient became combative and/or assaultive, as a registered nurse, respondent was required to participate in takedowns, using Management of Assaultive Behavior Techniques.

8. At the time that he filed his application, all registered nurses were required to perform the following tasks.

- Run 100 yards in 20 seconds or less
- Travel one-quarter mile in two minutes and 20 seconds or less
- Climb two flights of stairs, each flight having 11 steps, each step being 6.75 inches high, in 5.5 seconds or less
- Sprint 150 feet over a course that required the vaulting and dodging of obstacles (such as those found in dining halls, recreation areas, or therapy rooms) in 20 seconds or less
- Push a crash cart (or medicine cart), weighing 250 pounds, 300 feet in 55 seconds or less
- With the assistance of one other person, lift a 165-pound client from the floor to a gurney or treatment table which is 36 inches above the floor in 10 seconds or less
- With the assistance of three other people, lift a 165-pound client and carry the client 100 feet in 20 seconds or less
- Drag an unconscious 165-pound client 20 feet in 10 seconds or less
- Support a 165-pound client who had hung himself/herself for 10 seconds or more

9. In the CalPERS document (Physical Requirements of Position/Occupational Title), the physical requirements are described by how frequently a task is required to be

performed. "Constantly" is over six hours; "frequently" is three to six hours; "occasionally" is up to three hours.

In the position, as a registered nurse, respondent was required to: Sit, stand, run, walk, kneel, climb, squat, bend (neck), bend (waist), twist (neck), twist (waist), reach (above shoulder), reach (below shoulder), push and pull, fine manipulation, power grasp, simple grasp, use the keyboard, use the mouse, lift and carry 11 to 50 pounds and 100 plus pounds, walk on uneven ground, occasionally. In addition, he used his hands repetitively, lifted and carried 0 to 10 pounds, frequently.

History of Injury and Treatment

10. On November 9, 2008, respondent Sagala was assessing a patient. While taking vital signs, the patient punched respondent Sagala in the right jaw. The takedown team was contacted; the assailant was subdued and taken away. After the incident, respondent Sagala went home to rest and took Darvocet for the pain.

The next day, Roger Fox, M.D., evaluated respondent Sagala at the urgent care. He complained of pain in the neck extending into his upper back and trapezius. Also, he noted headaches and dizziness with episodes of vertigo. He was evaluated, x-rays and a magnetic resonance imaging (MRI) study was ordered. A course of physical therapy was prescribed. Respondent Sagala was taken off work for several months.

When the pain persisted, respondent Sagala was referred to orthopedics. The x-rays of his neck were normal, and he was released to return to work. Respondent Sagala worked modified duty for two weeks before returning to full duty in February or March 2009. In April 2009, Dr. Steinmann[2] evaluated respondent Sagala and released him from care in July 2009 with no restrictions.

Respondent Sagala had several falls at home which he attributed to persistent headaches and vertigo. He noted that he took Dilaudid twice a day for pain.

In December 2010, respondent had an episode of vertigo at work, fell and landed on the floor. He did not report the injury. He finished the shift that day and went home. His last day at work was December 2010, when he took a leave of absence.

The next day, respondent Sagala contacted his supervisor, who advised him to retain an attorney. He followed his supervisor's advice, retained an attorney and was referred to Jonathan Nissanoff, M.D., an orthopedic surgeon. He was seen by several physicians at the clinic. He was taken off work at that time. Physical therapy was prescribed. He underwent a cervical epidural steroid injection. Respondent Sagala obtained temporary/partial relief with this treatment.

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[2] No evidence was offered to establish Dr. Steinmann's first name.

A cervical MRI was obtained. It showed a bulging disc at the C5-6. Surgery was recommended, but respondent Sagala declined.

He underwent additional physical therapy, noting temporary/partial relief.

Respondent Sagala was referred to Fred F. Hafezi, M.D., an orthopedic surgeon. A repeat cervical MRI was obtained. The disc bulge was again noted and surgery recommended. Dr. Hafezi recommended surgery. Respondent Sagala declined.

Respondent Sagala was released from care in May 2011. He was made permanent and stationary with a restriction from lifting more than 20 pounds.

Respondent Sagala has not worked since December 2010.

Medical Evidence

11. The medical evidence in this case included testimony and reports of Keolanui G. Chun, M.D., and Edward G. Stokes, M.D., and various medical records, including medical studies, between November 10, 2009, and May 11, 2016.

Dr. Chun was retained by CalPERS to evaluate respondent Sagala as its independent medical examiner. Dr. Stokes, a qualified medical examiner, testified on respondent Sagala's behalf.

Doctors Chun and Stokes each took a history, performed a physical examination, reviewed medical records, reviewed and discussed the duties and physical requirements of registered nurse with respondent Patton and rendered opinions about whether respondent Sagala was substantially incapacitated for performance of his usual duties at the time he filed his application for disability retirement. The physicians did not review the same medical records. The hearing record included medical records not reviewed by either physician.

12. Dr. Stokes completed the CalPERS Physician Report (CalPERS report), dated January 31, 2013, and a Consulting Physician's Comprehensive Orthopedic Evaluation (orthopedic evaluation), dated December 17, 2015, a report prepared for respondent Sagala's workers' compensation case.

During the hearing, Dr. Stokes explained his opinions and the bases thereof.

He explained his statements, including abbreviations, included in his CalPERS report. Under Examination findings (section 3), Dr. Stokes stated: Worsening pain to the left jaw and cervical spine that radiates to the thoracic spine. Under Diagnosis (section 4), he stated: Cervical radiculopathy with positive MRI findings; neck range of motion – 35 on flexion, and 25 on extension; there is a 4-millimeter (mm) disc bulge at C5-6. In Dr. Stokes's opinion, respondent Sagala's subjective complaints were reasonably related/supported by the MRI; the 4-mm disc bulge found on the MRI was sufficient to cause radiculopathy and

symptomatology in the upper extremities in respondent Sagala; given the size of the disc bulge, i.e., 4-mm, in a man of respondent Sagala's height – five feet, six inches, the disc bulge almost definitely touches the cervical routes in his neck.

Under Member Incapacity (section 5) of the CalPERS report, Dr. Stokes stated that respondent Sagala was substantially incapacitated from performance of the usual duties of the position for this employer. When asked to describe specific job duties/work activities that respondent Sagala was unable to perform due to incapacity (considering the job duty statement and Physical Requirements of the Position/Occupational title), Dr. Stokes stated: "No lifting, pushing, pulling and/or carrying more than 15-20 pounds, no prolonged sitting, standing and/or walking."

In rendering his opinion, Dr. Stokes reviewed and relied on MRI reports, dated October 12, 2010, March 24, 2011, November 30, 2011, November 30, 2013. Based on the foregoing, in Dr. Stokes's opinion, respondent Sagala had multi-level disc bulges. As such, any significant activity rendered him susceptible to devastating injury, such as paralysis.

In his orthopedic evaluation, dated December 17, 2015, Dr. Stokes stated that respondent Sagala was not capable of working as a registered nurse or in any form of employment, given his symptomatology. During the hearing, Dr. Stokes testified that respondent Sagala was not capable of performing his duties as a registered nurse at Patton because of the potential for serious injury should he be assaulted again.

13. Dr. Chun performed his assessment of respondent Sagala on November 18, 2013. He took a history, performed the physical examination and then reviewed the medical records, including diagnostic studies, to determine if these records correlated with his clinical evaluation. Then, he answered the questions submitted by CalPERS.

His physical examination included evaluating respondent Sagala's cervical spine, lumbar spine, and upper extremities.

On the date of his examination, respondent Sagala's chief complaint was constant pain in the back of his neck that radiated to the trapezius and extended from his head to the upper back and interscapular regions.

When he examined the cervical spine, Dr. Chun administered several tests, the Spurling Maneuver, the Hoffman test, and the Adson tests. A Spurling's Maneuver is a nerve root compression test. If there is any irritated nerve root, typically this maneuver will pinch it, and there will be pain radiating along the irritated nerve root's distribution. In this case, it was negative; Dr. Chun was unable to elicit pain from that maneuver, which meant there was no irritated nerve root. Also, he administered the Hoffman's test, looking for myelopathy, hyperreflexia. The result was negative. On the Adson maneuver, Dr. Chun was looking for thoracic outlet syndrome which can mimic cervical radiculopathy. The result was negative, which meant that respondent Sagala likely did not have thoracic outlet syndrome. Dr. Chun administered the Babinski reflexes test, looking for evidence of

myelopathy or an abnormal spinal cord signal. The results were negative. There was no evidence of clonus[3] or spasticity[4] in the upper or lower extremity.

When Dr. Chun examined the thoracic spine, he looked to see if respondent Sagala had any gross scoliosis or if he had normal contour to his back. He palpated the muscles to determine if there were any areas of spasm or if he could hear any pain, to see if it was reproducible; then he looked at range of motion to see if the patient had thoracic radiculopathy or myelopathy. In his report, regarding the thoracic spine examination, Dr. Chun stated:

> There is no evidence of scoliosis or kyphosis. The paraspinous musculature do not show swelling or asymmetry. There are no surgical scars or other skin lesion. There is no evidence of muscle spasm.
>
> The patient has vague nonspecific inconsistent tenderness to palpation of the upper back. There is no evidence of radiculopathy or myelopathy.

Dr. Chun examined respondent Sagala's upper extremities, including his upper extremity strength on both arms. In doing so, he examined the various muscle groups on each arm to see if there was any weakness. Based on the results, Dr. Chun determined that respondent Sagala had normal muscular strength on both arms. Respondent Sagala administered the Jamar dynamometer test. This test helps demonstrate if there is good compliance. Certain instructions are given to the patient, and the test administrator tries to get as true a number as possible. Three efforts are given; they should be within 10 percent of each other to demonstrate a reasonable effort. In this case, based on his results, respondent Sagala's efforts were not within 10 percent of each other. Dr. Chun reported: "The patient exhibited minimal effort in performance of the Jamar dynamometer grip test."

To be complete, Dr. Chun evaluated respondent Sagala's shoulders and arms, his elbows, forearms, wrists, and hands, to rule out anything that could be possibly causing a problem or anything that could explain a problem.

After taking a history, performing the physical examination and reviewing medical records, Dr. Chun stated his impressions as follows:

1. C5-6, C6-7 Cervical Spondylosis

2. Symptom Magnification

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[3] Clonus is also a sign of myelopathy.

[4] Spasticity is also a sign of myelopathy or an upper motor neuron disease. If there is no evidence of spasticity, the likelihood of upper motor neuron disease goes down.

3. Normal Examination of the Thoracic Spine, Shoulders and Arm [sic]

Regarding his first impression, Dr. Chun explained that respondent Sagala had spondylosis (some arthritis in his neck at two levels) at the C5-6 and C6-7, something that he sees in most people who are respondent Sagala's age. Regarding his impression of symptom magnification, he explained that, on physical examination, he tested and retested, looking for consistency; things that hurt on one pass through should continue to hurt in the same fashion when tested with another maneuver. Dr. Chun did not find consistency. Therefore, Dr. Chun found that respondent Sagala was magnifying his complaints of pain. Regarding his third impression, Dr. Chun found no evidence, signs, or symptoms of orthopedic pathology to respondent Sagala's thoracic spine, shoulders, and arms.

14. After his evaluation, Dr. Chun opined that there are no job duties that respondent Sagala could not perform because of his physical condition and that he was not substantially incapacitated from the performance of those duties.

15. In rendering his opinion, Dr. Stokes testified that Dr. Chun's opinions were unreliable because Dr. Chun disregarded certain conditions/problems suffered by respondent Sagala. In Dr. Stokes's opinion, according to the October 12, 2010, MRI, respondent Sagala had a multi-level disc protrusion with annular tear. Because of the annular tear, the disc was weakened and more susceptible to injury; the disc pushes through the tear and subsequently compresses nerve roots. In addition, this MRI showed stenosis. Dr. Chun failed to include/consider the foregoing information in his report. Dr. Stokes testified, with these problems, he did not see how respondent Sagala could work in a combative environment.

16. During his testimony, Dr. Chun responded to Dr. Stokes's criticisms.

In his report, Dr. Chun reviewed four MRI studies, dated May 10, 2010, October 12, 2010, March 24, 2011, and November 30, 2011. During the hearing, he reviewed the MRI study performed on November 27, 2013, and distinguished the MRIs. He explained that the most recent is the most reliable MRI when assessing a patient's condition because things change. The discs in the neck are designed to be like shock absorbers so they will bulge; herniated discs can go away given time. In addition, different MRIs are performed in different ways and interpreted by different radiologists; different people can read and get a measurement that is a different measurement. In this case, it was odd to see that respondent Sagala had an MRI performed showing minimal degenerative things (May 2010) and then, a few months later (October 12, 2010), a 4-mm bulge and then a third MRI (March 24, 2011) that goes back. That is not consistent with the history that was obtained. There was no history of horrible neck pain and radicular symptoms that resolved back to normal level. Dr. Chun questioned the accuracy of the 4-mm bulge. A 2-mm or so bulge is within normal limits.

Also, prior to his testimony, Dr. Chun had not reviewed the November 2014 MRI report, which reflected stenosis at C3-4, C5-6, C6-7, and C7-T1, an age appropriate finding.

On cross-examination, he reviewed this MRI and was questioned about whether, after reviewing this MRI, he would have changed his diagnosis to include and/or discuss stenosis. Dr. Chun explained that stenosis is a way to reflect that the canal is smaller than normal; there are grades of stenosis – not as large as normal, a little smaller or severe. He explained that he would use the study to correlate with his clinical evaluation; since it did not correlate with his findings on physical examination, he would not have included a diagnosis of stenosis; the clinical diagnosis relies upon the correlation of imaging studies with clinical evaluation. Dr. Chun stated repeatedly that physicians treat patients, not film. Given that his physical examination does not correlate with a diagnosis of stenosis, his opinion did not change.

Dr. Chun was asked to explain the reason that he did include "annular tear" in his report. When asked to explain "annular tear", he said: "we [the spine community] don't know." Further, he explained that, on imagining studies, on the lumbar spine, we see a white dot, a bright water based signal is visualized in the back of the disc, but we do not know how to explain this; so, what has been posited is that this represented inflammation, and the only way one gets inflammation in the back of the disc is possibly from some type of injury like an annular tear in the lumbar spine; on multiple studies, we are unable to correlate the high intensity zone finding with any clinical findings; we have seen it in people who we thought had an annular tear but also have seen it in people who were completely asymptomatic; we have taken that diagnosis (finding and rationale) into the cervical spine where we see this high intensity zone signal finding in the back of the disc, and we are applying the same kind of rationale but we are not sure what it all means; this is a controversial subject as to what this represents. Considering the foregoing, Dr. Chun did not mention the annular tear in his report because, in his opinion, it was not a relevant finding. In addition, it is highly controversial as to what it is, what it means and how to treat it.

Evaluating Testimony of Expert Witnesses

17. The testimony and reports of the expert witnesses were contradictory. Therefore, the evidence was evaluated to ascertain which expert was more reliable.

The record included evidence of Dr. Chun's education, training, and experience. In addition to completing medical school, he completed a surgical residency, an orthopedic surgical residency, and a spine fellowship. He is licensed to practice medicine in California, Hawaii, and Texas. He is board certified in orthopedic surgery and regularly performs spine surgery. Although he provides forensic evaluations, 90 percent of his work is practicing as an orthopedic surgeon, performing spine surgery. On the other hand, minimal evidence was offered regarding Dr. Stokes's qualifications. He is not board certified. His letterhead states "orthopedic surgery"; presumably he is an orthopedic surgeon and is licensed to practice medicine in California.

Dr. Chun's opinions were based on his clinical evaluation. He established that respondent's subjective complaints were not supported by his physical examination of respondent Sagala. Dr. Chun explained the reasons that the MRI studies did not support

respondent's subjective complaints and provided reasonable explanations for differences in his and Dr. Stokes's reports. Dr. Stokes testified that he evaluated respondent Sagala on two separate occasions. Clearly, he did so prior to issuance of his report, dated December 17, 2015. No evidence was offered to establish the date of the second assessment. No report of a clinical assessment was attached to the CalPERS Physician Report, dated January 31, 2013; as such, the trier of fact was unable to evaluate the reliability of statements made in the CalPERS Physician Report, dated January 31, 2013.

In rendering his opinions, Dr. Chun understood and relied on the CalPERS criteria for disability retirement. Based on Dr. Stokes's testimony, it appears that Dr. Stokes did not understand or apply the CalPERS criteria for disability retirement.

Based on the foregoing, it is determined that Dr. Chun's opinions were more trustworthy and reliable.

LEGAL CONCLUSIONS

Relevant Statutes

1. On the date that he filed his application for industrial disability retirement, respondent Sagala was a safety member of CalPERS, seeking disability retirement pursuant to Government Code[5] section 21151.

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.

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 be retired for disability, pursuant to this chapter, regardless of age or amount of service.
> Section 21152 states, in part:

[5]Hereinafter all reference is to the Government Code unless otherwise stated.

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

(a) The head of the office or department in which the member is or was last employed, if the member is a state member other than a university member.

[¶] . . . [¶]

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

Section 21156 states in part:

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

Section 21166 states in part:

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

Burden of Proof

2. Respondent Sagala has the burden of proving entitlement to disability retirement. This rule is derived from two well-accepted legal principles.

First, although no court construing CalPERS law has yet to decide the issue, courts applying the County Employees' Retirement Law have held the applicant has the burden of proof. (*Harmon v. Board of Retirement of San Mateo County* (1976) 62 Cal.App.3d 689, 691; *Rau v. Sacramento County Retirement Board* (1966) 247 Cal.App.2d 234, 238.) It is well accepted that 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.) Since Government Code section 31724 (County Employees' Retirement Law) is similar to Government Code section 21151 (California Public Employees' Retirement Law), the rule concerning the burden of proof should be applied to cases under CalPERS law.

Second, Evidence Code section 664 creates the general presumption that a public agency or office has performed its official duty. CalPERS has fulfilled its duty to determine respondent Sagala's eligibility for disability retirement, and the burden falls on respondent Sagala to rebut this presumption by proving incapacitating disability.

Case Law

3. 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. (*Id.*, 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 substantial impairment that prevents him from performing those duties.

4. Substantial inability to perform one's usual duties must be measured by considering the applicant's present abilities; disability cannot be prospective or speculative. (*Hosford v. Board of Administration of the Public Employees' Retirement System* (1978) 77 Cal.App.3d 854, 863.) The fact that an activity might bother a person does not mean, in fact, he cannot do that activity. In *Hosford*, the Court of Appeal reasoned that the fact that Hosford testified to having to perform several of the duties described as only "occasional" and did those tasks without reporting any injury represented further evidence of Hosford's ability to perform the more strenuous aspects of his work. *(Ibid.)*

5. Neither risk of injury nor risk of aggravation of an injury is a 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 lifting 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.)

As evidenced by *Mansperger* and *Hosford*, and numerous subsequent cases that followed, mere difficulty in performing certain tasks is not enough to support a finding of disability. (See, e.g., *Harmon v. Board of Retirement of San Mateo County* (1976) 62

Cal.App.3d 689; *Cransdale v. Board of Administration* (1976) 59 Cal.App.3d 656; *Bowman v. Board of Administration* (1984) 155 Cal.App.3d 937.) A person must be substantially incapacitated from performing his duties.

Evaluation

6. Respondent Sagala filed an application for industrial disability retirement. Considering the testimony of the expert witnesses, Dr. Chun was found to be more reliable. Having considered the actual and usual duties of a registered nurse at respondent Patton, the position held by respondent Sagala on the date he filed his application, the duties and physical requirements of the position, and his clinical assessment, Dr. Chun concluded that respondent was able to perform the usual and customary duties of a registered nurse at respondent Patton. Therefore, insufficient competent medical evidence was offered to establish that his orthopedic (neck, back, arms and shoulders) condition prevented respondent Sagala from performing the usual duties of a registered nurse employed by respondent Patton.

7. Respondent Sagala was not substantially incapacitated from performing his duties usual and customary duties as a registered nurse employed by respondent Patton based on orthopedic (neck, back, arms and shoulders) condition.

ORDER

1. The decision of Anthony Suine, Chief, Benefit Services Division, California Public Employees' Retirement System, denying the application for industrial disability retirement of Harry R. Sagala, is affirmed.

2. The application for disability retirement of Harry R. Sagala is denied.

DATED: January 9, 2017

DocuSigned by:
Vallera J. Johnson
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VALLERA J. JOHNSON
Administrative Law Judge
Office of Administrative Hearings