ATTACHMENT A

THE PROPOSED DECISION

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

In the Matter of the Application for Industrial Disability Retirement of:

KIM L. CARTER and CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION, CALIFORNIA STATE PRISON – CORCORAN, Respondents

Agency Case No. 2021-0104

OAH No. 2021060302

PROPOSED DECISION

Tiffany L. King, Administrative Law Judge, Office of Administrative Hearings (OAH), State of California, heard this matter by telephone and videoconference on October 6, 2021, from Sacramento, California.

Charles Glauberman, Staff Attorney, represented the California Public Employees' Retirement System (CalPERS).

Kim L. Carter (respondent) represented herself.

There was no appearance by or on behalf of respondent California Department of Corrections and Rehabilitation, California State Prison – Corcoran (CDCR). At the

hearing, CalPERS established that CDCR was properly served with the Statement of Issues and Notice of Hearing. This matter therefore proceeded as a default against CDCR pursuant to Government Code section 11520.

Oral and documentary evidence was received, the record closed, and the matter submitted for decision on October 6, 2021.

ISSUE

On the basis of her orthopedic (low back, left shoulder, right knee) conditions, was respondent substantially incapacitated from the performance of her duties as a Correctional Officer (CO) for CDCR at the time she filed her industrial disability retirement application?

FACTUAL FINDINGS

1. Respondent was employed as a CO by CDCR at California State Prison – Corcoran for 14 years. By virtue of her employment, she is a state safety member of CalPERS subject to Government Code section 21151. On April 15, 2020, respondent signed and filed an application for service pending industrial disability retirement (Application), claiming disability on the basis of her orthopedic (low back, left shoulder, right knee) conditions. She retired for service, effective April 1, 2020, and has been receiving her service retirement allowance from that date.

2. In her Application, respondent described her disability as "(Back) Degenerative circumferential disc bulge and facet hypertrophy at L3/4 L4/5 and L5/S1 levels of the lumbar spine. (Right knee) No formal diagnoses to date. (Left shoulder)

No formal diagnoses to date." Her injuries occurred on March 6, 2019, when "while attempting to restrain a combative inmate, a struggle ensued and in the course of the struggle [respondent] sustained several injuries." Her asserted restrictions included no running, jumping, pushing or pulling more than 20 pounds, repetitive bending or stooping, or prolonged sitting, walking or standing.

3. CalPERS obtained medical records from respondent's medical providers[1] and a report from Don T. Williams, M.D., who conducted an independent medical evaluation (IME) of respondent's orthopedic conditions. After reviewing the records and the IME report, CalPERS determined respondent was not substantially incapacitated from the performance of her job duties as a CO for CDCR.

4. By letter dated December 3, 2020, CalPERS notified respondent that her Application was denied and advised her of her appeal rights. Respondent timely appealed and requested a hearing. On June 6, 2021, Keith Riddle, Chief, Disability and Survivor Benefits Division, CalPERS made and thereafter filed the Statement of Issues in his official capacity. This hearing followed.

Duties of a CO

5. As set forth in respondent's duty statement, her primary duties as a CO included: supervise, direct and provide security to inmates in correctional institutions; direct inmates on work assignments and patrol assigned areas; employ weapons or force to maintain discipline and order among inmates; escort inmates to and from

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[1] Respondent's medical providers included Henry Aryan, M.D., David Broderick, M.D., Brandon Sorensen, M.D., and Raul Perez, M.D.

facilities, for medical appointments, religious services, legal proceedings, etc.; conduct routine and random searches of inmates and cells for contraband; and prepare written incident reports. Additionally, a CO must be able to: (1) stand in a confined space for long periods of time; (2) run up to 400 yards in an "all-out effort" while responding to an alarm or serious incident; (3) lift and/or physically restrain an inmate, including wrestling him to the floor; (4) drag between 80 to 400 pounds in "very cramped spaces," with the assistance of others; (5) bend or stoop to inspect cells or search inmates; and (6) reach in front of the body or overhead.

6. On April 13, 2020, respondent signed a "Physical Requirements of Position/Occupational Title" form (Physical Requirements form), which was submitted to CalPERS. According to the Physical Requirements form, a CO is expected to: (1) constantly (over six hours a day) sit, stand, walk, bend and twist at the neck, engage in pushing and pulling, fine manipulation, power and simple grasping, and repetitive use of the hands and keyboard, lift or carry up to 25 pounds, and be exposed to extreme temperature, humidity, or wetness; (2) frequently (three to six hours a day) climb up to 150 steps, reach below the shoulder, push and pull, lift or carry up to 50 pounds, work at heights, and be exposed to dust, gas, fumes, or chemicals; and, (3) occasionally (up to three hours a day) run up to 400 yards, crawl, kneel, reach above the shoulder, use a keyboard and mouse, lift and carry from 51 to over 100 pounds, operate foot controls or engage in repetitive movement, be exposed to excessive noise, use special visual or auditory protective equipment, and work with biological hazards.

Medical Evidence

DAVID M. BRODERICK, M.D. – QUALIFIED MEDICAL EVALUATION

7. On January 24, 2020, Dr. Broderick conducted a qualified medical evaluation (QME) of respondent in relation to her workers' compensation case. He took respondent's history, reviewed her medical records and job duties, and issued a QME report. In total, he spent over three hours reviewing respondent's medical records and more than 30 minutes in-person with respondent.

8. At the QME, respondent presented with "constant aching pain in her lower back," mostly over the iliac crest posteriorly. Her symptoms were worse on her right side than her left. She had occasional tingling in her legs and left shoulder pain with forward flexion. She also had "pain radiating from her lower back to the lateral aspect of her right knee." Finally, she previously had symptoms in her left foot.

9. During the physical examination, Dr. Broderick noted respondent walked with a normal gait and was able to get up from the exam table without assistance. Straight leg raise bilaterally caused no back or leg pain. The sciatic stretch test was negative. Extensor hallucis longus motor strength was normal and symmetrical. There were normal deep tendon reflexes in both lower extremities. Palpation of the right and left posterior iliac crests produced some pain, more on the right than the left. Sitting straight leg test was negative to 90 degrees bilaterally.

There was no evidence of knee effusion, and she had full flexion and extension of both knees. Lachman's, pivot shift, and McMurray's tests[2] were all negative. Respondent indicated she sometimes felt increased back pain and pain that radiates over the lateral aspect of the right knee. She was able to toe and heel walk, though she indicated toe walking was painful. There was no evidence of a limp. Examination of the upper extremities showed good deltoid muscle strength and full shoulder range of motion, bilaterally. Lumbar spine range of motion was normal.

10. Dr. Broderick noted the following diagnostic impressions: (1) resolved foot strain; (2) chronic lumbosacral strain; (3) normal clinical examination of left shoulder; and (4) normal clinical examination of right knee. He opined that she had reached maximum medical improvement and was permanent and stationary for workers' compensation purposes. Regarding respondent's subjective constant lower back pain and intermittent pain in her left shoulder and right knee, Dr. Broderick noted these symptoms were minimal and her objective clinical presentation was unremarkable. He further commented she had no ratable impairment.

11. Notwithstanding his finding of no impairment, Dr. Broderick acknowledged respondent's pain caused some limitation of her activities of daily living including bathing, dressing, sexual function, standing and sitting. It also limited her hand activities, sleep, travel, as well as housework, yard work, cooking, and recreational activities. He commented, "[s]he would have slight pain which would equate to 1% whole person impairment as per the AMA Guidelines 5th Edition, page 575, table 18-3." Ultimately, Dr. Broderick concluded that respondent "would not be able to perform

[2] The Lachman's and pivot shift tests evaluate the anterior cruciate ligament (ACL). The McMurray test checks for tears in the meniscus within the knee.

[the] duties of correctional officer” and that she would “be a candidate for vocational training. However, he then completed and signed a Physician’s Return-to-Work & Voucher Report, dated January 24, 2020, wherein he indicated respondent could return to regular work.

DON T. WILLIAMS, M.D. – INDEPENDENT MEDICAL EXAMINATION

12. Dr. Williams is board-certified in orthopedic surgery and has been in private practice in Monterey, California, since 1986. He specializes in treating patients with a variety of orthopedic problems involving the shoulders, elbows, knees, hands, and fingers. He has performed evaluations as a qualified/agreed medical evaluator certified by the Division of Workers’ Compensation, and has performed IMEs for CalPERS.

13. At CalPERS’s request, Dr. Williams conducted an IME of respondent on November 13, 2020. He took respondent’s history, reviewed her medical records and job duties, and issued an IME report. In total, he spent three hours evaluating respondent’s condition. At hearing, Dr. Williams testified regarding his observations and findings consistent with his report.

14. Respondent presented with “occasional lower back pain going down the right leg with numbness in her second and third toes in the right foot.” She experienced grinding in her back with certain movements, and occasional numbness in her left shoulder and left trapezial muscles. She also reported a “burning coolness” in her left shoulder and right foot at night, as well as a burning on the outside of her right knee. She had no locking or catching of the right knee, though it was painful at times to put weight on it. She was able to walk one to two miles, which helped to keep her back “warm and loose.” She reported not being able to run or do heavy lifting. She

could walk around the house, but had difficulty with household chores (such as vacuuming) and yard work (squatting). She was able to drive but experienced pain if she drove longer than one hour. All of these symptoms stemmed from respondent's March 6, 2019 workplace injury, which Dr. Williams summarized more particularly below:

> A resistive inmate became assaultive while being escorted. He stepped on [respondent's] foot while pulling away from her yanking and trying to kick her. While trying to restrain him, she was tussled around using full strength and weight. The inmate was thrashing and kicking. She had bruises everywhere in her body, she hurt her back in the process, her shoulder, her knee and foot.

Respondent was taken off work the following day and has not returned. She has tried a variety of treatments including physical therapy, chiropractic adjustments, steroid injections, and nerve tests. Shortly before the IME, she had a lumbar epidural steroid injection "which was very helpful." X-rays and a magnetic resonance imaging (MRI) of the lumbar spine also showed "some degenerative changes."

15. Dr. Williams next physically examined respondent. She stood 5 feet, 2 inches tall, and weighed 135 pounds. Dr. Williams described her as "thin" and "well-developed." She was able to rise from a chair without difficulty, signifying good control

of her lower extremities. She had a normal gait with no foot drop[3] nor evidence of a knee or hip problem.

Respondent's cervical spine had normal range of motion. Her upper extremities measured bilaterally as follows: (1) flexion, 170 degrees; (2) extension, 50 degrees bilaterally; (3) rotation, 80 degrees; (4) abduction, 170 degrees; and (5) adduction, 40 degrees. Elbow and wrist motion was normal. She can make a normal fist. Dr. Williams explained all of these are within functional range of motion, though slightly diminished due to normal age degeneration.

In examining her lumbar spine, Dr. Williams noted respondent could walk on her heels and tip toes. Forward flexion was 70 degrees and extension was 50 degrees. Lateral bending was 30 degrees on both sides. She had some paraspinal muscle tenderness in her lower back. Supine straight leg raise was positive at 80 degrees on the right, and negative at 90 degrees on the left. Sitting straight leg raise was 90 degrees bilaterally. Patellar tendon reflexes and Achilles reflexes were normal. Extensor hallucis longus was normal, indicating no nerve injury. Squatting was 50 percent while holding on.

Respondent's hip motion was normal. Her knee motion was good bilaterally. She had no tenderness along the joint lines, though she had some decreased sensation on the lateral right knee. Anterior drawer test (ACL) and McMurray testing were negative. Her right knee had good stability and any discomfort was "more of a sciatic type pain."

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[3] Foot drop occurs when one puts their whole foot down first, rather than heel then front foot, demonstrating a lack of control of ankle motion.

16. Dr. Williams summarized the relevant portions of respondent's medical records. Initially following the workplace incident, respondent treated with Henry Aryan, M.D., of Visalia Medical Clinic, for lower back pain and right-sided sciatica. Dr. Aryan diagnosed her with spondylosis and facet arthropathy and recommended conservative treatment. In October 2019, she underwent a nerve conduction study and electromyography (EMG) of her bilateral lower extremity, both of which were normal. Respondent continued to suffer from acute bilateral low back pain and right sciatic pain.

On January 24, 2020, Dr. Broderick conducted a qualified medical evaluation of respondent in relation to her workers' compensation case. He noted respondent had localized pain over both sides of the posterior iliac crest and right knee, which limited her activities of daily living. Notwithstanding these limitations, Dr. Broderick opined respondent had no ratable impairment and could return to her regular duties.

Respondent continued to receive treatment at Visalia Medical Clinic for chronic bilateral low back pain, right side sciatica, and pain in her left shoulder and right knee. She continued with physical therapy and remained off work.

On August 14, 2020, respondent was seen by Gopi Kasturi, M.D., for chronic low back pain. Dr. Kasturi noted the mild to moderate pathology identified in respondent's lower spine was "out of proportion to the severe pathology that [respondent was] experiencing." He determined that respondent's hip was likely the primary pain generator and recommended steroid injections and an MRI of the right hip.

On September 29, 2020, she presented to Sierra Pacific Orthopedics with lower back pain. Her assessment was: spondylolisthesis, lumbar region; myalgia;

intervertebral lumbar disc; and spondylosis, lumbar region. She received a steroid injection which provided pain relief in her hip and thigh.

17. In response to specific questions posited by CalPERS, Dr. Williams opined that respondent was able to perform her job duties without limitation and was not substantially incapacitated for such performance. He explained:

> [Respondent] does have lower back pain with occasional radiation into the right leg. MRI scan shows mild multilevel disc bulges. The exam showed mild positive straight leg raise. She does have a good response to the lumbar epidural steroid injection. These changes are mild degenerative changes that do not require restrictions. She is able to do her job duties. EMG/NCV[4] is normal.

Respondent's Evidence

18. Respondent did not introduce any medical expert testimony, but testified on her own behalf. She is 58 years old. She suffers persistent back pain, including the feeling of something "moving and grinding" when she turns the wrong way. She sometimes needs to use a walker to avoid putting any weight on her leg. Respondent has tried multiple treatments since the onset of her injury in March 2019, including chiropractic sessions and physical therapy, to no avail. The steroid injections are the only treatment that has provided any relief. They enable her to walk through the house without pain so long as she does not do anything too strenuous. She exercises regularly to stay in shape and follows her doctors' orders consistently. She has

[4] NCV stands for nerve conduction velocity test.

declined to take pain medications because they make her "feel really depressed and [not] want to do anything." She cannot take non-steroidal anti-inflammatory drugs because of her ulcerative colitis.

19. Respondent relied on Dr. Broderick's representation in his QME report that she is unable to perform the duties of a CO and would be a candidate for vocational training. She does not understand why Dr. Broderick also then signed the voucher saying she can return to work. She requested multiple times that Dr. Broderick, as well as her other medical providers, document what her limitations and workplace restrictions are. However, the doctors could not agree on whose responsibility it was to determine those matters.

20. Respondent elected to service retire based on Dr. Broderick's QME findings. According to respondent, CDCR will not allow her to return to her CO position unless she is "at 100 percent capacity;" limited or light duty is not an option. Respondent does not believe she can perform the duties of a CO, and will never be able to do so. She could not respond to an incident or alarm, restrain an inmate, or defend herself or another. She cannot run, climb stairs, lift food trays, or bend over to open and shut food ports. She can walk on flat surfaces only as uneven terrain causes her back to hurt. She cannot stand in a tower with a weapon, pass weapons qualification, or use a baton, all of which are required for COs. She believes she would be a target if inmates observed her limitations and deemed her to be weak. She is worried returning to her job will worsen her injuries more than they currently are.

Analysis

21. Respondent sought disability retirement on the bases of orthopedic (low back, left shoulder, right knee) conditions. No competent medical evidence was

presented at hearing to establish that respondent was substantially incapacitated to perform the usual duties of her position of CO due to any of these medical conditions at the time she filed her application.

22. That is not to say respondent does not suffer from pain or ailments which may make it more difficult for her to perform her job duties. But discomfort alone, even if it makes performance of one's duties more difficult, is insufficient to establish a substantial incapacity. (*Smith v. City of Napa* (2004) 120 Cal.App.4th 194, 207 (*Smith*); citing, *Hosford v. Bd. of Admin.* (1978) 77 Cal.App.3d 854, 862 (*Hosford*).) Similarly, an increased risk of further injury is insufficient to demonstrate a present disability. (*Hosford, supra*, 77 Cal.App.3d at p. 863.) Rather, the written reports by Drs. Williams and Broderick, as well as Dr. Williams's testimony were persuasive that respondent was not substantially incapacitated on the basis of an orthopedic condition.

23. Respondent was required to produce a competent medical opinion to establish her substantial incapacity. (Gov. Code, § 21156, subd. (a)(2).) She introduced no expert medical testimony at hearing. Her sole medical documentation was the QME report by Dr. Broderick, which concluded she could return to her duties as a CO, and does not address specifically the issue of substantial incapacity. Respondent's lay testimony concerning her disability was insufficient to establish her substantial incapacity. (*Peter Kiewitt Sons v. Industrial Accident Commission* (1965) 234 Cal.App.2d 831, 838 ["Where an issue is exclusively a matter of scientific medical knowledge, expert evidence is essential to sustain a commission finding; lay testimony or opinion in support of such a finding does not measure up to the standard of substantial evidence"].)

LEGAL CONCLUSIONS

1. Respondent has the burden of proving she qualifies for disability retirement, and she must do so by a preponderance of the evidence. (*McCoy v. Bd. of Retirement* (1986) 183 Cal.App.3d 1044, 1051-1052, fn. 5.) Evidence that is deemed to preponderate must amount to "substantial evidence." (*Weiser v. Bd. of Retirement* (1984) 152 Cal.App.3d 775, 783.) To be "substantial," evidence must be reasonable in nature, credible, and of solid value. (*In re Teed's Estate* (1952) 112 Cal.App.2d 638, 644.)

2. Government Code section 21151, subdivision (a), provides that any state safety member incapacitated for the performance of duty as a result of an industrial disability shall be retired for disability, regardless of age or amount of service. The application for disability retirement may be made by the member's employer or the member herself. (Gov. Code, § 21152, subds. (a) & (c).)

3. An application for disability retirement must be made while a member is still in state service or within four months after the discontinuance of their] state service. Upon receiving the application, the board must order a medical evaluation of the member to determine if they are incapacitated for the performance of duty. (Gov. Code, § 21154.) "In determining whether a member is eligible to retire for disability, the board or governing body of the contracting agency shall make a determination on the basis of competent medical opinion and shall not use disability retirement as a substitute for the disciplinary process." (Gov. Code, § 21156, subd. (a)(2).)

4. As defined in Government Code section 20026,

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

5. In *Mansperger v. Public Employees' Retirement System* (1970) 6 Cal.App.3d 873, 876 (*Mansperger*), the court interpreted the term "incapacity for performance of duty" to mean "the *substantial* inability of the applicant to perform his usual duties." (Italics in original.) Discomfort alone, even if it makes performance of one's duties more difficult, is insufficient to establish a substantial incapacity. (*Hosford, supra,* 77 Cal.App.3d at 853.) Subjective complaints alone, without competent medical evidence to substantiate the complaints, are insufficient to support a finding of permanent and substantial incapacity. (*Harmon v. Bd. of Retirement* (1976) 62 Cal.App.3d 689, 697 (*Harmon*).)

6. Several CalPERS precedential decisions have applied and adopted the reasoning in *Mansperger*, *Hosford,* and *Harmon*, which requires the presentation of competent medical evidence to support a finding that a respondent is disabled or substantially incapacitated from the performance of her usual duties. (See *In the Matter of the Application for Reinstatement from Industrial Disability Retirement of Willie Starnes* (Precedential Decision 99-03); *In the Matter of the Application for Disability Retirement of Theresa V. Hasan* (Precedential Decision 00-01); *In the Matter of the Application for Disability Retirement of Ruth Keck* (Precedential Decision 00-05).)

7. Findings issued for the purposes of workers' compensation or social security disability benefits are not evidence that respondent's injuries are substantially incapacitating for the purposes of disability retirement. (*Smith v. City of Napa* (2004)

120 Cal.App.4th 194, 207; *English v. Bd. of Admin. of the Los Angeles City Employees' Retirement System* (1983) 148 Cal.App.3d 839, 844; *Bianchi v. City of San Diego* (1989) 214 Cal.App.3d 563.)

8. Given the Factual Findings as a whole, respondent has not demonstrated through competent medical evidence that she is substantially incapacitated from performing the normal and usual employment duties of a CO. Thus, respondent did not meet her burden of establishing, by a preponderance of the evidence, that she is permanently and substantially incapacitated such that she qualifies for disability retirement. Accordingly, her application must be denied.

ORDER

The application of respondent Kim L. Carter for industrial disability retirement is DENIED.

DATE: November 8, 2021

TIFFANY L. KING
Administrative Law Judge
Office of Administrative Hearings