ATTACHMENT A

THE PROPOSED DECISION

BEFORE THE
BOARD OF ADMINISTRATION
CALIFORNIA PUBLIC EMPLOYEES' RETIREMENT SYSTEM

In the Matter of the Involuntary Reinstatement from Disability Retirement of:	Case No. 2011-230
KAREN CULVERSON,	OAH No. 2013080605
Applicant/Respondent	
and	
CALIPATRIA STATE PRISON, CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION,	
Respondent.	

PROPOSED DECISION

Administrative Law Judge Coren D. Wong, Office of Administrative Hearings, State of California, heard this matter on June 17, 2014, in Sacramento, California.

Cynthia A. Rodriguez, Senior Staff Attorney, represented the California Public Employees' Retirement System (CalPERS).

Respondent Karen Culverson represented herself.

No one appeared for or on behalf of respondent Calipatria State Prison, California Department of Corrections and Rehabilitation.[1]

Evidence was received, the record was closed, and the matter was submitted for written decision on June 17, 2014.

[1] Respondent Calipatria State Prison, California Department of Corrections and Rehabilitation was duly served with the Accusation and Notice of Hearing. A Notice of Defense was not filed on its behalf. The matter proceeded as a default proceeding against this respondent pursuant to Government Code section 11520, subdivision (a).

SUMMARY

Respondent's application for industrial disability retirement was approved by CalPERS based on an orthopedic (left knee) condition, and she was retired for disability effective April 21, 2001. CalPERS subsequently conducted a review of respondent's medical condition and determined that she is no longer substantially incapacitated for the performance of the usual job duties of a Correctional Sergeant with the California Department of Corrections and Rehabilitation and should be reinstated to her former position. Respondent appealed CalPERS's determination. As discussed below, CalPERS failed to demonstrate that, upon the basis of a medical examination, respondent is no longer substantially incapacitated for the performance of the usual job duties of a Correctional Sergeant and should be reinstated to her former position. Therefore, her appeal should be granted.

Procedural Background

1. Respondent was employed as a Correctional Sergeant by Calipatria State Prison, California Department of Corrections and Rehabilitation. By virtue of her employment, she was a state safety member of CalPERS.

2. On June 14, 2000, respondent signed an application for industrial disability retirement and submitted it to CalPERS. She alleged that she was disabled based on left knee pain and lower back pain.

3. On April 21, 2001, CalPERS sent correspondence to respondent notifying her that her application had been approved and she had "been found incapacitated for the performance of [her] duties as a Correctional Sergeant with the California Department of Corrections based upon [her] orthopedic (left knee) condition." Her industrial disability retirement was "effective immediately." Respondent was 31years old as of the effective date. She was 45 years old as of the date of hearing.

4. CalPERS's decision to grant respondent's application was based, at least in part, on a written report of a November 15, 1999 orthopedic consultation performed by John R. Lake, M.D., an orthopedic surgeon.

5. In his report, Dr. Lake described the history of respondent's injury as follows:

> The patient stated that she was injured while working on 11/15/99. She rapidly ran a distance of approximately 100 yards in sort of a twisting course to respond to a false alarm in the central health facility. That afternoon she developed gradually increasing pain about her left knee. She does not recall any particular injury to her knee that occurred while running. She stated that she had not had problems with her knee prior to this. The patient continued to have gradually increasing pain that

night and the next day. She said that she noticed slight swelling about the front of her knee. The very next day another alarm occurred. This time while she was running her left knee popped. She stated that it now hurt much worse. She informed her supervisor of the injury and received medical treatment for the problem at Pioneer Memorial Hospital.

Subsequently the patient continued to have problems with her knee despite evaluation and treatment by multiple physicians with medications, injections, physical therapy, and other nonoperative [*sic*] treatments.

6. Dr. Lake wrote the following about his physical examination of respondent's left knee:

The patient walks with an antalgic gait favoring the left lower extremity as manifested by a somewhat shortened stance based on the left side and lack of full motion of the knee. The patient is unable to squat beyond approximately 90 degrees. The majority of her weight is borne on the right lower extremity when she attempts to squat. The patient is able to easily hop on the right lower extremity; she will not even attempt this on the left lower extremity. The patient easily ascends a step stool on the right side; she is unable to perform this act on the left side.

[¶]... [¶]

Inspection of the knees and lower extremities is unremarkable except for some atrophy in the region of the distal aspect of the left thigh. There is no difference in coloration between the two extremities. The knee itself appears normal to inspection. There is no effusion.

The patient extends the left knee almost fully with some difficulty because of pain. She lacks perhaps 1 or 2 degrees of full extension of the left knee when lying comfortably supine. She has a full range of motion of the left knee with flexion to approximately 140 degrees, the heel missing the buttock by approximately two or three inches. On the left side she cannot flex to beyond approximately 90 degrees without complaints of severe pain in the left knee.

There is no effusion of the left knee. She does not have any ligamentous instability of the left knee. There is no crepitus with range of motion of the left knee. The patient has diffuse

> and seemingly inappropriate tenderness to palpation about the entire left knee. This does not localize to any specific anatomic structure. For instance, the patient has equal tenderness to palpation at the medial joint line and just above the medial joint line on the distal aspect of the femur medially and the proximal aspect of the tibia just distal to the medial joint line. She has similar tenderness to palpation about the entire patella, the patellar ligament, tibial tubercle and the lateral joint line area.

7. Dr. Lake diagnosed respondent with "a regional complex pain syndrome involving the left knee; this condition has been known as reflex sympathetic dystrophy." And he provided the following discussion of his diagnosis:

> The patient's treatment seems to be appropriate. This is a notoriously difficult syndrome to treat and it is just as difficult to understand from an etiological standpoint. It can appear following relatively innocuous or trivial trauma, which apparently happened in this case. Her prognosis is guarded but there will probably be some resolution of symptomatology gradually over the next several years. This cannot be accurately predicted and also because this will probably take at least several years it is clear that from an orthopedic standpoint, the patient cannot be expected to perform successfully the relatively vigorous activities that are occasionally demanded of a Correctional Sergeant.

8. Dr. Lake concluded: "The patient is unable to perform as a correctional [*sic*] Sergeant, given the job description that I have reviewed."

9. On March 3, 2001, Dr. Lake prepared a supplemental report in which he wrote the following regarding respondent's work restrictions: "The patient has a disability regarding her left lower extremity such that she is restricted to work that is predominately in a sitting position at a bench, desk or table with a minimum of demands for physical effort and with some degree of walking and standing being permitted."

10. On February 17, 2011, CalPERS sent respondent correspondence advising her that her "file is under review to determine if you continue to qualify for industrial disability retirement." She was told to report to Mohinder Nijjar, M.D., for an Independent Medical Examination (IME).

Essential Job Duties in Functions of a Correctional Sergeant

11. The essential functions of respondent's position as a Correctional Sergeant with the California Department of Corrections and Rehabilitation included the following:

- Walking or standing for long periods of time
- Running to the scene of a disturbance or emergency
- Running up and down stairs
- Maintaining visual surveillance of institutional grounds from an observation tower or central security area
- Discern color differences on a control panel, uniforms and crowded yard, etc.
- Defending self against an inmate armed with a weapon
- Disarming, subduing, and applying restraints to an inmate
- Watching for indications of illegal activity in relative darkness or in normal lighting
- Reading daily journals, facility rules, procedures, regulations, post orders, and other written materials relevant to job performance
- Writing various reports, memorandums, and other performance
- Taking periodic counts of inmates
- Preparing count slips for all types of inmate counts and clearing counts with the control office
- Conducting clothed/unclothed body searches
- Acting as entrance gate officer and searching visitors and transport vehicles for contraband
- Carrying, lifting, or dragging heavy objects, such as a disabled or unconscious inmate
- Jumping or pulling self over obstacles, such as fences
- Firing weapons in combat situations
- Listening for unusual sounds that may indicate illegal activity or disturbances

The physical demanding tasks of that position included the following:

- Ascend or descend several tiers of stairs at a fast pace in response to emergency situations with or without a gurney
- Run or walk rapidly to the scene of a disturbance or emergency situation as first officer on the scene or assist another officer during the disturbance or emergency
- Walk or stand for long periods of time with little or no opportunity to relieve strain on feet and legs. This occurs in gun towers and supervising the inmate food service areas

• Walk and/or run over rough ground in search of escaped inmates when patrolling the perimeter inside and outside an institution where the terrain may be irregular and trees and brush common
• Pursue inmates on foot or attempt to apprehend escaped inmates, which could involve running, jumping, scaling fences, running on slippery surfaces, etc.
• Bend, squat, stoop, kneel, twist, crouch in order to find concealed weapons, contraband, etc.
• Crawl in confined areas (e.g., attics, crawl-space)
• Balance while carrying a weapon on uneven or narrow surfaces including rooftops, walks, etc., while running, walking rapidly to an emergency
• Jump or vault over obstacles or quickly dodge obstacles
• Pull oneself up and over obstacles (e.g., walls, fences)
• Drag heavy objects (e.g., disabled or unconscious inmate or pieces of equipment)
• Lift heavy objects (e.g., disabled or unconscious inmate or pieces of equipment)
• Carry heavy objects (e.g., disabled or unconscious inmate or pieces of equipment)
• Push hard to move objects to protect inmates, self or other staff
• Operate difficult to operate gates, doors, or locks manually
• Use body force to gain entrance through barriers (e.g., locked doors/gates)
• Deflect thrown or moving objects to protect inmates, self or other staff
• Use weaponless defense tactics such as dodging, moving and pulling away rapidly
• Physically prevent escape attempts
• Defends self against an inmate armed with a weapon; disarm and subdue inmate
• Perform body searches of inmates
• Load and unload supplies, materials or equipment
• Perform duties while wearing heavy equipment (e.g., air pack)
• Climb up and down stairs during the course of routine duty. Depending on the institution design, the cumulative total could include up to 60 flights of stairs in an 8-hour shift
• Climb up to elevated surface (e.g., roof and stairwells)
• Climb straight up as it on a truck or building, or climb ladders straight up into gun towers
• Physically subdue or restrain a violent, combative or psychotic inmate or move resistant inmates from one area to another with assistance

- Tackle fleeing inmate
- Enter a cell and remove an armed or combative inmate search prison areas for contraband or escapees
- Physically separate two fighting inmates
- Search areas that are not easily accessible for contraband
- Apply restraints
- Place inmates in or remove inmates themselves
- Restrain inmates with hands or body to prevent a fight, after a fight to prevent further violence, or to prevent an inmate from leaving his assigned area
- Break up fights between inmates, which involves physical separation of inmates
- Distribute or remove inmates' food trays, which could include pushing a food cart (approximately 800 pounds from the food service facility to the housing unit – up to 300 yards); unload and carry 60-pound containers up to two to three flights of stairs
- Carry, maintain, qualify on and accurately fire weapons
- Qualify periodically on and be able to properly use a baton
- Properly operate a motor vehicle in Code 3 Emergency conditions and be certified in defensive driving techniques[2]

Medical Evidence

12. Respondent saw Dr. Nijjar on March 15, 2011, for an IME. After the IME, Dr. Nijjar prepared a report.

13. According to the written report, Dr. Nijjar took an oral history of respondent's injury and current complaints. He wrote that respondent reported suffering left knee pain 80 to 90 percent of the time and rated the pain between a 3 and an 8 on a scale of 1 to 10. Dr. Nijjar also wrote that respondent reported taking only Tylenol and ibuprofen for pain.

14. With regard to his neurologic examination of respondent's lower extremities, Dr. Nijjar wrote:

> Deep tendon reflexes and knee and ankle jerks were 2+, positive and equal on both sides. Plantar reflexes were equal bilaterally. Sensations to touch and pinwheel did not show any dermatomal loss of sensation in the lower extremities, patchy area of hyperesthesia or anesthesia. Motor strength tested in muscle groups around hips, knees and ankles was grade 5/5.

[2] Neither party moved into evidence the Correctional Sergeant Job Analysis that was pre-marked as Exhibit 15. Therefore, Exhibit 15 was not admitted for any purpose.

He described respondent's measurement at thigh level as "39 cm left and 39 cm right," and her measurement at calf level as "32 cm left and 32 cm right."

15. Dr. Nijjar described his physical examination of respondent's left knee as follows:

> There was no discoloration, hyper- or dysesthesias around the knee joint. The member had no effusion in the knee joint. The extensor mechanism on the knee was well aligned and had an angle of 12 percent. The member had minimal retropatellar tenderness.
>
> The member had no instability medially or laterally with tests done at full extension and 30 degrees flexion. The member's anterior drawer sign, posterior drawer sign, Lachman's sign, along with pivot shift test were all negative. The member had negative McMurray's test and Apley's grading tests indicated no medial/lateral instability, anterior/posterior instability or tear in menisci.

He described the range of motion of respondent's knee joint on extension as "0/0°" and on flexion as "135/135°."

16. Dr. Nijjar's relevant diagnoses were "sprain/strain of left knee" and "CRPS,[3] left knee, following injury and is resolved." He concluded that respondent is not substantially incapacitated for the performance of her usual job duties, and explained:

> The examination indicated that the member's symptoms are more subjective in their severity than objective. The member is currently taking Tylenol or ibuprofen for pain. With that in consideration it would appear that the member's reported symptoms are much more than the findings identified in this case.
>
> There was no limitation of range of motion in the neck, no muscle spasm, no neurological deficit in the upper extremities and no limitation of range of motion in the lumbar spine. In the lower extremities, regarding the left knee, the member had no effusion in the knee joint. No signs of CRPS were present at this time and the member demonstrated full range of motion. No other significant findings were identified (including no chondromalacia patella). In my medical opinion, there is a

[3] Chronic reflex pain syndrome.

reasonable certainty that this member can perform all the functions of Correctional Officer/Sergeant.

17. Dr. Nijjar testified at hearing. When asked generally whether his written report accurately reflects his findings after physical examination of respondent, Dr. Nijjar stated it does. When asked to describe the specific process he followed when conducting respondent's IME, Dr. Nijjar explained that he had no specific recollection of examining respondent because it was so long ago, and said he assumed he followed his normal procedure which was documented in his written report. Dr. Nijjar did not respond to respondent's contention that his physical examination of her consisted solely of him asking her to bend at the waist to touch her toes and bend her knees while in the prone position. Nor did he respond to her allegation that he never physically touched her or measured any of her body parts. Nonetheless, Dr. Nijjar's report, which was admitted for all purposes, documents that he performed a physical examination of respondent and is persuasive evidence of such examination and his subsequent findings. It is not unreasonable for him to have had no independent recollection of that examination at hearing since it occurred more than four years prior.

18. Dr. Nijjar explained a hearing that he reviewed the video of CalPERS's sub rosa investigation of respondent's daily activities, which is discussed further below. In his report, he described the video as depicting respondent walking briskly, and being "able to kneel, bend at the waist, and at the neck, use the shovel and accurately perform most of the activities and was actually seen jumping during a regular walk in the videotape." As discussed further below, Dr. Nijjar's description of the video is not entirely accurate. Furthermore, he did not explain how he was able to determine that respondent was able to "accurately perform most of the activities ... ."

19. Respondent did not call any medical expert witnesses at hearing. However, she testified generally that she can no longer perform her duties as a Correctional Sergeant because of her left knee pain. She also explained that she currently is on "many pain medications."

20. Respondent also introduced a report dated June 10, 2014, written by her primary care physician, Jeffrey O. Brownwood, D.O., a Board Certified Family Practice physician.[4]

21. With regard to respondent's current and ongoing complaints, Dr. Brownwood wrote, in relevant part: "Left knee: history RSD[5] posttraumatic, wax and wane. In the last year you have had more issues with the RSD than prior.".

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[4] While complainant's hearsay objection to the report was overruled, the report was considered only to the extent it explained or supplemented respondent's testimony that she could no longer perform her job duties because of her left knee pain.

[5] Reflex sympathetic dystrophy.

22. After clarifying that he is not a Qualified Medical Examiner for the State of California, Dr. Brownwood concluded:

> With this in mind, it is apparent that you sustained injuries in the workplace in 1994 and 1999 that caused permanent residual injury related effects. I do not think that you are capable of returning to your usual and customary employment as a Correctional Officer with the restrictions these chronic injuries oppose upon your life.

23. Respondent's medical records support Dr. Brownwood's conclusion that she had more problems with RSD this year than in prior years.[6] On January 7, 2014, respondent treated with Dr. Brownwood for constant, diffuse pain in her left knee that began approximately two or three days prior. Dr. Brownwood diagnosed respondent with a "strain of knee" and ordered a splint and crutches for one to two weeks. He also prescribed Ibuprofen, 600 mg. An x-ray of respondent's left knee revealed that bone and joint spaces were within normal limits, and there was no fracture or joint effusion.

The following week, respondent sent Dr. Brownwood an electronic message reporting that her "knee seems to be hurting a bit more and there is more swelling than last week. I keep getting sharp pains underneath my kneecap." He responded by advising that "the best thing to do is keep doing all the supportive care. These can take 4-8 weeks to calm down."

24. On January 27, 2014, respondent returned to Dr. Brownwood, complaining of "late intermittent wax and wane pain at knee and foot." Dr. Brownwood diagnosed her with "Reflex Sympathetic Dystrophy" and "Strain of Knee," and prescribed Gabapentin, 100 mg, Nortriptyline, 10 mg, and Lidocaine, 5 percent, for pain.

25. On February 12, 2014, Dr. Brownwood sent respondent an electronic message stating that a recent MRI of the left knee confirmed that there was no hidden fracture or tear of the meniscus. He advised that "supportive care" was the key to mending, and surgery was not indicated.

CalPERS's Sub Rosa Investigation

26. Chad Sandry, a Senior Special Investigator with CalPERS, conducted a sub rosa investigation of respondent over a five-day period between July 21 and 29, 2010, during which he observed, documented, and videotaped her performing various daily activities.

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[6] Again, the records were considered only to the extent they explained or supplemented respondent's testimony about her inability to perform her job duties.

27. Senior Special Investigator Sandry prepared a written report of his investigation. While his report for the most part documents his having observed respondent participate in normal daily activities that were not inconsistent with her disabled status, he also documented the following observations:

> July 27, 2010: 8:26 a.m. I filmed Culverson as she helped the adult male work in front of the church. She was filmed moving a big rock, shoveling and raking the dirt area in front of the church.
>
> July 27, 2010: 10:17 a.m. They arrived at *The New Song Church* at 585 D Street in Lincoln. I filmed Culverson working in front of the Church. She was filmed shoveling, measuring, squatting, sitting, standing, kneeling, and raking.
>
> July 27, 2010: 1:55 p.m. They returned to the church. I filmed Culverson again as she worked in front of the church. She was filmed squatting, kneeling, standing, measuring, shoveling, and sweeping.
>
> July 28, 2010: 9:31 a.m. They returned to the church. I filmed Culverson as she helped the adult male pour concrete. She was filmed walking around, standing, squatting, kneeling, jogging to the truck, using a water hose to wash off tools, sweeping, and bending.

28. The video of respondent's activities described above showed her and her husband outside the church digging a trench (July 27) and pouring concrete (July 28). However, respondent's husband did all of the physically demanding work. For instance, respondent's husband used a pick axe to dig the trench, while respondent used a shovel to remove the loose dirt. Additionally, respondent's husband poured and spread the concrete, while respondent used a trowel to smooth it. And while she moved a "big rock," she did so by rolling it and she struggled physically. She was squatting and kneeling while holding a tape measure for her husband and smoothing the concrete with a trowel. But the video did not show her "jogging to the truck" as reported in Senior Special Investigator Sandry's report or "jumping during a regular walk" as reported in Dr. Nijjar's.

Discussion

29. As discussed below, complainant has the burden of producing evidence that, based upon a medical examination, respondent is no longer substantially incapacitated for the performance of her usual job duties as a Correctional Sergeant with the California Department of Corrections and Rehabilitation and should be reinstated in her former position. Dr. Nijjar's written report documenting his physical examination of respondent is

more persuasive than her contention that his examination was limited, he took no measurements, and did not physically touch her.

Nonetheless, Dr. Nijjar's conclusion that respondent is no longer substantially incapacitated for the performance of the usual duties of a Correctional Sergeant is not persuasive. He provided no explanation, in his report or at hearing, of how his findings upon examination supported his conclusion that respondent is no longer substantially incapacitated. (See, e.g., *Jennings v. Palomar Pomerado Health Systems, Inc.* (2004) 114 Cal.App.4th 1108, 1117 ["An expert who gives only a conclusory opinion does not *assist* the jury to determine what occurred, but instead supplants jury by *declaring* what occurred."]; italics in original.) Additionally, Dr. Lake, the orthopedist upon whom CalPERS relied in granting respondent disability retirement, found that she had no effusion of the left knee, as did Dr. Nijjar. Also, Dr. Lake found respondent to have a greater range of motion of her left knee upon flexion than Dr. Nijjar found (140 degrees versus 135 degrees), while finding her to be substantially disabled. Ultimately, Dr. Nijjar failed to explain how respondent's condition had improved from the time of Dr. Lake's examination to such an extent that she was no longer substantially incapacitated for the performance of her duties as a Correctional Sergeant.

30. Senior Special Investigator Sandry's sub rosa investigation does not constitute medical evidence that can properly support a determination that a member previously retired for disability is no longer disabled and should be reinstated in her former position. Furthermore, complainant introduced no evidence establishing that the activities respondent was observed engaging in were inconsistent with her disabled status. The work restrictions Dr. Lake imposed in his March 3, 2001 supplemental report did not preclude all physical activity by respondent and permitted "some degree of walking and standing ... ."

31. While Dr. Brownwood does not specialize in orthopedic medicine and appeared to have applied the standard for determining whether a patient is eligible for workers' compensation benefits, rather than disability retirement, such factors affect the weight to which his opinion is entitled and do not render his opinion inadmissible. Besides, complainant did not make a prima facie showing that respondent is no longer disabled.

32. When considering all the evidence, complainant failed to meet its burden of demonstrating that, based upon a medical examination, respondent is no longer substantially incapacitated for the performance of her usual job duties as a Correctional Sergeant with the California Department of Corrections and Rehabilitation and should be reinstated to her former position. Therefore, respondent's appeal from CalPERS's determination to the contrary should be granted.

LEGAL CONCLUSIONS

Burden/Standard of Proof

1. Complainant has the burden of proving by a preponderance of the evidence that respondent is no longer substantially incapacitated for the performance of her usual job duties as a Correctional Sergeant with the California Department of Corrections and Rehabilitation and should therefore be reinstated in her former position. (*In the Matter of the Application for Reinstatement from Industrial Disability Retirement of Willie Starnes* (January 22, 2000, Precedential Decision 99-03) <http://www.calpers.ca.gov/eip-docs/about/leg-reg-statutes/board-decisions/past/99-03-starnes.pdf>.)

Applicable Law

2. Respondent was a safety number of CalPERS by virtue of her employment as a Correctional Sergeant with the California Department of Corrections and Rehabilitation. She was granted disability retirement effective April 21, 2001, based on an orthopedic (left knee) condition pursuant to Government Code section 21151, subdivision (a), which provides the following:

> 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.

3. "Disability" and "incapacity for performance of duty" are defined in Government Code section 20026, which provides:

> "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, or in the case of a local safety member by the governing body of the contracting agency employing the member, on the basis of competent medical opinion.

(See, *Mansperger v. Public Employees' Retirement System* (1970) 6 Cal.App.3d 873, 876 ["We hold that to be 'incapacitated for the performance of duty' within section 21022[7] means the *substantial* inability of the applicant to perform [her] usual duties."]; italics original.)

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[7] Predecessor to Government Code section 20026.

4. When a member has been retired for disability prior to the minimum age at which she can voluntarily retire for service, CalPERS may require the member to undergo a medical examination to determine if she is still disabled.

> The board, or in case of a local safety member, other than a school safety member, the governing body of the employer from whose employment the person was retired, may require any recipient of a disability retirement allowance under the minimum age for voluntary retirement for service applicable to members of his or her class to undergo medical examination, and upon his or her application for reinstatement, shall cause a medical examination to be made of the recipient who is at least six months less than the age of compulsory retirement for service applicable to members of the class or category in which it is proposed to employ him or her. The board, or in case of a local safety member, other than a school safety member, the governing body of the employer from whose employment the person was retired, shall also cause the examination to be made upon application for reinstatement to the position held at retirement or any position in the same class, of a person who was incapacitated for performance of duty in the position at the time of a prior reinstatement to another position. The examination shall be made by a physician or surgeon, appointed by the board or the governing body of the employer, at the place of residence of the recipient or other place mutually agreed upon. Upon the basis of the examination, the board or the governing body shall determine whether he or she is still incapacitated, physically or mentally, for duty in the state agency, the university, or contracting agency, where he or she was employed and in the position held by him or her when retired for disability, or in a position in the same classification, and for the duties of the position with regard to which he or she has applied for reinstatement from retirement.

(Gov. Code, § 21192.)

5. The minimum age for service retirement for a state safety member of CalPERS is 55 years old. Respondent was 31 years old as of the effective date of her disability retirement (April 21, 2001), and 45 years old as of the date of hearing (June 17, 2014).

6. If the member is determined to no longer be substantially incapacitated for performing her usual duties, she shall be reinstated to her former position.

> If the determination pursuant to Section 21192 is that the recipient is not so incapacitated for duty in the position held

when retired for disability or in a position in the same classification or in the position with regard to which he or she has applied for reinstatement and his or her employer offers to reinstate that employee, his or her disability retirement allowance shall be canceled immediately, and he or she shall become a member of this system.

If the recipient was an employee of the state or of the university and is so determined to be not incapacitated for duty in the position held when retired for disability or in a position in the same class, he or she shall be reinstated, at his or her option, to that position. However, in that case, acceptance of any other position shall immediately terminate any right to reinstatement. A recipient who is found to continue to be incapacitated for duty in his or her former position and class, but not incapacitated for duty in another position for which he or she has applied for reinstatement and who accepts employment in the other position, shall upon subsequent discontinuance of incapacity for service in his or her former position or a position in the same class, as determined by the board under Section 21192, be reinstated at his or her option to that position.

If the recipient was an employee of a contracting agency other than a local safety member, with the exception of a school safety member, the board shall notify it that his or her disability has terminated and that he or she is eligible for reinstatement to duty. The fact that he or she was retired for disability does not prejudice any right to reinstatement to duty which he or she may claim.

(Gov. Code, § 21193.)

7. As discussed in Factual Findings 29 through 32, complainant failed to establish that, upon the basis of examination, respondent is no longer substantially incapacitated for the performance of the usual job duties of a Correctional Sergeant with the California Department of Corrections and Rehabilitation and should be reinstated to her former position. Therefore, her appeal from CalPERS's determination to the contrary should be granted.

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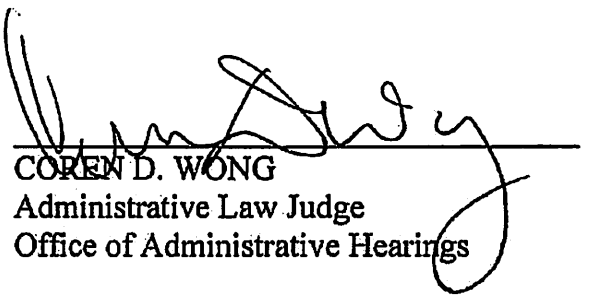
ORDER

Respondent Karen Culverson's appeal from CalPERS's determination that she is no longer substantially incapacitated for the performance of the usual duties of a Correctional Sergeant with the California Department of Corrections and Rehabilitation and should be reinstated to her former position is GRANTED. The Accusation is therefore DISMISSED.

DATED: July 15, 2014



COREN D. WONG
Administrative Law Judge
Office of Administrative Hearings