



Office of the Inspector General
U.S. Department of Justice



**A Review of Certain Public Safety
Officers' Benefits Act Claim
Determinations by the Director of the
Bureau of Justice Assistance, Office of
Justice Programs**

EXECUTIVE SUMMARY

The Department of Justice (DOJ) Office of the Inspector General (OIG) conducted this review after receiving allegations that Denise E. O'Donnell, the Director of the Bureau of Justice Assistance (BJA) within DOJ's Office of Justice Programs (OJP), approved and directed the payment of one or more claims filed with the BJA under the Public Safety Officers' Benefit Act (PSOBA), 42 U.S.C. § 3796 et seq., in direct contravention of various statutory provisions imposing conditions or limitations on the payment of benefits.

Enacted in 1976, the PSOBA provides disability benefits to public safety officers (police persons, firefighters, and other first responders) who become permanently disabled, and death and education benefits to survivors of public safety officers who die, as a direct and proximate result of a personal injury sustained in the line of duty. Claimants have the burden of persuasion as to all material issues of fact and benefits may be denied if the officer, or his survivors, contributed to or caused the injury.

Claims for benefits are administered by DOJ's Public Safety Officers' Benefits Office (PSOB Office), an office within the BJA. Claims are initially approved or denied by benefits specialists within the PSOB Office based on a review of claim forms and supporting documentation. Upon a denial, claimants may seek review by a Hearing Officer. Final administrative determinations are made by the BJA Director, who reviews all claims approved by a Hearing Officer and, at the request of claimants, any claims denied by a Hearing Officer. Claims denied by the BJA Director may be appealed to the U.S. Court of Appeals for the Federal Circuit.

The complainant raised questions as to six claims approved by Director O'Donnell. The complainant alleged that O'Donnell approved one of the six claims in violation of the law, approved four of the six claims before the record had been fully developed and the legal sufficiency of the claims clearly established, and approved the sixth claim even though she had not reviewed the case file. However, in reviewing the case files, we found that O'Donnell had not yet made a final determination with respect to two of the six claims, and therefore concluded that there was no basis for the OIG to assess O'Donnell's handling of those two matters.

In evaluating the allegations regarding the remaining four cases, we undertook an assessment to determine whether there was evidence that O'Donnell had systemically failed to follow the law in approving these PSOB claims. While it is squarely within the OIG's mission to investigate allegations that a Department official made a decision in violation of a law, rule, or regulation resulting in the improper expenditure of Department funds, we also recognize that senior Department officials make numerous decisions involving complex matters daily and that we are not to substitute our judgment for theirs simply because we may have reached a different conclusion based on the facts

learned during our investigation. We therefore determined that, in evaluating the decisions made regarding the claims, we would use a standard of review analogous to what a court would use in deciding an appeal of a final administrative determination. In general, a court reviewing a final agency determination will apply an "abuse of authority" standard. A court will reverse the agency's decision under this standard only if: (a) it was made without "substantial compliance" with the statutory requirements and provisions of implementing regulations; (b) there was "arbitrary and capricious" action on the part of the government officials involved; or (c) it was not supported by "substantial evidence."

We reviewed the administrative records and O'Donnell's determinations in connection with the four claims. In all four cases, we concluded O'Donnell had considered and applied the relevant portions of the statute and regulations in making her determinations. However, we found O'Donnell's decision to award benefits in one case to be arbitrary and capricious and unsupported by "substantial evidence." That case involved a police officer who was killed while driving home alone after leaving a bar where he had been on an undercover assignment drinking with a target of a criminal investigation. Blood tests showed the officer's blood alcohol level to be well above the legal limit, and the PSOPA prohibits payment of a claim where an officer is intoxicated at the time of death. The accident occurred when the officer's vehicle, while on a straight portion of a 4-lane road, crossed the center turn lane and two opposing traffic lanes, drove up onto the sidewalk on the opposite side of the road, traveled down an embankment, traveled through a thicket of vegetation, hit another embankment, went airborne, struck the roofline of a house, and dropped tree limbs and debris onto an unoccupied parked car before descending upon/crashing into and causing significant damage to the left side of another unoccupied parked car. The state accident investigation team found no mechanical problems with the officer's vehicle, no evidence of vehicle tampering, that weather conditions were good, that the road surface was dry, and that the car was moving at approximately 57 miles per hour (mph) when it became airborne (the speed limit was 45 mph).

Both the PSOB office and the PSOB hearing officer denied the claim, finding that the officer was intoxicated at the time of death. In order to reach a contrary conclusion, O'Donnell had to find, among other things, that there was clear and convincing evidence the officer was not acting in an intoxicated manner immediately prior to death, namely at the time of the car accident. O'Donnell found that there was such evidence and determined that the officer's actions were undertaken with a "reasonable excuse." She also found that any negligence on his part was not "great, heedless, wanton, indifferent, or reckless."

Our review of the record revealed fundamental defects in O'Donnell's final determination. First and foremost, in her 13-page written decision, O'Donnell completely ignored the extreme circumstance of the crash that was itself among the strongest evidence of intoxicated behavior. Additionally, O'Donnell was

selective in what testimony she accepted and what testimony she rejected, and her rationale for discrediting certain portions of witness accounts was inconsistently applied and premised on a mischaracterization of the witnesses at the bar as “subjects” of the criminal investigation. We also found a number of O’Donnell’s explanations and conclusions ran counter to the evidence.

As to each of the remaining three cases, we found sufficient support for O’Donnell’s decisions. In the second case, the record supports O’Donnell’s decision to award benefits. Although her approach exposed procedural idiosyncrasies in the adjudication of PSOB claims, we found nothing improper about her final determination granting the award. In the third case, although she initially proposed awarding benefits based on incomplete evidence, O’Donnell ultimately rejected the claim after referring the matter to a Special Master and considering the findings thereof, which we found refuted the allegation that she granted the claim illegally. Finally, in the fourth case, we found insufficient evidence to support the allegation that O’Donnell affirmed an award of benefits without reviewing the associated case file.

Based on these reviews, while we found that O’Donnell improperly decided to award benefits in one of the cases we examined, we did not find evidence that O’Donnell had systemically failed to follow the law in approving PSOB claims. We refer this report to the Department for its review and any action it deems appropriate.

I. Introduction

On August 3, 2014, the Department of Justice (DOJ) Office of the Inspector General (OIG) received a whistleblower complaint alleging that Denise O'Donnell, Director of the Bureau of Justice Assistance (BJA) within the Office of Justice Programs (OJP), approved and directed payment of one or more claims under the Public Safety Officers' Benefit Act (PSOBA), in direct contravention of various statutory provisions that expressly forbid payment under the circumstances presented. The OIG previously received other complaints about the PSOB claim process, including concerns about the delay in resolving claims, which resulted in an audit being conducted by the OIG.¹ This report summarizes the results of a review by the OIG following receipt of the allegations contained in the August 2014 complaint letter.

The complaint included an allegation that O'Donnell directed payment of a PSOB claim contrary to law in connection with the death of police officer Kurt Harper.² Harper died from injuries sustained when, with an elevated blood alcohol level, he lost control of and crashed his car upon leaving an undercover assignment. The complaint also identified four other claims as examples of claims that O'Donnell allegedly deemed payable before the record had been fully developed and the legal sufficiency of the claims clearly established. Copies of O'Donnell's determination in the Harper matter and the complainant's comments thereon were attached to the complaint. Also attached to the complaint were internal OJP memoranda addressing the merits of the four other claims identified as representative of O'Donnell's alleged misconduct.

The complaint identified a sixth claim that O'Donnell allegedly approved for payment although she had not reviewed the case file. The complainant did not challenge the legal sufficiency of the award in this matter. The complaint, rather, alleged that O'Donnell affirmed the award determination prior to the file being sent to her office.

We examined the case files and conducted a review for each of the six claims that were the subject of the whistleblower's complaint in order to assess whether there were systemic issues regarding the BJA Director's handling of the claim approval process, as the complainant alleged. We found that O'Donnell had not yet made a final determination with respect to two of those six claims, and therefore concluded that there was no basis for the OIG to assess whether

¹ "Audit of the Office of Justice Programs' Processing of Public Safety Officers' Benefit Programs," DOJ OIG Audit Division 15-21 (July 2015), <https://oig.justice.gov/reports/2015/a1521.pdf> (accessed April 1, 2016). In addition, over the years the OIG's Investigations Division has investigated several allegations that fraudulent PSOBA claims that have been filed with the BJA.

² "Kurt Harper" is a pseudonym. For privacy reasons, pseudonyms have been used, and some factual details have been omitted, for each of the claims addressed herein.

O'Donnell's handling of those two matters was in contravention of the law. This report presents the OIG's analysis of the allegations made regarding the other four claims identified in the complaint and whether their handling reflected systemic issues regarding the PSOB claim approval process.

II. Background

A. The Public Safety Officers' Benefits Act

Enacted to assist with the recruitment and retention of law enforcement officers and firefighters, the Public Safety Officers' Benefits Act of 1976, 42 U.S.C. § 3796 et seq. (PSOBA), provides death and education benefits to survivors of law enforcement officers, firefighters, and other first responders who die, and disability benefits to officers permanently disabled, as a direct and proximate result of a personal injury sustained in the line of duty.³

1. Procedures

Claims for benefits are administered by the Public Safety Officers' Benefits Office (PSOB Office) within the BJA, which is a component of the OJP. 42 U.S.C. § 3796(a); 28 C.F.R. § 32.3. Generally, claims for death and disability benefits must be filed within 3 years of the death or disability. 28 C.F.R. §§ 32.12 and 32.22. First level review of claim forms and supporting evidence is accomplished by benefits specialists who prepare an initial determination approving or denying the claim, which is reviewed and signed by the Director of the PSOB Office. Claims denied by the PSOB Office benefits specialists may be appealed for *de novo* review by a BJA appointed Hearing Officer. 28 C.F.R. §§ 32.17; 32.29; 32.37. Claims denied by a Hearing Officer may be appealed for *de novo* review by the BJA Director, who also may review denials on her own motion. 28 C.F.R. §§ 32.46; 32.53(b)(1). The regulations also provide that the BJA Director shall review all Hearing Officer claim approvals. 28 C.F.R. § 32.53(a). Claimants are allowed to present additional legal arguments and evidence, including the opinions of experts, at the Hearing Officer and BJA Director levels of review. 28 C.F.R. §§ 32.42(b); 32.52(b).

Independent medical examiners and other experts may be retained by the PSOB Office at each stage of review. 28 C.F.R. § 32.5(g). The BJA Director's decision constitutes the final agency determination. 28 C.F.R. § 32.55. Pursuant to an OJP Order issued in 2010, concurrence from the OJP Office of the General Counsel (OGC) was required for all claim determinations administered

³ The implementing regulations for the PSOBA, which include the time limits for filing claims, definitions of key terms, and the procedural construct for claims processing, appear at 28 C.F.R. Part 32. Part 32 is divided into six subparts. Subpart E pertains to Hearing Officer Determinations and Subpart F pertains to Director Appeals and judicial review.

by OJP, including but not limited to PSOBA claim determinations.⁴ However, on May 9, 2013, OJP issued an Order excluding claims arising pursuant to the PSOBA from the OGC concurrence requirement.⁵ According to the final rule codifying the transfer of the legal review function from OGC to the PSOB Office, this change was implemented in order to simplify the claims administration process, eliminate duplicative efforts across components, and increase overall programmatic efficiency.⁶

The regulations require that the BJA Director make written findings of fact and conclusions of law to explain her decision to deny any claim at any stage of review. 28 C.F.R. § 32.54(a). BJA Director denials may be appealed to the Court of Appeals for the Federal Circuit. 42 U.S.C. § 3796c-2.

2. Legal Standard for Awarding Claims

As noted, the PSOBA provides benefits to public safety officers or their survivors for death or disability occurring “as the direct and proximate result of a personal injury sustained in the line of duty.” 42 U.S.C. §§ 3796(a) and (b). The implementing regulations provide that an injury is a “direct and proximate” cause of death (or disability) if it is a “substantial factor” leading to death (or disability). 28 C.F.R. § 32.3. A factor is considered a “substantial factor” if it alone was sufficient to have caused the death, injury, or disability; or no other factor (or combination of factors) contributed to the death, injury, or disability to so great a degree as it did. *Id.* Claimants have the burden of persuasion as to all material issues of fact by the standard of proof of “more likely than not.” 28 C.F.R. § 32.5(a).

III. Analytical Construct: the Standard of Review

In considering the complaint made in this case, and whether and how to review the allegations, the OIG was mindful of the challenge that it presented. On the one hand, it is squarely within the OIG’s mission and responsibility to

⁴ See OJP Order No. 1001.5A, ¶ 2.e (March 11, 2010), which provided, “No payment, appointment, finding, determination, affirmance, reversal, assignment, authorization, decision, judgment, waiver, or other substantive ruling, arising from or in connection with any programmatic claim against the United States under any program administered by OJP (*e.g.*, 42 U.S.C. ch. 46, subch. XII and 42 U.S.C. § 10603c) may be made without the concurrence of the GC.” See *also*, DOJ Order No. 2110.39A, ¶ 1 (November 15, 1995), advising “Accountable Officers to seek the advice of their component general counsel when they are in doubt about the legality of authorizing the obligation or payment of government funds.”

⁵ See OJP Order No. 1001.5B, signed by Acting Assistant Attorney General Mary Lou Leary on May 9, 2013.

⁶ See Department of Justice, Public Safety Officers’ Benefits Program, Final Rule, 78 Fed. Reg. 29233 – 29234 (May 20, 2013) (codified at 28 C.F.R. §§ 32.43 and 32.44) (removing the requirement that Hearing Officers provide OGC notice of their claim determinations and the factual findings and legal conclusions made to support them and establishing that they provide the same to the PSOB Office.)

investigate an allegation that a Department official made a decision in violation of a law, rule, or regulation that resulted in the improper expenditure of Department funds, particularly where the whistleblower alleges a pattern of improper approvals involving a substantial Department program. On the other hand, in making that assessment, we recognize that Department managers and senior officials make numerous decisions every day and that we are not to substitute our judgment for theirs simply because we might have made a different decision based on the facts we learned during our investigation.

With these considerations in mind, the OIG determined that it was appropriate for us to evaluate these allegations given the systemic nature of the concerns raised and our responsibility to conduct oversight of the PSOB program. We further determined that in analyzing the allegations we should apply the same deferential standard of review that a reviewing court would use in adjudicating an appeal of a final agency PSOBA determination.⁷ In general, a court reviewing the BJA Director's decision on behalf of the Department with respect to a PSOBA claim will apply an "abuse of authority" standard, which seemed to us appropriate given the nature of the allegations. A court will reverse the agency's decision under this standard only if: (a) it was made without "substantial compliance" with the statutory requirements and provisions of implementing regulations; (b) there was "arbitrary and capricious" action on the part of the government officials involved; or (c) it was not supported by "substantial evidence." *Morrow v. United States*, 227 Ct. Cl. 290, 296; 647 F.2d 1099, 1102, *cert. denied*, 454 U.S. 940; 102 S. Ct. 475; 70 L. Ed.2d 247 (1981).

"Substantial compliance" has been defined as compliance with the essential requirements, whether of a contract or statute, so as to satisfy its purpose or objective even though its formal or technical requirements are not met. See *Blacks Law Dictionary* 1428 (6th Ed. 1990). Additionally, the purpose of the substantial compliance doctrine is "to avoid the harsh consequences that flow from technically inadequate actions that nonetheless meet a statute's underlying purpose." *Galik v. Clara Maass Med. Ctr.*, 167 N.J. 341, 354, 771 A.2d 1141 (2001)

An agency's actions have been held to be "arbitrary and capricious" on appellate review "if the agency has relied on factors which Congress has not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise." *Motor Vehicle Mfrs.*

⁷ In practice, only denials of PSOBA claims are ever appealed, because there is no party who would have an incentive or legal standing to appeal a grant of a PSOBA benefit. Although we are reviewing decisions to grant claims in this report, we believe that the standard of review used in reported appeals of PSOBA claim denials, which is based on principles of appellate review of a broad range of agency actions, is appropriate for our analysis.

Ass'n v. State Farm Ins. Co., 463 U.S. 29, 43, 103 S. Ct. 2856, 77 L. Ed.2d 443 (1983).

"Substantial evidence" required to support an agency decision is defined as "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Consol. Edison v. NLRB*, 305 U.S. 197, 59 S. Ct. 206, 83 L. Ed. 126 (1935). "Substantial evidence" also "is something less than the weight of the evidence, and the possibility of drawing two inconsistent conclusions from the evidence does not prevent an administrative agency's findings from being supported by substantial evidence." *Consolo v. FMC*, 383 U.S. 607, 86 S. Ct. 1018, 16 L. Ed.2d 131 (1966).

IV. OIG Evaluation of Individual Case Decisions

In this Section we examine each of the four final PSOBA claims determinations that the complaint identified as improper.

A. Kurt Harper Claim

The complaint identified the Harper claim as the claim that O'Donnell "approved" and "directed payment thereupon" "in direct contravention of various statutory provisions that expressly forbid payment under the circumstances presented in the claim." In the Harper matter, BJA Director O'Donnell vacated the determination of the Hearing Officer and the PSOB Office and approved an award of death benefits to the family of an undercover narcotics agent who died when he drove off the road and crashed his vehicle shortly after he left a bar where he had met and drank with a target of a narcotics investigation. The testing of the officer's blood following the accident showed an alcohol content of .18%. As detailed below, in order to grant the claim, O'Donnell was required to make a determination that the officer was not voluntarily intoxicated at the time of the fatal accident; the officer did not engage in intentional misconduct in driving his vehicle after drinking at the bar; and the officer did not perform his duties in a grossly negligent manner at the time of the accident that resulted in his death.

1. Applicable Statutory Provisions

As set forth in Section II.A.2. above, the PSOBA provides monetary benefits to public safety officers who are catastrophically injured or the survivors of public safety officers who die "as the direct and proximate result of a personal injury sustained in the line of duty." 42 U.S.C. § 3796(a). However, benefits are not awarded if the officer contributed to or caused the injury in certain respects. The Act provides, in relevant part, with respect to the actions or status of the public safety officer himself:

No benefit shall be paid under this subchapter –

- (1) if the fatal or catastrophic injury was caused by the intentional misconduct of the public safety officer or by such officer's intention to bring about his death, disability, or injury;
- (2) if the public safety officer was voluntarily intoxicated at the time of his fatal or catastrophic injury;
- (3) if the public safety officer was performing his duties in a grossly negligent manner at the time of his fatal or catastrophic injury.

42 U.S.C. §§ 3796a(1)-(3).⁸

The Act defines *intoxication* as,

a disturbance of mental or physical faculties resulting from the introduction of alcohol into the body as evidenced by –

- (i) a post-injury blood alcohol level of .20 per centum or greater; or
- (ii) a post-injury blood alcohol level of at least .10 per centum but less than .20 per centum unless the Bureau receives convincing evidence that the public safety officer was not acting in an intoxicated manner immediately prior to his fatal or catastrophic injury;

or resulting from drugs or other substances in the body.

42 U.S.C. § 3796b(5).

According to the PSOB regulations, *gross negligence* means great, heedless, wanton, indifferent, or reckless departure from ordinary care, prudence, diligence, or safe practice –

- (1) In the presence of serious risks that are known or obvious;
- (2) Under circumstances where it is highly likely that serious harm will follow; or
- (3) In situations where a high degree of danger is apparent.

28 C.F.R. § 32.3.

⁸ 42 U.S.C. §§ 3796a(4) and (5) provide, respectively, that benefits shall not be awarded to a potential beneficiary whose actions substantially contributed to the officers injury or death, and where the officer was employed in a capacity other than a civilian capacity. These subsections were omitted above because the circumstances addressed therein did not arise in the cases we reviewed.

The regulations provide the following regarding *intentional misconduct*:

A public safety officer's action or activity is intentional misconduct if

–

- (1) As of the date it is performed,
 - (i) Such action or activity –
 - (A) Is in violation of, or otherwise prohibited by, any statute, rule, regulation, condition of employment or service, official mutual-aid agreement, or other law; or
 - (B) Is contrary to the ordinary, usual, or customary practice of similarly-situated officers within the public agency in which he serves; and
 - (ii) He knows, or reasonably should know, that it is so in violation, prohibited, or contrary; and
- (2) Such action or activity –
 - (i) Is intentional; and
 - (ii) Is –
 - (A) Performed without reasonable excuse; and
 - (B) Objectively unjustified.

28 C.F.R. § 32.3.

2. Facts

a. Background

Kurt Harper was an undercover narcotics agent with a local law enforcement agency. On the night in question, he accompanied the target of a narcotics investigation and two of the target's friends ("Friend 1" and "Friend 2") to a night club. Although Harper was alone when he met with the target and the target's friends, he had discussed his plans to meet with the target with his control agent earlier that day.

Early the next morning, Harper was involved in a fatal automobile accident in which the vehicle that he was operating, while driving on a straight road, crossed a center turn lane and two opposing traffic lanes, drove up onto the sidewalk on the opposite side of the road, traveled down an embankment, traveled through a thicket of vegetation, hit another embankment, went airborne, struck the roofline of a house, and dropped tree limbs and debris onto an unoccupied parked car before descending upon/crashing into and causing

significant damage to the left side of another unoccupied parked car. Harper was transported to the hospital by ambulance where, despite the efforts of emergency room personnel, he was pronounced dead.

An autopsy performed later that day determined that Harper sustained extensive injuries. A preliminary postmortem examination report and an amended report listed the cause of death as "multiple trauma due to motor vehicle traffic collision-driver."

The coroner's office sent blood samples collected at the time of Harper's hospital presentation and a urine sample collected during the autopsy to a laboratory for analysis. Testing of the blood samples reflected an alcohol (ethanol) level of .18%. (It is unlawful to drive in the jurisdiction in question with a blood alcohol content (BAC) of .08 % or higher.) Consistent with the autopsy report, a death certificate certified by the coroner listed the cause of death as "Multiple Trauma, Due To (Or As A Consequence Of): Motor Vehicle Collision." "Accident" is marked as the "Manner of Death" and "restrained driver-single vehicle collision" is noted for "How [the] Injury Occurred."

An investigation by the state accident investigation team found no mechanical problems with the vehicle that Harper was driving at the time of the accident. There was also no evidence of vehicle tampering. The environment was determined to be a non-contributing factor, as the weather conditions that morning were described as "good" and records reflect that the surface of the 4-lane road with a center turn lane on which Harper was traveling was "dry." The posted speed limit in the area where the accident took place was 45 mph. Accident investigators estimated that Harper's car was moving at approximately 57 mph when it became airborne. The accident report also states, "This is the speed where the vehicle became airborne. It does not take into account any reduction of velocity from the point where the vehicle left the roadway prior to it becoming airborne." (As noted, before it became airborne, the vehicle drove up a sidewalk, down an embankment, through a thicket of vegetation, and up another embankment.)

Investigators from the local law enforcement agency took sworn statements from the target of the undercover investigation that Harper was conducting and two of the target's friends within a week of Harper's death. The target, who had a history of arrests and sentences for various crimes, was arrested on a drug charge shortly after Harper's death. He gave a statement a few days after his arrest, by which time he was aware Harper had been an undercover officer.⁹

⁹ At the time of the interview, the target was informed that what he said in the interview would not be used against him with regard to the then-pending charges, and that as long as he was truthful regarding the statement he made in the interview, nothing he said would be used against him later.

The target told investigators that he called Harper on the night in question about going to a club. At the time, one of the target's friends, Friend 2, was with the target. Harper and the target agreed that the target would pick Harper up from a restaurant. After the target picked Harper up, Harper, the target and Friend 2 rode together in the target's car to pick up Friend 1 and then went to the club. The target estimated that they arrived at the club at around 10:45 p.m. The target said that he paid for the drinks and that they all had about eight rounds. The target said that they stayed at the club (which he believed closed at 5:00 a.m.) until around 4:30 a.m. According to the target, Harper drank as many rounds and "was on the same pace" as the others.

The target said that before the group of four left the club, he was told by the club's owner that Harper was throwing up in the bathroom and that they needed to leave. He also said that Harper threw up in the club parking lot and that the group purchased turkey wings from an establishment near the club that sold food from a trailer until the early morning hours. The target said that although they bought wings for Harper, Harper did not eat any of them. The target also said that although he did not know who Harper was calling, he saw Harper go behind the trailer to use his cell phone. The target said he also used Harper's phone to place a call because his cell phone needed to be charged.

According to the target, after they left the club parking lot, they had to pull over in the median along the road so that Harper could throw up again. The target, who was driving, dropped off Friend 1 first and then drove to the restaurant where Harper's vehicle was parked. The target said that he offered to take Harper home, but Harper said that he "had it." The target said that as they were pulling away, Friend 2 told him not to leave Harper in the state he was in so he turned around and again offered Harper a ride. The target said that Harper was behind the wheel of his vehicle, opened the door to talk, and said that he was "okay." The target said that he then drove to where Friend 2's car was parked, which was in front of the target's cousin's house, and that he stayed at his cousin's house for the night.

The target said that he learned that Harper was a law enforcement officer after he was arrested for selling to an undercover agent. The target said that prior to his death, he thought of Harper as a friend and that he and Harper had drunk alcohol together previously, but not heavily.

Statements were taken from Friend 1 and Friend 2. Neither had a criminal arrest record and each was informed at the beginning of the interview that he was not being detained for anything and was free to leave at any time. Their statements were substantially consistent with the target's. Both said that they traveled in the target's car to the club; they stayed over 4 hours; the target bought everyone's drinks; the target bought many (up to eight) rounds of alcohol; Harper drank alcohol with them; they left the club close to closing time; Harper appeared drunk; Harper threw up in the club parking lot; they bought food as they left the club; and that they talked about whether Harper was okay to drive after they left the club.

Friend 1 said that Harper seemed intoxicated to him, but upon later learning that Harper was an undercover officer, he was “not sure if he [Harper] could have been faking, or not.” He also said that he did not actually see Harper throw up, but heard him throwing up. However, Friend 1 added that if Harper was acting he did a good job because he certainly looked drunk. Friend 1 also said that he wasn’t paying very close attention as to whether Harper was actually drinking or not, but that he thought Harper was drinking at the time and that Harper and the target drank every time a round came. Friend 1 recalled that a bouncer saw Harper throwing up and offered Harper ginger ale when they were in the parking lot, but Harper did not drink it. Friend 1 said that once they were inside the car, Harper fell over into his lap and he had to help him back up into the sitting position. Friend 1 also recalled that they ate the wings in the car, but Harper did not eat any. Friend 1 stated that they pulled over to allow Harper to throw up after leaving the club. He also said that Harper said that he wanted to be dropped off at his car, but he (Friend 1) suggested that he be taken home instead.

Friend 2 said that Harper had as many rounds as the others and that he was “positive” that Harper was drinking the alcohol because he was sitting right beside Harper most of the time. He also said that Harper was drunk and throwing up. Friend 2 said that there was no doubt in his mind that Harper was drunk and that he was confident that Harper was throwing up liquor because he could smell it. Friend 2 said that Harper stepped outside the club before he and the others did and that a club security employee came to tell them that one of their friends was throwing up. Friend 2 said that when he got outside, Harper was still throwing up and that he saw Harper throw up two or three times. Although he did not recall Harper throwing up again after they left the club parking lot, Friend 2 said that Harper rode with the window down. Friend 2 said that he did not recall whether Friend 1 or Harper was dropped off first, but recalled Harper – with slurred speech – telling the target that he was all right to drive.

Friend 2 also said that a few weeks before the accident, the target told him that he had a funny feeling that Harper might be an undercover officer and, referring to Harper’s braces, they joked that Harper had to have a good dental plan in order to have braces on his teeth. However, Friend 2 said that he did not think the target really believed that Harper was an undercover officer because the target continued to hang around Harper.

The claimant filed a claim for PSOB benefits on behalf of Harper’s family. The PSOB Office informed the claimant by letter that Harper’s death was not covered by the Act and that the claim was being denied. As grounds, the letter stated that given Harper’s blood alcohol level of .18%, Harper was presumed to be voluntarily intoxicated unless there was convincing evidence that he ‘was not acting in an intoxicated manner immediately prior to his death’ or that Harper did not intentionally introduce alcohol into his body. Finding no such evidence,

the benefits representative stated, "the presumption that [Harper] was intoxicated holds."¹⁰

b. Hearing and Hearing Officer's Determination

The claimant retained an attorney and requested by letter that a Hearing Officer review the claim denial. The claim was assigned to an Independent Hearing Officer, who conducted a hearing. Those who testified included the claimant; a State Highway Patrol Officer; a former undercover FBI agent who served as an expert for the claimant; the head of the local law enforcement agency that employed Harper; the deputy chief of the agency's Criminal Investigations Division; Harper's Control Officer; Harper's fellow undercover agent and roommate; and a pathologist/toxicologist who testified as claimant's expert.

Claimant's expert challenged the recorded BAC of .18 per centum as being artificially inflated. He identified what he perceived as problems with the chain of custody of the samples and indicated that there was a delay in analyzing them. He stated that the types of tubes the samples were collected in had no preservatives which allowed additional fermentation and an artificial increase in the BAC. Claimant's expert also stated that trauma to Harper's body may have caused a sharp rise in his blood alcohol level just before the samples were collected. Noting that testing of the serum or liquid part of the blood alone, rather than whole blood, would have resulted in a higher BAC, claimant's expert also stated that it was not clear what type of blood was tested. In his summary memorandum to the Hearing Officer, Claimant's attorney made several arguments to justify Harper's actions, including that Harper was not voluntarily intoxicated because the undercover nature of his work required him to drink in order to fit in with the target, and that Harper had made several unscheduled calls to his control officer to report that he was in need of assistance.

Following the hearing, the Hearing Officer requested additional documents, including records related to Harper's death and his phone calls to his control officer, and a report addressing the reliability of the BAC test results from a forensic toxicologist from a prominent institute of pathology. The forensic toxicologist opined that if stored properly and analyzed soon after collection, the type of tube would not have made a significant difference in the measured blood alcohol level. He was also of the opinion that trauma to Harper's body was not a factor in this instance because the blood samples were collected at the hospital for treatment, and therefore, were most likely peripheral (rather than cavity) blood, collected away from the site of the trauma. Although the forensic toxicologist agreed with claimant's expert that

¹⁰ The PSOB Office stated that its decision was "based on the information in the record" which included the autopsy reports, the toxicology report, a report from the hospital identifying the cause of death as multiple trauma due to a motor vehicle traffic collision, the report submitted by the local law enforcement agency, and the Claim for Death Benefits submitted by the claimant.

the BAC of serum is .12 – 20% higher than that of whole blood, in this case he opined that the difference would have made the BAC .15 rather than .18 per centum.

The Hearing Officer issued a determination denying benefits. She found that Harper was a public safety officer and that his accident occurred “in the line-of-duty.” However, she concluded that Harper’s BAC of .18%, in the absence of convincing evidence that he was not acting in an intoxicated manner immediately prior to his death, prohibited an award of benefits. In reaching her conclusion, the Hearing Officer found that the forensic toxicologist’s responses provided a satisfactory rebuttal to claimant’s expert’s challenges to the reliability of the .18% BAC. She also credited the statements of the eyewitnesses – the target and his friends – that Harper appeared very drunk, was vomiting, and had slurred speech as they exited the club. She noted that according to the accident report, Harper’s car was estimated to have been traveling at a speed of 57 mph when it became airborne and may have been traveling at a higher speed before it left the highway.

The Hearing Officer commented that although the head of the law enforcement agency that employed Harper testified that he had confidence in Harper’s judgment and believed that because Harper was calling his control officer for help and was wearing his seat belt, he was exercising good judgment prior to the accident, she could not agree. Although she acknowledged that it was necessary for Harper to drink with his target as part of the undercover operation, she took issue with the amount of alcohol he consumed, noting that he had placed himself in serious danger. She also was not persuaded that Harper’s consumption of alcohol was not voluntary because he needed to drink in order to fit in with the target. Citing the policies and procedures of the agency that employed Harper, which allow for the consumption of a “limited quantity” of alcohol, she stated that the “expectation is that the agent will drink in moderation and in accordance with established policies.” Additionally, she found that there was no evidence to support the theory presented by the claimant that Harper was being pursued. Ultimately, the Hearing Officer stated that she must be guided by the plain language of the Act, which given the BAC, required convincing evidence that Harper was not acting in an intoxicated manner immediately prior to his death. She found that “on the contrary, the vomiting and slurred speech support a finding of intoxication.”

c. Director’s Determination

The claimant sought review of the Hearing Officer’s determination by the BJA Director, as the PSOPA provides. Additional documentation was added to the record. This included a supplemental report from claimant’s expert and hospital records responsive to a request from O’Donnell for additional evidence regarding the handling of the blood samples.

O’Donnell issued a 13-page written determination awarding benefits. She found that the claimant’s submissions established that the measured BAC of

.18% "may be artificially inflated" and that it was therefore "unreliable." By how much it was inflated, O'Donnell found unclear. O'Donnell also noted that the claimant's evidence pointed to "possible, but not actual mishandling" of the blood samples by the hospital and laboratory. Recognizing that the evidence "rests on speculation," O'Donnell nevertheless concluded that "the BAC evidence indicates that Officer [Harper] had a BAC level above the .10 threshold, which requires clear and convincing evidence establishing that he was not acting in an intoxicated manner immediately prior to his fatal injury to award PSOB Act benefits."¹¹ She determined that there was such evidence.

O'Donnell stated that because the entire relationship between an officer and his target in an undercover operation rests on deception, and it was "[Harper's] job to make the suspects think that he 'fit in,'" evidence of Harper's general character was more probative than the perceptions of the target and his friends as to whether Harper acted in an intoxicated manner immediately prior to his death. O'Donnell cited several other reasons for giving "little weight" to the statements of the only eye witnesses who testified regarding Harper's behavior. First, she noted that "at least one of the witnesses [the target] was a target in a drug trafficking ring with a criminal record of arrests and jail time" and "the other two [Friend 1 and Friend 2] were associates of the target, and at least one of them reportedly knew that the target sold cocaine." O'Donnell stated, "I find no reason to afford credibility to any of the targets' observations in light of these circumstances."

Second, O'Donnell posited that there "are a host of reasons why" the witnesses' statements "may not be the best indicator of what occurred on the night [in question.]" O'Donnell noted that their statements were taken by police investigating the death of an agent who died after spending the night in a club with them and that "it is quite likely there was a vacuum of trust between the suspects and law enforcement in the interviews." Finally, O'Donnell stated that the statements themselves were "internally inconsistent," noting that one of the target's friends said the target told him a few weeks before Harper's death that he had a "funny feeling" that Harper was an undercover officer. However, during his interview, the target never indicated that he suspected Harper was an officer but had thought of Harper as "a friend."

O'Donnell commented that while "sparse" there were "certain facts establishing that [Harper] undertook his actions with caution, thereby indicating that he was not acting in an intoxicated manner." In support of her determination that there was clear and convincing evidence that Harper was not acting in an intoxicated manner, O'Donnell cited the following:

¹¹ Although section 3796(b)(5) of the Act requires only "convincing" evidence, the regulations define convincing evidence as "clear and convincing evidence." 28 C.F.R. § 32.3. "Clear and convincing" proof is "that proof which results in reasonable certainty of the truth of the ultimate fact in controversy" and "will be shown where the truth of the facts asserted is highly probable." Black's Law Dictionary 251 (6th ed. 1990) (citations omitted).

- (1) Harper declined the target's offer to drive him home. O'Donnell stated that by doing so, Harper preserved his and his roommate's undercover operation, which showed that "operational security was at the forefront of his mind" and demonstrated "tact and lucid thought."
- (2) Harper attempted several times to contact his supervisor after leaving the club. O'Donnell commented that though we may not know specifically why Harper attempted to contact his control officer, she credited the testimony of the head of Harper's agency and claimant's undercover expert that doing so was abnormal and done only when the undercover officer needs assistance. O'Donnell stated that this action indicates that Harper "acted out of self-preservation, and again, a motivation to preserve the undercover operation" which showed "sound judgment."
- (3) Harper wore his seatbelt. O'Donnell found that this reflected "caution and adherence to principles of safety."
- (4) Harper was driving over the speed limit, but he was not driving at a grossly excessive speed. O'Donnell stated that the highway patrol estimated that Harper was travelling at 57 mph on a 4-lane road with a speed limit of 45 mph.
- (5) O'Donnell stated that "a brief look at [Harper's] career supports the conclusion that he was not acting in an intoxicated manner immediately prior to his death." O'Donnell noted that prior to working for the local law enforcement agency, Harper worked as a narcotics officer for a different agency, was in top physical condition, trained twice a day, was recruited to work deep undercover because of his abilities and personality, and had always exhibited sound judgment and good law enforcement skills according to the head of the agency for which Harper last worked. Also, according to his friends, Harper had never been seen drunk because he rarely drank. O'Donnell's stated, "there is nothing in the record to indicate that Harper would have recklessly put his life in danger . . ." and that "engaging in reckless behavior such as consuming alcohol to excess while with three suspects . . . is not consistent with the make-up of undercover officers in general, or [Harper] in particular."

O'Donnell then turned to the questions of whether Harper engaged in intentional misconduct or was performing his duties in a grossly negligent manner, noting that a finding that Harper's actions constituted either would require a denial of benefits. O'Donnell recognized that "[Harper] could be seen to have engaged in intentional misconduct or gross negligence by operating a vehicle under the influence of alcohol." However, she found that he engaged in neither. Rather, she determined that when Harper drove his vehicle after being dropped off by the target, he "was performing that which was required by the undercover operation."

In support of her finding, O'Donnell stated:

The record reflects he was driven to his car by the target and the target's friends. Reportedly, the target insisted on driving [Harper] home. [Harper], though, *could not* accept the offer, as he was living with another officer who was in the midst of his own undercover operation at the time. The target alleged that he returned to the parking lot after leaving [Harper] to offer [Harper] a ride home a second time. [Harper] again refused. [Harper]'s attempts to contact his supervisor – again, an action taken only when the undercover officer is in distress – were unsuccessful.

O'Donnell concluded, "Given these circumstances, I find that [Harper]'s actions were undertaken with a reasonable excuse, and therefore do not rise to the level of intentional misconduct."

Citing the definition for "gross negligence" in the PSOPA regulations, O'Donnell commented that drinking and driving "is certainly a departure from ordinary care, prudence, diligence, or safe practice." However, she found that Harper "operated his vehicle because he felt he had to depart before the target and company returned again." O'Donnell again referenced "the circumstances [Harper] faced," the target of a highly sensitive undercover operation insisting on bringing him to a home shared with another undercover officer, not knowing whether or when the target may return and insist again, and an inability to reach his supervisor" and concluded, "I do not believe this departure was 'great, heedless, wanton, indifferent, or reckless.'"

3. OIG Analysis

Our analytical construct requires us to examine the record and evaluate whether O'Donnell's determination did not substantially comply with the statute and the regulations, was arbitrary and capricious, or was not supported by substantial evidence. O'Donnell made two principal findings to support her determination that benefits were awardable in this claim: (1) that there was convincing evidence that Harper was not acting in an intoxicated manner immediately prior to death (namely at the time of his car accident); and (2) that Harper was in fear of the target and his friends, believed he was in danger, and therefore had a reasonable excuse for driving while under the influence of alcohol. We found that O'Donnell applied each of the relevant portions of the statute and the regulations in making her determination. However, for the reasons set forth below, we found that O'Donnell's findings were arbitrary and capricious and not supported by substantial evidence.

a. O'Donnell's finding that Harper was not acting in an intoxicated manner

To reach the conclusion that there was "convincing evidence" that Harper was not "behaving in an intoxicated manner," O'Donnell offered explanations for her decision that we find ran "counter to the evidence before the [PSOB]," and

“entirely failed to consider an important aspect of the problem.” See *Motor Vehicle Mfrs. Ass’n.*, 463 U.S. at 43. As such, we concluded that there was little evidence, let alone “substantial evidence,” to support her conclusion and that her decision was therefore arbitrary and capricious.

First, and most significantly, O’Donnell’s lengthy written opinion completely ignored perhaps the most critical piece of evidence in the record as to whether Harper was intoxicated immediately prior to the crash: the extraordinary nature of the accident itself. The accident, in which Harper drove his car across two oncoming lanes of traffic, then traveled up onto a sidewalk, down an embankment, through a thicket of vegetation, up another embankment, became airborne, and finally fell into another parked car, is extraordinarily strong evidence that Harper was acting in an intoxicated manner. Moreover, Harper’s vehicle was going 57 mph (the speed limit was 45 mph) when his car went airborne *after* traveling through a thicket of vegetation and hitting an embankment. This is simply not the way a sober person drives. Diagrams created by the state accident investigation team reflect that the accident occurred on a straight portion of the roadway. The state accident investigation team made several additional findings, including that the weather was not a factor and the road was dry, there were no mechanical problems with the vehicle, and that – based on the toxicology reports – the BAC of the driver was .18%, which “is above the legal inference of .10% as prescribed by [state] law.”¹² There was no evidence before O’Donnell that Harper was rendered unconscious at the outset of these events, or other evidence of any external contributing factor explaining the extraordinary nature of this crash besides Harper’s actions or inactions (for instance, no mechanical failure, no other vehicle, no bad road conditions). These circumstances strongly support the inference of impairment that O’Donnell was required to overcome with sufficient other evidence such that the totality was “convincing” evidence that Harper was not acting intoxicated at the time. O’Donnell never even discussed the significance of the crash evidence on the question of whether Harper was behaving in an intoxicated manner. As such, she “entirely failed to consider an important aspect of the problem.”

O’Donnell actually identified the speed of Harper’s car as evidence that Harper was *not* behaving in an intoxicated manner, even though he was driving well above the speed limit. O’Donnell stated that the state highway patrol reconstruction team “estimated that Officer [Harper]’s vehicle was travelling at 57 miles per hour on the 4-lane road where the speed limit was 45 miles per hour” and declared that although Harper was over the speed limit, he was “not driving at a grossly excessive speed.” This finding by O’Donnell misstated the evidence. The evidence was not that Harper was “only” going 57 mph. The evidence was that he was going 57 mph when his car went airborne *after* traveling through a thicket of vegetation and hitting an embankment. Although O’Donnell appeared to acknowledge this in a footnote, she did not explain why

¹² As noted above, the legal limit in [the state] is in fact .08%.

she nevertheless identified Harper's speed of 57 mph in a 45 mph zone as one of the factors that showed he was not acting in an intoxicated manner.¹³

Moreover, we do not understand the implication that speeding is evidence of sobriety merely because the driver theoretically could have been going even faster – which Harper almost certainly was before he left the roadway. We recognize that driving 57 mph in a 45 mph zone is something that both sober and drunk drivers might do, and that speeding at this rate would not be conclusive evidence of acting in an intoxicated manner. However, the Director was required to find clear and convincing evidence that Harper was *not* behaving in an intoxicated manner. While it may be true that driving even more recklessly would provide additional evidence that the driver was intoxicated, we see no basis to believe that speeding at this rate is evidence that makes it *more* likely that the driver was sober than, for instance, if no evidence of his rate of speed were available.

Central to O'Donnell's decision was her near complete rejection of the detailed testimony of the three eyewitnesses who observed Harper's behavior in the hours just before his death. The witnesses testified that Harper consumed many rounds of drinks, appeared drunk, repeatedly vomited, and fell over into the lap of one of them when they were in the car leaving the club. Although not clearly articulated in her determination, O'Donnell offered two principal alternative theories for dismissing the witnesses' accounts: 1) that the witnesses lied in describing the events and Harper's behavior because they are untrustworthy criminals; or 2) that even if the witnesses accurately described what they saw, Harper's behavior was an act designed to gain the confidence of the target. We address these alternatively in order below.

The witnesses' accounts of Harper's behavior were not credible because they were criminals or associates of criminals. In rejecting key aspects of the testimony of all three witnesses, O'Donnell repeatedly and inaccurately characterized all three as "targets" or "suspects" (plural) and alluded to them having criminal histories, stating, "At least one of the witnesses was a target in a drug trafficking ring, with criminal arrests and jail time. The other two were associates of the target, and at least one of them reportedly knew that the target sold cocaine." O'Donnell stated that it was "quite likely there was a vacuum of trust between the suspects and law enforcement in the interviews." O'Donnell referenced the plural "suspects" 17 times and "targets" 12 times in her final determination and concluded that there was "no reason to afford credibility to any of the *targets'* observations in light of these circumstances." (Emphasis added.)

¹³ In footnote 14 of her determination, O'Donnell quoted, but did not elaborate on this aspect of the investigative report, stating, "According to the [state] highway patrol Accident Investigation team, this speed 'does not take into account any reduction of velocity from the point where the vehicle left the roadway prior to becoming airborne.'"

Review of the record makes clear that, while the target had a long criminal history, there is no evidence that either of the target's friends had a criminal history, was suspected of selling drugs, was a "suspect" or "target" of any kind, or participated in any criminal activity. When interviewed by investigators following Harper's death, each was informed at the beginning of his interview that he was not being detained for any reason. Additionally, when asked by the Hearing Officer if the "targets" were arrested, the deputy chief testified, "Yes, the main target was. The other two guys were just kind of peripheral friends of his."¹⁴ In short, O'Donnell's basis for disbelieving the testimony of Friend 1 and Friend 2 – that they were "suspects" or "targets" who therefore had a "vacuum of trust" with law enforcement – was contradicted by the evidence before her and had no basis in fact.

Moreover, although O'Donnell stated that she found no reason to credit *any* of the witnesses' observations, she nevertheless credited at least a portion of the testimony of the target and his friends when it was beneficial to the claimant. In this regard, O'Donnell was selective in what testimony she accepted and what she rejected. As detailed below, a critical fact that O'Donnell cited in support of her conclusion that Harper had an excuse for driving while intoxicated was that the target and his friends "insisted" on driving Harper home and that Harper felt he had to depart before they returned again. This theory depends on O'Donnell believing the testimony of the target and his friends that they repeatedly offered to drive Harper home. If O'Donnell had not credited *any* of the witnesses' observations, as she asserted, she would not have believed the witnesses' statements that they offered Harper a ride several times – a fact that was critical to her conclusion that Harper felt he was in danger and therefore needed to depart before the target and his friends came back. Indeed, if the witnesses were lying or exaggerating about Harper's behavior, and Harper in fact did not behave in an intoxicated manner, then the target would have had no reason to offer him a ride. (They might have had a reason to falsely claim they made such an offer, in order to look good to the police, but there would be no reason to believe them on this fact while disbelieving them on everything else.) The obvious reason for the target to make such an offer was that Harper was acting in an intoxicated manner. Yet O'Donnell provided no justification for believing the witnesses' accounts about offering Harper a ride but rejecting their accounts that he was acting in a manner that would have precipitated their offer.

Harper's apparent intoxication was merely an act, in furtherance of his undercover operation. O'Donnell explained Harper's apparent intoxication in the evening and in the early morning hours the following day as an act designed to gain the confidence of the target of an undercover operation. O'Donnell asserted that Harper pretended to be intoxicated in order to fit in with

¹⁴ Although, as noted above, one of the target's friends admitted that he knew that the target sold cocaine, we do not believe that such knowledge renders his testimony about Harper's behavior inherently untrustworthy, particularly in light of the corroborating evidence in the record, such as the elevated BAC and the nature of the accident itself.

the target and his associates and, thus, the witnesses “were not witnessing reality.” Under this line of reasoning, the witnesses may not have been lying about what they saw but rather were simply deceived by an undercover officer who was just acting drunk in furtherance of his investigation and, therefore, offered him a ride having fallen victim to his deception.

The first problem with this explanation is that it cannot be reconciled with O’Donnell’s finding that Harper’s BAC was above .10%. Moreover, even if O’Donnell was positing that Harper was drunk, but not as drunk as he was acting, it is implausible that Harper would have taken the act to such an extreme. For example, there is no reason why Harper would have felt compelled to repeatedly vomit or fall over into the lap of one of the target’s friends in order to fit in, as there is no evidence that others in the group vomited or had trouble sitting up. Moreover, pretending to be intoxicated to this degree would not have offered Harper any advantage. If anything, it created exactly the type of risk Harper would have wanted to avoid – that the others would become concerned for his safety and insist on taking him home. O’Donnell offers no explanation for why Harper, who she thought had operational security and the preservation of both his and his roommate’s undercover operations “at the forefront of his mind” would have taken such a gamble.

Other issues with O’Donnell’s opinion. As additional support for her conclusion that there was “convincing evidence” that Harper was not “behaving in an intoxicated manner,” O’Donnell relied substantially on the finding that Harper made several attempts to contact his supervisor after leaving the club. According to O’Donnell, Harper’s attempt to contact his supervisor “shows sound judgment and suggests that he sought to further the operation.”

However, the suggestion that Harper made any such attempts to telephone his control officer “immediately prior to” the time of the accident, which would be the relevant time under the statute in assessing his conduct, was specifically denied by the officer himself. Harper’s control officer testified that Harper did *not* call at around 4:00 a.m., just before the accident. Harper’s control officer testified that Harper called him in the early afternoon and later in the evening, “somewhere maybe around midnight, maybe just after midnight.” When asked by claimant’s attorney if he recalled any contacts from Harper “around four something in the morning . . . just before the accident, the control officer answered, “No, it was sometime around midnight when he tried to call me.” The Hearing Officer followed up on this line of questioning:

Q: “And then the next time was closer to the time of his death, is that right?”

A: “No ma’am. . . . Both of those attempts were right back to back.”

. . .

Q: “But he never called you anywhere near the 4:30, four o’clock time frame, 3:30?”

A: "No, ma'am."¹⁵

Although other witnesses testified that Harper attempted to contact his control officer just before the accident, each lacked personal knowledge of the alleged calls and none identified a reliable basis for his testimony. The former undercover FBI agent's testimony in this regard was based on his review of unspecified documentation that he received from claimant's counsel.¹⁶ The head of the local law enforcement agency testified that he "was made aware" that Harper had tried to get in touch with his control officer on more than one occasion and that he knew that Harper tried to contact his control officer "just prior to the accident," but he was not asked and did not provide an explanation of by whom or what he had been informed. Similarly, the deputy chief of the agency's criminal investigations division testified that he understood "that several calls were made just preceding the accident itself." However, the deputy chief did not state how he came to that understanding and when asked, said he did know at what time Harper had made any of the calls or the time of Harper's last call before the accident. O'Donnell provided no explanation for crediting the second-hand conclusory testimony of the head of the local law enforcement agency, the former undercover FBI agent, and the deputy chief of the agency's criminal division that a call was made while ignoring the specific denial of Harper's control officer, the person who would have been called. When the Hearing Officer commented to Harper's control officer that the other officers had indicated that Harper tried to call him at around 4:00 a.m., Harper's control

¹⁵ According to the target, Harper placed a call to someone from the parking lot area as they purchased the food after leaving the club. However, O'Donnell did not address this reference in the record, presumably because she found "no reason to afford any credibility to any of the targets' observations." The record also contains telephone records for the cell phones of several employees of the local law enforcement agency during the relevant time period and the deputy chief's testimony suggested that the call log on Harper's telephone reflected that the target used Harper's phone while the group was at the club. However, no testimony was offered regarding – and O'Donnell did not address – whether the telephone records reflect the number of calls Harper placed to his control officer or the specific times of those calls. We reviewed the available records and could not discern whether, or at what time, Harper attempted to contact his control officer because although the records include a number for an employee whose first name and the first initial of the last name match those of Harper's control officer, there is nothing to verify that the number is in fact Harper's control officer's. There is also nothing in the records we reviewed identifying Harper's telephone number. Moreover, even if one assumes that the number reflected is Harper's control officer's, the records reflect 9:48 p.m. as the time of the last incoming call on October 15, 2003, and 8:49 a.m. as the time of the first incoming call on October 16, 2003. While we recognize that the available records may not capture all of the means by which Harper may have attempted to contact his control officer, it is clear that the available records do not contradict the control officer's testimony that he did not receive a call from Harper near the time of the accident.

¹⁶ The former undercover FBI agent testified that the documents he reviewed indicated that Harper "was trying to contact his supervisor or handler numerous times subsequent to the meeting." However, when the Hearing Officer commented that she was aware of only one call and asked him if he had the document that indicated that there were numerous calls, he stated, "I do not."

officer stated that from his memory, the calls occurred around midnight, and that the two calls around midnight “is what everybody knows about.”¹⁷

As an additional basis for rejecting the witnesses’ statements. O’Donnell identified “internal inconsistencies,” which we did not find supported by substantial evidence in the record. O’Donnell averred, “one witness stated that in the weeks prior to the accident, the primary target revealed that he had a ‘funny feeling’ that [Harper] was an undercover officer . . . though [when interviewed by the police following Harper’s death], the target never indicated that he suspected that [Harper] was an undercover officer” We examined the statements for the asserted inconsistencies.

We note that the target’s friend was asked, “Did you or [the target] ever suspect that the guy was an undercover police officer?” and responded that approximately 2 to 3 weeks earlier, the target told him that he suspected Harper may be an undercover officer. The target’s friend also told police that he didn’t think the target really believed Harper was an officer because the target continued to hang around with Harper and did not say specifically why he thought Harper may be an officer, but only that he had a “funny feeling” about him.

The target, however, was not asked whether he had ever *suspected* that Harper was an undercover officer. The target was asked a different question, “When did you *realize* that [Harper] *was* a police officer?” The target responded that he realized Harper was an undercover officer when the control officer told him; when he was told that he had sold to an undercover officer and that prior to that, he had thought of Harper as a friend. Hence, while the target’s statement to the police that he thought of Harper as a friend may be somewhat inconsistent with his statement to his friend a few weeks earlier that he had a “funny feeling” that Harper may be an undercover officer, it is not, in our view, of such a consequence to render the witnesses’ statements wholly unreliable.

In sum, we find O’Donnell’s reasons for rejecting the statements of the witnesses who observed Harper’s behavior immediately prior to his death extremely weak given the evidence that supports a finding that Harper was

¹⁷ O’Donnell identified two other actions that Harper took “with caution, thereby indicating that he was not acting in an intoxicated manner”: 1) he declined the target’s offers of a ride home, thereby preserving his undercover operation; and 2) he wore his seatbelt. While O’Donnell’s speculation about Harper’s thinking is plausible, she did not address the equally plausible theory that Harper’s decision to refuse a ride home reflected impaired judgment from intoxication. As news reports regularly reflect, many intoxicated drivers, even those who are extremely intoxicated, attempt to drive home in the mistaken belief that they will be able to do so safely. Moreover, while no doubt a good safety measure, putting on a seatbelt does not equate with sobriety. For example, National Highway Traffic Safety Administration (NHTSA) data shows that in 2007, one-third (approximately 34%) of alcohol-impaired (BAC of .08+%) drivers and motorcyclists involved in fatal crashes were wearing their seatbelts/helmets. NHTSA, “Travel Safety Facts: 2007 Traffic Safety Annual Assessment — Alcohol-Impaired Driving Fatalities,” Aug. 2008, <http://www-nrd.nhtsa.dot.gov/Pubs/811016.PDF> (accessed Nov. 10, 2015).

indeed intoxicated. This evidence includes the fact Harper was not an experienced drinker, was drinking heavily well into the early morning hours, had an elevated blood alcohol level of well over .10 per centum, and was involved in an extraordinarily serious and prolonged car accident in which he tragically was killed. Hence, we believe that the conclusion underlying O'Donnell's decision that there was "convincing evidence" that Harper was not "behaving in an intoxicated manner" prior to the accident was arbitrary and capricious based on the record before her. We also do not believe that there was "substantial evidence" sufficient to persuade a reasonable mind of this conclusion.

b. O'Donnell's finding regarding whether Harper committed intentional misconduct or performed his duties in a grossly negligent manner

In order to find in favor of the claimant, O'Donnell was also required to find that Harper did not commit intentional misconduct or perform his duties in a grossly negligent manner by driving while under the influence of alcohol. As noted above, although O'Donnell questioned the accuracy of the .18% blood test, she concluded that Harper's blood alcohol level was at least .10%, above the threshold level for intoxication under the statute. Driving at this level of intoxication would violate the local state law as well.

O'Donnell posited that Harper believed he was in danger, was unable to reach his supervisor and, therefore, was required to drive himself in order to preserve the undercover operation. In focusing on Harper's "excuse" for driving drunk, O'Donnell ignored that he committed misconduct by allowing himself to become intoxicated in the first place. The head of the local law enforcement agency that employed Harper testified that the agency instituted written policies regarding the use of alcohol by undercover officers during his tenure. The relevant portion of the policy states that, officers in plain clothes, with the consent of their supervisor, may drink "*limited quantities*" while on duty when "necessary to accomplish the mission." (Emphasis added). Significantly, there is no exception in the policy that allows an officer to drink more than "limited quantities" of alcohol as part of an undercover operation.

It is undisputed that Harper drank enough to have a BAC of at least .10%, and as much as .18%, at the time of the crash. It would be unreasonable to interpret "limited quantities" to permit the consumption of so much alcohol that driving would be illegal, especially during an operation in which Harper drove to the scene and would obviously anticipate that he would be driving home.

O'Donnell apparently believed that Harper was forced to drink the amount he did by operational necessity. While we understand the need to preserve his undercover identity, if Harper felt pressured to drink more than a "limited quantity," he had the option, if not the obligation, to abort the operation and leave before he became intoxicated. Under applicable policy and pursuant to common sense, however, he did not have the option or the excuse of drinking to

the point that driving would be illegal, and put himself and potentially others at risk. O'Donnell completely failed to address this significant point.

Because the evidence established that Harper committed misconduct before he even left the club, the question of whether he had an excuse to drive is beside the point. However, we found that O'Donnell's apparent determinations that Harper believed he was in danger, was unable to reach his control officer and, therefore, was required to drive himself, were not supported by substantial evidence. Much of her analysis was based on speculation about Harper's state of mind. Also, again, this reasoning depends in large part on the finding that Harper attempted to contact his control officer at around 4:00 a.m., which the control officer himself denied and there is no documentary or non-conclusory testimonial evidence that contradicts him. In short, we conclude that O'Donnell's analysis of Harper's decision to drive while impaired was arbitrary and capricious and not supported by substantial evidence.

We find O'Donnell's conclusion that Harper believed he was in danger and "felt that he had to depart before the target and company returned again" to be based largely on speculation and conjecture. Although she acknowledged in a footnote that the local law enforcement agency's investigation "was unable to resolve whether [Harper] felt he was in danger," O'Donnell found that he did. In so finding, O'Donnell credited the testimony of the former undercover FBI agent, who testified that Harper's actions reflected a belief that his safety was at serious risk. Three principal assumptions underlie O'Donnell's finding on this point: that the target and his friends "insisted" on taking Harper home and may have followed Harper; that Harper made multiple attempts to contact his control officer after leaving the club; and that Harper would not have attempted to contact his control officer unless he was in trouble. A review of the evidence of record reveals that there is no probative, fact-based support in the record for these assumptions.

The record does not reflect that the target pressured Harper to accept a ride home. The concept that the target "insisted" on driving Harper home was introduced by O'Donnell through her characterization of the evidence. According to the target's statement, after dropping off Friend 1, he and Friend 2 drove Harper to his car, but offered to take Harper home because they were concerned that Harper was too intoxicated to drive. The target's statement indicates that as he was pulling out of the parking lot, he immediately turned his car around at the suggestion of Friend 2 and talked to Harper again about whether he needed a ride. However, to support her finding that Harper believed he was in danger, O'Donnell stated that the target "insisted" on giving Harper a ride.¹⁸

¹⁸ As noted above, O'Donnell does not explain why she accepted, to the point of exaggeration, the witnesses' testimony about offering Harper a ride home after having rejected their testimony about how Harper was acting that would have led to the offer. O'Donnell also concluded that, even if the witnesses were candid in their descriptions of Harper's behavior, he was just putting on an "act" in furtherance of his operation. However, she failed to explain why it would make sense for him to take that act to such an extreme (vomiting or even arguably

(Cont'd.)

The theory that Harper was “in trouble” and may have been followed by the target was introduced by claimant’s counsel at hearing. The claimant testified that Harper had told her that he intended to spend the night at her house and that the accident occurred approximately a mile past where, based on his direction of travel, Harper would have logically turned to go to her home. Counsel for claimant then asked, if it was “possible he was – he didn’t make the turn because he was being chased or do you know?” The claimant, who also testified that Harper was “very discreet” and did not talk about his work much answered, “I would assume that would be the only reason why. I guess he was in trouble.” However, claimant’s counsel laid no foundation for her testimony regarding police matters or Harper’s interactions with the target or, specifically, any reason to believe that he was being chased or actually in trouble as opposed, for instance, to being drunk and accidentally driving past the turn to her residence – a theory that seems to us at least equally plausible.

Furthermore, there is no objective evidence to suggest that Harper was being followed. The State Highway Patrol’s primary investigating officer testified that there was no indication in the investigative report that Harper’s vehicle was being pursued. Similarly, the head of the local law enforcement agency testified that with the exception of Harper purportedly having placed the speculative early morning phone call, “we don’t have any evidence of pursuit.”

With regard to that purported call, as discussed at length above, the record is devoid of any direct or reliable evidence that Harper made several attempts to call his control officer after he left the club. Again, in finding that he did, O’Donnell relied on the assumptions and beliefs of witnesses who had no direct knowledge of Harper’s actions. Furthermore, as noted above, those beliefs and assumptions were rebutted by the control officer himself, who presumably would have been in the best position to know.¹⁹

O’Donnell’s finding that Harper did not commit misconduct and was not grossly negligent was not supported by substantial evidence. She ignored the fact that Harper clearly violated applicable policy by drinking more than a “limited amount” at the club. Because she “entirely failed to consider an important aspect of the problem,” we believe her decision was arbitrary and capricious. *See Motor Vehicle Mfrs. Ass’n.*, 463 U.S. at 43. Moreover, her finding that Harper had a reasonable excuse for driving with a BAC over the

pretending to vomit repeatedly and falling over) that the three witnesses would feel compelled to “insist” on driving him home.

¹⁹ The evidence of record was contradictory on the question of whether Harper’s purported attempt to make a call to his control officer just before the accident suggested Harper was in trouble. The former undercover FBI agent and the head of the agency for which Harper worked testified that they believed that this was the case. However, Harper’s roommate, a fellow undercover narcotics agent, testified that it was “normal” for them, as undercover officers, “to call our – what we call our contact agent to advise them of our whereabouts after we have been – after we depart from a location.” In any event, as noted above, there was no direct or reliable evidence in the record that Harper attempted to call his control officer after he left the club.

legal limit is legally untenable, and factually unsupported by any direct, relevant evidence. Rather, it rests in large part on the assumption that Harper attempted to call his control officer and that his call shows he felt he was in danger. However, because there was no direct or reliable evidence in the record before O'Donnell that Harper attempted to make such a call, it cannot be said to be supported by substantial evidence. As noted above, substantial evidence is defined as "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." Case law supports our conclusion that speculation and conjecture do not constitute substantial evidence. "Speculation does not constitute substantial evidence." *Univ. of S. Carolina v. Univ. of S. California*, 367 F. App'x. 129 (Fed. Cir. 2010), *citing Novosteel SA v. United States*, 284 F.3d 1261, 1276 (Fed. Cir. 2002) (Dyk, J., dissenting) ("It is well established that speculation does not constitute 'substantial evidence.' "). See also *Tommasetti v. Astrue*, 533 F.3d 1035, 1042 (9th Cir. 2008) (ALJ's "own speculation" does not constitute substantial evidence supporting ALJ's conclusion).

c. Conclusions Regarding Harper

We are not unmindful of the difficult circumstances that O'Donnell had to address in this case, with a well-regarded law enforcement agent tragically dying while indisputably in the line of duty and after doing something, drinking, with which he was not experienced and making that and subsequent decisions that he may well have believed were necessary to maintain a law enforcement operation and to protect his own cover. But under the PSOPA acting in the line of duty is the beginning of the analysis, not the end, and even assuming that Harper was motivated solely by a desire to protect the undercover investigation, the PSOPA does not provide any exception for agents who are killed while driving intoxicated in the line of duty, or who engage in intentional misconduct or grossly negligent conduct in the line of duty. Operational necessity, even if it existed – a point that the evidence did not support in our view – does not permit recovery under the statute.

Therefore, even applying the very deferential standard we utilized in this review, we found that O'Donnell's decision to grant the Harper claim was flawed. Review of all of the evidence of record reveals that O'Donnell minimized, ignored, or sought to discredit the direct evidence – the eye witness accounts, the evidence from the accident investigation, and the blood alcohol analysis – while crediting contradicted hearsay and testimony based on speculation in reaching her conclusion that officer Harper was not acting in an intoxicated manner immediately prior to his death and neither engaged in intentional misconduct nor performed his duties in a grossly negligent manner. Several of O'Donnell's findings were directly contradicted by the evidence and she failed to consider key evidence relevant to the decision before her. Accordingly, while procedurally compliant, we found that O'Donnell's conclusions were arbitrary

and capricious and not supported by substantial evidence, and concluded that O'Donnell granted the claim improperly.²⁰

B. Mark Davis Claim

In the Mark Davis case, BJA Director O'Donnell approved an award of death benefits to the widow of a firefighter who suffered a stroke while conducting emergency response activity and died of another stroke 6 days later.²¹ As detailed below, the Davis claim required O'Donnell to make findings about the role of bacterial endocarditis in causing Davis's death. In reaching her decision, O'Donnell agreed with the conclusions of the Hearing Officer and a Special Master that she had appointed. The complaint to the OIG did not identify specific objections to O'Donnell's *final* determination, but rather attached a memorandum identifying several objections to her *proposed* determination concurring with the Hearing Officer's decision to award benefits based on the evidence in the record prior to the appointment of the Special Master. The memorandum asserted that the claim could not lawfully be paid under the record as then constituted.

1. Applicable Statutory Provisions

With the passage of the Hometown Heroes Survivors' Benefits Act of 2003, officers who suffer heart attacks, strokes, or vascular ruptures while engaging in non-routine stressful or strenuous physical activity on duty or within 24 hours of being on duty, are entitled to a presumption that they have sustained a line of duty personal injury. Pub. L. 108-182, § 2 (Dec. 15, 2003); 42 U.S.C. § 3796(k). The presumption may be overcome by competent medical evidence that establishes that the heart attack, stroke, or vascular rupture was unrelated to the officer's line of duty activity or was caused by something other than the mere presence of cardiovascular-disease risk factors. 42 U.S.C. § 3796(k)(3). "Competent medical evidence to the contrary" is defined as evidence indicating to a degree of medical probability that extrinsic circumstances, considered in combination or alone, were a substantial factor in bringing about the heart attack or stroke. 28 C.F.R. § 32.13.

2. Facts

The Davis matter involved the Chief of a Volunteer Fire Department in a small town who responded to a mutual aid call from a neighboring community following a natural disaster. He and another firefighter drove around in a fire

²⁰ After reviewing a draft of this report, O'Donnell submitted a comment in which she stated that our conclusion that her decision in this case was arbitrary and capricious "suggests that [she] acted in bad faith." Although we determined that O'Donnell granted this claim improperly, we found nothing to indicate, and did not conclude, that she acted maliciously, had a dishonest purpose, or otherwise acted in bad faith. We have attached O'Donnell's response to our draft as Appendix A to this report.

²¹ Mark Davis is a pseudonym.

truck checking for downed power lines and trees, and checking homes for people in need of assistance. During their approximately one and one-half hour trip, Davis, who was wearing personal protective equipment that weighed 25-30 pounds, got out of the truck several times to move tree branches and other debris from the roadway and to walk up bluffs to homes to check on residents. At some point during their trip, the other firefighter found Davis sitting on the ground. Davis said he had "either gotten dizzy or tripped over something." The other firefighter, who is also an emergency medical technician, noted that Davis' speech was slurred and that Davis was having difficulty using his left arm. The other firefighter gave Davis oxygen to assist with his breathing for 4 -5 minutes and later stated his belief that Davis had likely suffered a mild stroke. Medical assistance was not called to the scene. Although urged to do so, Davis refused to go to the hospital. He continued with work activity (traveling to a command post or staging area), and drove himself home later that evening.

The next day, Davis called in sick. The second day after responding to the mutual aid call, Davis collapsed and was taken to a hospital where he was diagnosed as suffering an acute stroke and eventually placed in the Intensive Care Unit. Medical evaluation revealed a history of dental abscesses 2 months before the stroke, a heart murmur, an elevated white blood cell count, and blood cultures positive for a bacterium that causes endocarditis and is associated with dental abscesses. Davis was later diagnosed with and treated for bacterial endocarditis.

The medical literature of record describes endocarditis as an inflammation of the endocardium, the lining of the inside of the heart that is most commonly caused by bacterial infections, particularly the varieties that normally reside in the mouth. Blood clots form in the damaged areas of the endocardium, trapping infectious microorganisms, which multiply and cause further infection. According to the literature, the clots or clumps of microorganisms can break off, travel through the blood stream, and block major blood vessels in the lungs (resulting in pulmonary embolisms), or in the brain (causing strokes).

Although Davis had begun to show signs of improvement in the hospital, he suffered a major stroke and died 6 days after responding to the mutual aid call. No autopsy was performed. The death certificate lists the cause of death as bacterial endocarditis.

Davis's family filed a PSOPA claim for survivor's benefits 7 months after Davis's death. The final processing of this claim took more than 5 years.

Approximately 11 months after the claim was filed, a PSOB Office benefits specialist denied the claim. The denial was based, in part, on an independent medical review by Dr. A, a PSOB-retained forensic pathologist, who determined that the medical records indicated that Davis died as the result of a stroke caused when bacterial emboli (clots or clumps of bacteria) traveled to the brain restricting blood flow and that medical documentation, including results of carotid ultrasound studies, did not support that the stroke was due to stenosis

(narrowing) of the vessels to the brain. In his report, Dr. A stated that he found documentation of a heart murmur, positive bacterial cultures, and the diagnosis on the death certificate of bacterial endocarditis to be strongly suggestive of an infected heart as the source of the stroke. Doctor A concluded that Davis suffered from "an infectious medical condition which was not associated with a line of duty injury."

The PSOB Office benefits specialist determined that Davis's death was not covered by the presumption established by 42 U.S.C. § 3796(k). The PSOB Office benefits specialist found that the record indicated to a degree of medical probability that extrinsic circumstances were a substantial factor in bringing the stroke about and, accordingly, any presumption raised under section 3796(k) had been overcome. The PSOB Office benefits specialist adopted the conclusion of the death certificate and the independent medical reviewer that bacterial endocarditis, which was not the result of line of duty activity, was the cause of death and hence, that the claim should be denied. The following month, Davis's family requested that a Hearing Officer review the claim.

A hearing before Hearing Officer James Kennedy, M.D., J.D., was held approximately two and a half years after Davis's death.²² Several fact witnesses testified, including Davis's wife and the fire fighter who accompanied Davis in responding to the mutual aid call. As we were told is common at PSOB claims hearings, no testimony was taken from medical experts.

The Hearing Officer issued a determination awarding the claim 10 months after the hearing. The Hearing Officer found that Davis died of a massive stroke not caused by bacterial endocarditis and that the presumption of 42 U.S.C. § 3796(k) was implicated. Focusing on the fact that Davis's echocardiogram results did not show vegetations indicative of endocarditis, an electrocardiogram EKG showing the electrical activity of the heart to be within normal limits, a chest x-ray showing a normal heart size, the lack of evidence of septic emboli in the fingertips (Janeway lesions/Osler nodes), and Davis's treating physicians' several references to bacterial endocarditis as only the "most likely" etiology of his stroke, the Hearing Officer stated that he was "not persuaded by the rendered diagnosis of bacterial endocarditis."²³

The Hearing Officer commented that Dr. A had erred in following the logic of the treating physicians and concluding that bacterial endocarditis existed despite the lack of evidence of bacterial vegetations on the echocardiogram. Hearing Officer Kennedy also found it "of primary significance" that one of the

²² James Kennedy is a pseudonym.

²³ Vegetations are wart-like projections or clots composed largely of fused blood platelets, fibrin, and sometimes bacteria, adherent to the endocardium of a diseased heart valve. Stedman's Medical Dictionary 1692 (25th ed. 1990); Taber's Cyclopedic Medical Dictionary 2117 (17th ed. 1989).

cardiologists who treated Davis in the hospital, Dr. B, had expressed surprise over not finding vegetations on the echocardiogram.

The Hearing Officer found that the onset of the stroke that led to Davis's death began with his "exceptionally strenuous exertion while on duty" and that "this exertion alone, regardless of the presence of an underlying disease process, could be sufficient to produce reduced blood flow to the brain and [the] resultant stroke." Ultimately concluding that there was insufficient evidence to establish that bacterial endocarditis was a substantial factor in bringing about Davis's stroke, the Hearing Officer determined that more likely than not, Davis's "exceptional exertion while rendering [sic] mutual-aid assistance" on the day in question resulted in the initial stroke which continued to propagate and culminated in his death [6 days later]."

O'Donnell began her review of the Hearing Officer's approval of the claim pursuant to 28 C.F.R. § 32.53(a) 9 months after the Hearing Officer's determination was issued. Simultaneously, OGC reviewed the file and the Hearing Officer's determination in order to provide legal advice to the BJA Director, and when appropriate, concurrence with her proposed determination.²⁴

Shortly after O'Donnell began her review, a report was issued by another forensic pathologist, Dr. C, who provided a medical review of the case at the request of OGC. Dr. C opined that Davis died of complications of a stroke, finding that Davis suffered at least three strokes: a small stroke while on the mutual aid call; an additional stroke at home 2 days later; and a lethal stroke 6 days after the responding to the mutual aid call and while he was admitted to the hospital. Dr. C stated a "clinical impression" that Davis's heart was showering emboli to his brain from bacterial endocarditis and that another stroke occurred as each bolus of infected material broke off from the infected heart valve. Dr. C stated that the smaller strokes, more likely than not, contributed in some way to the large, lethal stroke, but that "their influence, however, may have been relatively minor in that an unrelated bacterial embolus may have been the main trigger."

Dr. C also commented, "without the benefit of an autopsy, the diagnosis of bacterial endocarditis remains presumptive," noting that several factors supported the diagnosis (presence of fever, elevated white blood cell count, blood cultures positive for a bacterium that causes endocarditis and is associated with dental abscesses, and the heart murmur), while several factors militated against it (negative cardiac imaging studies, lack of physical findings typically associated with endocarditis – such as Osler nodes and Janeway lesions – and the fact that Davis didn't appear ill prior to the first stroke). Dr. C stated that if endocarditis was present, it caused the strokes. Dr. C found the

²⁴ See OJP Order 1001.5A (Mar. 11, 2010) which required concurrence of OGC for the Director's Determination and is described more fully in Section II A.1. above. According to the Director of the PSOB Office, the General Counsel and legal advisors at OGC met regularly with the BJA Director to discuss the merits of cases under the Director's review.

neuroimaging studies “highly suggestive” of an embolic etiology for the strokes and the blood cultures “compelling” for endocarditis. He also found the absence of valvular disease on the heart images (echocardiograms) “problematic for this diagnosis,” and commented, “but I have seen many false negative imaging studies over my career and [echocardiograms] have a 15% false negative rate in endocarditis.” Dr. C stated that based on the totality of the findings, it was his opinion, more likely than not, that bacterial endocarditis was present and was the underlying cause of death. However, in response to the question of whether the stroke would have occurred in the absence of bacterial endocarditis, Dr. C wrote, “it is not disputable that multiple strokes occurred. Therefore, if there was no endocarditis, they would have happened anyway.”²⁵

Nine months after beginning her review, O’Donnell forwarded a memorandum to OGC requesting that OGC prepare a draft Director Determination awarding benefits. In the memorandum, O’Donnell briefly recited the procedural history of the claim, noted that the Hearing Officer had approved the claim, that OGC had recommended that she deny the claim during one of their briefings, and stated that after careful review of the record and multiple briefings by OGC, she concurred with the Hearing Officer. O’Donnell characterized the issues in dispute as “factual in nature” and identified the principal question as whether the Hometown Heroes presumption applied. O’Donnell concluded that it did and that there was not competent medical evidence to the contrary sufficient to rebut the presumption.

O’Donnell commented that the Hearing Officer was a trained cardiologist who had rejected endocarditis as the cause of death due to insufficient medical evidence and instead concluded that Davis died of a stroke caused by “exceptionally strenuous exertion while on duty.” O’Donnell stated that she had reviewed the opinions of Drs. A and C but had found Dr. Kennedy’s (the Hearing Officer’s) analysis “the most comprehensive and ultimately, the most persuasive.” She found his analysis to be well-supported by the record and noted that he did not rely solely on the results of the echocardiogram in rejecting the endocarditis diagnosis, but had cited other factors such as the normal heart size and the lack of septic emboli in the fingertips as evidence that endocarditis was not present. Noting that the standard of proof “is simply ‘more likely than not,’” O’Donnell concluded that there was sufficient evidence to find that “[Davis] died of a massive stroke triggered by his emergency response duties” and that there was “not competent medical evidence to the contrary to sufficiently rebut the Hometown Heroes presumption.”

About 2 months later, OGC responded with a memorandum critiquing O’Donnell’s analysis and conclusions.²⁶ This memorandum, which is described

²⁵ We found this to be an odd comment given Dr. C’s findings that endocarditis caused the strokes.

²⁶ The copy of OGC’s memorandum we received was undated. However, O’Donnell identified the date of the memorandum in her response to it.

more fully below, argued that the Hearing Officer had improperly served as both an expert witness and as the finder of fact. It also argued that there was insufficient evidence to conclude that the first stroke, which occurred during Davis's emergency response activity, was the proximate cause of the fatal stroke 6 days later. The memorandum emphasized the record evidence suggesting that bacterial endocarditis was the proximate cause of the fatal stroke.

O'Donnell responded to the memorandum's critique by referring the matter to a Special Master pursuant to 28 C.F.R. § 32.54. O'Donnell asked Dr. Kennedy to serve as a Special Master to "further develop the facts, gather relevant evidence (including medical evidence), and recommend factual findings." O'Donnell stated that Kennedy's "expertise in this area, particularly in light of [his] previous work on this matter, is particularly well-suited for this assignment." Kennedy accepted the assignment.²⁷

Eleven months later, Kennedy issued a report recommending that the claim be awarded. Kennedy explained that in reaching his conclusions, he had reviewed relevant medical literature, the opinion of Dr. A, and additional opinions from Drs. B and C.²⁸ Kennedy identified the central issue as whether Davis's death "was, in fact, the direct and proximate result of bacterial endocarditis."

In support of his recommendation to award benefits, Kennedy applied standards he identified as "the Duke criteria," which he described as "the

²⁷ Pursuant to the regulations, the Director may refer any claim before him "to a Hearing Officer (as a special master), to recommend factual findings and dispositions in connection therewith." 28 C.F.R. § 32.54. The regulations do not specifically address whether the appointment of a Hearing Officer who previously reviewed the claim to serve as the Special Master is prohibited. It is not clear from the information available how often it is done.

²⁸ In a response to an inquiry from Kennedy concerning the cause of death, Dr. B stated that although Davis's clinical presentation had caused him to be surprised to find no vegetations on Davis's echocardiogram, he had reviewed more than 30,000 echocardiograms during his career and had seen only a dozen or two valvular vegetations. Dr. B commented further that vegetations are not found on transthoracic echocardiograms of most people with vegetative endocarditis, noting that it is logical that many embolize (break loose) and are therefore not seen. Dr. B concluded by reiterating the opinion he held as Davis's treating physician that "Mr. Davis indeed died as a direct result of stroke from embolization from his heart valves."

Dr. C provided a supplemental "Question/Answer" report 8 months after Kennedy began his review. In it, he commented that Davis's was a "complicated case" and opined that the worsening of Davis's symptoms at the hospital, "either represents an extension of the stroke from the [stroke Davis suffered while on duty] or a new, major stroke." Dr. C also stated, "in my opinion, more likely than not, the stroke [that Davis suffered while on duty], contributed, at least in part, to his subsequent strokes by rendering the brain tissue in the area susceptible to further injury" and that "based on the records provided . . . [Davis's] strokes seem to be related to multiple emboli to his brain secondary to bacterial endocarditis." Dr. C reiterated his belief that endocarditis was present in Davis's case and stated, "there was a strong clinical impression of bacterial endocarditis as the underlying disease process that result in his clinical presentation and death, despite the fact that imaging studies of the heart were not confirmatory." He opined that bacterial endocarditis was the "proximate cause" of death.

internationally accepted criteria for [the] diagnosis of infective endocarditis."²⁹ Kennedy determined that Davis had only one of the major criteria (positive blood cultures) and "one or perhaps two" of the minor criteria (a vascular phenomenon [a stroke], and predisposition [heart murmur]). Hence Kennedy found that Davis did not meet the criteria for a definite diagnosis of bacterial endocarditis, and given what he described as "alternative diagnoses . . . to explain the evidence that may have suggested . . . endocarditis," ultimately concluded that Davis did not suffer from the condition. Acknowledging that there was at least some evidence in support of an endocarditis diagnosis, Kennedy stated that "even if the possibility exists, the evidence does not support a conclusion that more likely than not, Mr. [Davis] did, in fact, have endocarditis which caused the stroke." On the question whether the initial stroke was responsible for Davis's death, Kennedy noted that Dr. C had opined that it had contributed, at least in part, to Davis's subsequent strokes by weakening his brain tissue.³⁰ On this basis, he concluded that "the stroke Mr. [Davis] suffered [], at the [natural disaster] site, directly and proximately caused his death."

Director O'Donnell issued her determination awarding benefits about a week after Dr. Kennedy made his recommendation. In so doing, she stated that with the exception of the issues specifically addressed in her determination, she adopted the Hearing Officer/Special Master's analysis and conclusions as her own. She credited his *de novo* review of the claim with uncovering "crucial factual inconsistencies not apparent during the PSOB Office's initial review of the claim" and stated that "his careful analysis of the inconsistencies led to his recommendation that the claim be approved." O'Donnell stated that she was writing separately "to address the difficult factual questions presented by this claim and to apply the Hometown Heroes Act (as amended by the Dale Long Public Safety Officers' Benefits Improvement Act of 2013[sic]) to those facts."³¹

²⁹ Citing a March 1994 article in the American Journal of Medicine, Kennedy described the criteria as discussing three diagnostic categories for endocarditis: "(1) 'definite' by pathologic or clinical criteria, (2) 'possible' and (3) 'rejected.'" Kennedy stated that the categories are "defined by two 'major criteria' (typical blood culture and positive echocardiogram) and six 'minor criteria' (predisposition, fever, vascular phenomena, immunologic phenomena, suggestive echocardiogram, and suggestive microbiologic findings)." According to Kennedy, "definite" endocarditis can be diagnosed based on the presence of two major criteria, or one major criterion and three minor criteria, or five minor criteria.

³⁰ Dr. B similarly opined that the stroke Davis suffered while responding to the mutual aid call contributed to Davis's death, stating in his report that damage from the first stroke "subsequently caused disruption of blood vessels within the brain tissue that led to his death."

³¹ As noted above, the Hometown Heroes Act amended the PSOBA to provide that if a public safety officer dies as the direct and proximate result of a heart attack or stroke sustained in the line of duty or within 24 hours of performing line of duty activities, that officer shall be presumed to have died as the direct and proximate result of a personal injury sustained in the line of duty, absent competent medical evidence to the contrary. 42 U.S.C. § 3796(k). The Dale Long Public Safety Officers' Benefits Improvement Act of 2012 restated the presumption (and what is required for the presumption to be overcome), and broadened the presumption to include vascular ruptures. Pub. L. 112-239 § 1086 (Jan. 2, 2013).

O'Donnell made the focus of her determination the presence or absence of bacterial endocarditis, commenting that she had "requested that the Hearing Officer serve as Special Master . . . to conduct additional fact-finding to resolve any confusion surrounding this issue." Noting that the Special Master had recommended a finding that Davis suffered a stroke while on duty, directly and proximately resulting in his death, and that this stroke was not directly and proximately caused by bacterial endocarditis, O'Donnell stated and that she was deferring to the Special Master's recommended findings of fact in rendering her decision. She also noted that independent forensic pathologist Dr. C, had examined the record, particularly as it related to the presence of bacterial endocarditis, and had stated in his report "that endocarditis was a presumptive diagnosis and that there was medical evidence both for and against this diagnosis."

Deferring to the Special Master's factual findings and applying the amendments to the PSOPA, O'Donnell found that, on the day in question, Davis "engaged in a situation involving nonroutine stressful or strenuous physical emergency response activity, and that he died as a direct and proximate result of a stroke suffered while so engaging." Furthermore, she "did not find that Mr. [Davis]'s stroke was unrelated to his engagement or that it was directly and proximately caused by something other than the mere presence of cardiovascular risk factors." O'Donnell concluded her determination by stating that after conducting a review of the Hearing Officer's determination approving benefits and the Special Master's recommended findings of fact, "I adopt those findings as my own and find that Mr. [Davis] died as the direct and proximate result of an injury sustained in the line of duty. Accordingly, the Claimant's claim for benefits is approved."

3. OIG Analysis

The complaint did not identify specific objections to the Director's Determination in the Davis matter. Instead, a copy of the OGC's memorandum to O'Donnell described above was attached thereto. That memorandum outlined the history of OGC's communications with Director O'Donnell about the claim and identified several objections to the Director's proposed determination concurring with the Hearing Officer and awarding benefits.

The memorandum explained that OGC's advice was not that the claim be denied, but rather, "although an ultimate determination of approval may not necessarily be precluded by any evidence now before BJA, under the record as currently constituted, the claim lawfully may not be paid." The memorandum expressed concerns about several aspects of the Hearing Officer's determination. To address some of these concerns, the OGC memorandum proposed that follow up questions be posed to Dr. C, the independent medical reviewer, to clarify any ambiguities in his opinion. The memorandum's principal assertions were:

- The Hearing Officer (Dr. Kennedy) improperly based his determination on his own medical analysis of the record evidence, because the Hearing Officer could not serve as both an expert witness and the finder of fact.
- Application of the Section 3796(k) presumption was improper absent evidence that the first stroke (which occurred within 24-hours of the covered activity) was the direct and proximate cause of the fatal stroke 6 days later. Further evidence was needed to determine whether damage from the first stroke was sufficient to cause the death, and whether other factor(s) contributed to so great a degree as the first stroke.

a. Kennedy's Reliance on His Own Expertise

In support of the proposition that Dr. Kennedy could not rely on his own medical expertise in his capacity as Hearing Officer, the OGC memorandum referenced 28 C.F.R. § 32.5(c), the regulation expressly incorporating specific Federal Rules of Evidence into PSOPA proceedings. Among the evidentiary rules incorporated by this regulation is Federal Rule of Evidence 702, addressing when an expert may offer testimony. However, Rule 702 does not address the capacity of a fact finder to rely on his own opinion, based on his knowledge, skill, experience, training, and education, in the matter over which he is presiding. The memorandum also stated, "Among other things, the conflict in such a case would be manifest . . . akin to a person filing the roles of prosecutor *and* judge in the same case." We found this analogy inapt. Dr. Kennedy was not acting as both an advocate for one of the sides and as a judge in the same case. We believe that a more apt analogy would be to a judge who is not precluded from relying on his own legal expertise to determine the outcome of a disputed issue of law.

Moreover, agency administrative proceedings are often "inquisitorial" rather than "adversarial" in nature. See *United States v. Loughner*, 672 F.3d 731, 762 (9th Cir. 2012) citing *Sims v. Apfel*, 530 U.S. 103, 110-11, 120 S. Ct. 2080 (2000) ("Social Security proceedings are inquisitorial rather than adversarial."); *Walters v. Nat'l Ass'n of Radiation Survivors*, 473 U.S. 305, 309-11, 105 S. Ct. 3180 (1985) (explaining that the Veterans' Administration benefits system is not an "adversary mode"). In the inquisitorial mode, the judge or decision maker is an inquisitor who actively engages in the solicitation and production of the evidence, often calling and posing questions to witnesses. In the adversarial mode, the hearing officer or judge is a neutral decision maker who makes a decision based on the evidence and arguments presented by the parties. *Id.* In some instances, the statutes or implementing regulations for administrative adjudication directly state that the adjudicator is appointed for and expected to rely upon his personal expertise. See, e.g., Procedures for Involuntary Administration of Psychiatric Medication, Bureau of Prisons, Department of Justice, 28 C.F.R. § 549.46(a)(4) ("The hearing is to be conducted by a psychiatrist other than the attending psychiatrist, and who is not currently involved in the diagnosis or treatment of the inmate."); and

Professions of the Healing Arts, Grounds for license denial, suspension or revocation - Reporting misconduct, Tenn. Code. Ann. § 63-6-214(g) (West 2014) (“For purposes of actions taken . . . in which the standard of care is an issue, any Tennessee licensed physician serving as a board member, hearing officer, designee, arbitrator or mediator is entitled to rely upon that person’s own expertise in making determinations concerning the standard of care and is not subject to voir dire concerning such expertise.”)

The PSOBA regulations confirm that PSOBA Hearing Officer proceedings are inquisitorial rather than adversarial in nature. Specifically, the regulations provide that “the PSOB Office may assign a particular claim to a specific Hearing Officer if it judges, in its discretion, that his experience or expertise suit him especially for it” and that the Hearing Officer shall hold a hearing “for the sole purposes of obtaining: (1) Evidence from the claimant and his fact or expert witnesses; and (2) Such other evidence as the Hearing Officer, at his discretion, may rule to be necessary or useful.” 28 C.F.R. §§ 32.43(b) and 32.45(a)(2). While the PSOBA regulations do not expressly state that a Hearing Officer may rely on his own medical training in reaching a decision in a case to which he has been assigned, and this case is distinguishable from the examples cited above in that the PSOBA Hearing Officer is presumably appointed foremost for his legal expertise, we found nothing that proscribed the Hearing Officer from bringing his medical training to bear in evaluating the evidence before him.

In any event, Dr. Kennedy’s role in this matter had changed by the time of O’Donnell’s final decision. At that point, O’Donnell rather than Dr. Kennedy was the deciding official. O’Donnell’s determination was *de novo*; she was entitled to rely on Dr. Kennedy as a special master and to adopt his factual findings as a basis for her own conclusions. The PSOBA regulations explicitly provide that the Director may refer any matter related to a claim before him to a Hearing Officer, acting as a special master, to recommend both factual findings and dispositions in connection with those factual findings. See 28 C.F.R. § 32.54(c)(3). We found nothing in the Act, the regulations, or the PSOBA case law, that prohibited O’Donnell from referring this matter to Dr. Kennedy for recommendations as to the findings of fact and the ultimate question in this case. We also found nothing to prohibit O’Donnell from adopting those findings and recommendations as her own, much as a District Judge might adopt the findings of a Magistrate Judge to whom a matter is referred for fact finding.

b. O’Donnell’s Application of the Hometown Heroes Presumption

Section 3769(k) creates a presumption that a stroke suffered by a public safety officer will qualify for benefits if certain conditions are met. It effectively relieves the claimant from the burden of proving that strenuous activity in the line of duty was the direct and proximate cause of the stroke if the stroke happens during or within 24 hours after the public service activity. However, the evidence must establish that the stroke was the proximate cause of the death. This can be complicated where the stroke occurs within the 24 hour

period but the death occurs sometime later, when intervening causes may play a role.

Most of the conditions required under Section 3769(k) do not seem to be in dispute. Davis was a “public safety officer” who was engaged in “a situation involving nonroutine stressful or strenuous physical . . . emergency response activity.” He suffered a stroke while engaged in that activity.³² For purposes of the Section 3796(k) analysis, therefore, O’Donnell was entitled to presume that the initial stroke was proximately caused by Davis’s covered activity.³³

The harder question is whether the initial stroke “directly and proximately” resulted in Davis’s death 6 days later. Under the regulations, something directly and proximately causes a wound, condition, or cardiac-event, if it is a “substantial factor” in bringing the wound, condition, or cardiac-event about. The regulations further state that a factor substantially brings about a death if: (1) the factor alone was sufficient to have caused the death; or (2) no other factor (or combination of factors) contributed to the death to so great a degree as it did. 28 C.F.R. § 32.3.

If the evidence had established that the initial stroke Davis suffered on duty “alone was sufficient to have caused the death” 6 day later, the requirement of 3796(k)(3) would have been satisfied. However, the evidence does not appear to go quite that far. Kennedy noted that an independent medical reviewer (Dr. C) opined that the initial stroke contributed to the subsequent strokes – including the massive stroke that killed Davis 6 days later – by weakening Davis’s brain tissue. Specifically, Dr. C stated that the first stroke more likely than not contributed at least in part to the chain of events

³² The record is somewhat unclear on the basis of the conclusion that Davis had a stroke at the scene of the mutual aid activities, but that conclusion does not appear to be in dispute. As noted above, another firefighter who helped Davis on the scene described his symptoms and stated his personal belief that that Davis had suffered a stroke. It was apparently on the basis of this testimony that Dr. Kennedy and Dr. C concluded that Davis suffered a stroke while on duty. Tellingly, the OGC memorandum did not raise this as an issue and itself described three separate strokes.

³³ Section 3796(k) also offers a means to challenge the presumption that the initial stroke was caused by Davis’s line-of-duty activity. Under the statute, the presumption can be overcome by “competent medical evidence” establishing that the stroke was “unrelated to the engagement or participation or was directly and proximately caused by something other than the mere presence of cardiovascular-disease risk factors.” 42 U.S.C. § 3796(k)(3). The complaint does not appear to make an argument based on the cause of the initial stroke. In fact, the OGC memorandum stated that Section 3796(k) “makes irrefragably clear, whether ‘strenuous exertion while on duty’ caused a decedent’s stroke or not is utterly irrelevant, as a legal matter, to the issue of whether ‘the Hometown Heroes presumption applies’” In any event, we are not aware of any evidence that conclusively demonstrates that the initial stroke was “unrelated” to Davis’s strenuous activity. And the only extrinsic factor identified in the record that might potentially have contributed to the stroke was bacterial endocarditis. As explained below, although there was evidence going both ways, we found substantial evidence to support O’Donnell’s conclusion that bacterial endocarditis was not present (and therefore did not directly and proximately cause the initial stroke). Therefore, O’Donnell’s application of the statutory presumption with respect to the initial stroke was supportable.

leading to Davis's death. He did not state specifically, however, whether the initial stroke alone was sufficient to have caused the death 6 day later.

Accordingly, O'Donnell was required to consider the second prong of the "substantial factor" test: whether any other factor or combination of factors contributed to the deadly stroke 6 days later more than the damage from the initial stroke did. It was in this context that O'Donnell was required to consider the relative role of bacterial endocarditis as a factor that contributed to the fatal stroke. Under the regulatory definition of "substantial factor," if bacterial endocarditis was a larger contributor to the fatal stroke than was the damage from the initial stroke, O'Donnell could not find that the initial stroke was the direct and proximate cause of death.

O'Donnell effectively resolved this question by concluding that bacterial endocarditis was not present, which obviated the need to determine whether it was bacterial endocarditis or the initial stroke that was the larger contributor to the death. The evidence that O'Donnell and Dr. Kennedy (as Special Master) relied on in reaching this conclusion based on an application of the "Duke factors" included: the lack of valvular vegetations on Davis's echocardiogram; the lack of evidence of new valvular regurgitation (heart murmur); and the lack of physical findings (Janeway lesions/Osler nodes) commonly associated with endocarditis. Dr. Kennedy also commented that the record contained evidence that the diagnosis should be rejected based on the "Duke criteria," including the fact that Davis's positive blood culture for relevant bacteria resolved after just 2 days of antibiotic therapy, whereas bacterial endocarditis usually requires long courses of antibiotic therapy.

The OGC memorandum, which was written before Dr. Kennedy's report, stressed the blood cultures that were positive for a bacterium that causes endocarditis, the history of dental abscesses, the presence of a heart murmur, and the fact that that Dr. C commented that approximately 15% of cases do not demonstrate detectable vegetations on echocardiogram.³⁴ Kennedy's report

³⁴ Dr. C's observation that 15 percent of patients with bacterial endocarditis will have a clear echocardiogram (false negative) is potentially misleading. It does not mean that a randomly selected stroke victim who tests negative on an echocardiogram has a 15% chance of having endocarditis. That percentage cannot be calculated without knowing the incidence of endocarditis among stroke victims. According to one article, infective endocarditis affects about 10,000 to 20,000 persons in the United States each year. <http://circ.ahajournals.org/content/107/20/e185.full> (accessed April 1, 2016). Citing the U.S. Centers for Disease Control and Prevention, the Internet Stroke Center estimates that approximately 800,000 Americans suffer from strokes each year. <http://www.strokecenter.org/patients/about-stroke/stroke-statistics/> (accessed April 1, 2016). Even assuming that all endocarditis sufferers have strokes (which is the upper limit of possibilities), at most only 20,000 of 800,000 stroke victims (2.5%) have endocarditis. Of the 20,000 who have the disease, you would expect 17,000 (85 percent) to test positive on an echocardiogram and 3,000 (15 percent) to test negative. Assuming that there are no false positives, all 780,000 of the stroke victims without endocarditis would test negative. Now, if a single person from the population of stroke victims tests negative on the echocardiogram, what are the odds he in fact has the disease? In this population, a total of 783,000 will test negative, of whom 3,000 in fact have the disease. The chances that a stroke victim who tests negative has

(Cont'd.)

addressed most of these facts in the context of the Duke criteria and concluded that insufficient Duke factors were present to support a diagnosis of bacterial endocarditis. We found that Dr. Kennedy's assessment of the foregoing facts constituted "substantial evidence" to support O'Donnell's conclusion that bacterial endocarditis was not present. While the General Counsel's presentation of contrary evidence was not unpersuasive, we did not find that it was so compelling that it rendered the evidence on which O'Donnell relied to be something less than substantial.³⁵

4. Conclusions Regarding Davis

For these reasons, we concluded that there was substantial evidence to support O'Donnell's decision to award benefits to Davis's family, based on her application of the statutory presumption in Section 3796(k) of the PSOPA. We did not find a sufficient basis in OGC's disagreement with O'Donnell's decision to support a conclusion that the award in this case was forbidden by statute or otherwise improper.

C. Hamilton Williams Claim

The Hamilton Williams claim involved a firefighter who suffered a heart attack and collapsed at the scene of a fire, and died soon thereafter.³⁶ It required O'Donnell to determine if the firefighter had experienced a personal, traumatic injury in the line of duty as defined by the Act. Although O'Donnell initially proposed that the claim be approved, she subsequently referred the matter to a Special Master for the development of additional evidence. After reviewing the Special Master's findings, O'Donnell denied the claim for lack of evidence that Williams died as a result of a personal injury suffered in the line of duty. Notwithstanding, the complaint identified Williams as an example of a claim that O'Donnell deemed payable despite legal insufficiencies.

the disease would be at most 3,000 out of 783,000, or just 0.38 percent. Everything else being equal, in this hypothetical a negative echocardiogram would be very strong evidence (over 99.62 percent) that a stroke victim does not have the disease. (These numbers do not change significantly if you assume a nonzero rate of false positives.) At most, Dr. C's observation would mean that the fact that someone has a clear echocardiogram does not prove with absolute 100 percent certainty that they don't have the disease.

³⁵ OGC did not have an opportunity to cite Dr. B's statement that "vegetations are not found on transthoracic echocardiograms of most people with vegetative endocarditis, "because Dr. B made that statement in a report that post-dated the OGC memorandum to O'Donnell. See footnotes 27 and 29 above. Even so, we do not believe O'Donnell and Dr. Kennedy were wrong to rely on the clear echocardiogram as strong evidence that endocarditis was not present, given the importance placed on echocardiogram results in diagnosing this disease, both as part of the "Duke criteria" and as expressed by the other experts. See footnote 33 above. Indeed, Dr. B himself said he was "surprised" at the clear echocardiogram given his belief that Davis had endocarditis, a statement that seems inconsistent with Dr. B's belief that most people with this disease do not show vegetations on their echocardiograms. Dr. C also found the clear echocardiogram "problematic for this diagnosis."

³⁶ Hamilton Williams is a pseudonym.

1. Applicable Statutory Provisions

The PSOBA provides monetary benefits to the survivors of public safety officers who die “as the direct and proximate result of a personal injury sustained in the line of duty.” 42 U.S.C. § 3796(a). However, not all injuries that occur in line of duty and result in death are compensable. “Injury” is specifically defined in the implementing regulations as:

a traumatic physical wound (or a traumatized physical condition of the body) directly and proximately caused by external force (such as bullets, explosives, sharp instruments, blunt objects, or physical blows), chemicals, electricity, climatic conditions, infectious disease, radiation, virii, or bacteria, but does not include – (1) Any occupational disease; or (2) Any condition of the body caused or occasioned by stress or strain.

28 C.F.R. § 32.3 (2002).

2. Facts

a. Background

Hamilton Williams was a 49 year-old captain and shift commander with a small city fire department when he responded to a fire in an apartment above a garage on an autumn morning. After the fire had been largely suppressed by other firefighters, Williams, the on-scene commander, and several other firefighters began climbing an outside stairway to the apartment where the fire had originated. Williams collapsed upon ascending approximately two to three steps. Cardiopulmonary Resuscitation (CPR) was performed by his fellow firefighters until emergency medical technicians (EMTs) arrived. The EMTs found Williams to be in ventricular fibrillation and restored his heart rhythm using defibrillation before transporting him to the hospital.³⁷

Hospital records reflect that Williams presented “after having a cardiac arrest with ventricular tachyarrhythmia needing defibrillation” and “had smoke inhalation and had collapsed at the scene.” Williams’s previous medical history was significant for atherosclerotic coronary artery disease, coronary angioplasty,

³⁷ Ventricular fibrillation is a severely abnormal heart rhythm that is life threatening. It is an uncontrolled twitching or quivering of muscle fibers (fibrils) in the lower chambers of the heart. During ventricular fibrillation, blood is not pumped from the heart and sudden cardiac death results. The most common cause of ventricular fibrillation is a heart attack. However, it can occur whenever the heart muscle does not get enough oxygen for any reason.

<http://www.nlm.nih.gov/medlineplus/ency/article/007200.htm> (accessed July 10, 2015). “The most common cause is a lack of blood flow to the heart muscle due to coronary artery disease, such as occurs during a heart attack. Other risk factors include: drowning; drugs that affect electrical currents in the heart (such as sodium or potassium channel blockers); electrical shock; very low blood pressure, which can result from coronary artery disease and other disorders; very low levels of potassium in the blood (hypokalemia).” <http://www.cedars-sinai.edu/Patients/Health-Conditions/Ventricular-Fibrillation.aspx> (accessed July 17, 2015).

stenting of the right coronary artery, arterial hypertension, pancreatitis, and congestive heart failure. Williams was under the care of a cardiologist and had been prescribed the anticoagulant Coumadin.

Williams underwent an emergency cardiac catheterization after an electrocardiogram suggested restricted blood flow to the heart. However, no significant blockage in any coronary arteries was found. He also was noted to have a low level of potassium, which was supplemented. While in intensive care, Williams experienced additional episodes of ventricular fibrillation. Despite the insertion of a temporary pacemaker the following day, Williams died 2 days after the fire. The death certificate identified the immediate cause of death as "Ventricular Tachyarrhythmia" due to (or as a consequence of) "Anoxic Encephalopathy."³⁸ The cause of death was determined by Dr. D, a cardiologist who had treated Williams during his short hospitalization. No autopsy was performed, as Williams had been seen by a physician within 24 hours and the death certificate was signed by an attending physician.³⁹

b. Initial PSOB Office Decision

Williams's family (the claimants) filed a claim for death benefits. At the request of the PSOB Office, Williams's medical records were reviewed by a medical examiner, Dr. E. Dr. E noted Williams's history of atherosclerotic coronary artery disease, hypertension, and congestive heart failure and commented that "ventricular fibrillation is strongly suggestive of cardiac disease." He determined that "the lack of oxygen to the brain during the ventricular fibrillation resulted in hypoxic/anoxic brain injury and eventually death." Responding to specific questions posed by the PSOB Office, Dr. E concluded that Williams did not suffer a traumatic injury as defined in the regulations, but rather, his pre-existing cardiac disease was a substantial factor in his death. He identified arteriosclerotic cardiovascular disease as the most likely cause of death.

About 6 months after the claim was filed, the PSOB informed the claimants by letter that their claim was denied. The letter explained that pursuant to the PSOPA and regulations, a public safety officer's death that results from a chronic, congenital, or progressive disease or other condition of the body is not covered under the PSOPA unless a traumatic injury was a

³⁸ Encephalopathy is a term for any diffuse disease of the brain that alters brain function or structure. Encephalopathy has numerous causes, including: infectious agents, brain tumors or increased pressure in the skull, prolonged exposure to toxic elements (including solvents, drugs, radiation, paints, industrial chemicals, and certain metals), poor nutrition, and lack of oxygen or blood flow to the brain. <http://www.ninds.nih.gov/disorders/encephalopathy/encephalopathy.htm>. "Anoxic" refers to the almost complete lack of oxygen. Steadman's Medical Dictionary 92 (27th ed. 2000).

³⁹ A letter from the County Deputy Coroner states, "Since Mr. [Williams] was in the hospital, was under a doctor's care, and had been seen by a physician within the last twenty-four hours, I was not required by law to order an autopsy. The attending physician signed the death certificate and Mr. [Williams]'s case was not considered a coroner's case."

substantial factor in the death. Based on the documentation in the file, the PSOB Office had determined that Williams's death was not the result of a personal or traumatic injury as defined by the PSOPA and regulations, and therefore, his survivors were ineligible to receive benefits.

About a month after receiving the letter denying the claim, the claimants sought review by a Hearing Officer. A hearing conducted at the offices of claimants' attorney included testimony from the claimants, neighbors at the scene of the fire, and two firefighters who were part of the response team. At the hearing, claimants' attorney argued that Williams's cardiac arrest was caused or exacerbated by smoke inhalation.

Prior to issuing his determination, the Hearing Officer also reviewed the transcript of a deposition of Dr. D by claimants' attorney. In response to questions by claimants' attorney, Dr. D opined that coronary artery disease had been considered as a potential cause for Williams's cardiac arrest, but was "definitely ruled out" by the negative findings from the cardiac catheterization and that Williams's ventricular fibrillation was probably secondary to stress and smoke inhalation. Although he noted that Williams's potassium level was low upon admission, he stated that it was corrected. Dr. D also noted that Williams was not anemic and had normal kidney function and calcium levels. Considering all of the factors, Dr. D ultimately concluded that since the most probable cause of Williams's ventricular fibrillation (heart disease) had been ruled out, and the other potential causes (low potassium) had been corrected, smoke inhalation had caused Williams's heart attack, ". . . so then out of exclusion, I can say it was the smoke inhalation which led to the cardiac arrest."⁴⁰

c. Hearing Officer's Determination

The Hearing Officer issued a determination denying benefits over 5 years after the claim was originally filed. Although he found Williams to be a public safety officer who suffered a "line of duty" injury, he found that claimants had not established that Williams died as a proximate result of a "personal injury sustained in the line of duty" as defined by the Act and regulations. Relying on the city fire department's report on the incident and the testimony of the firefighters who were also on the scene, the Hearing Officer found that the evidence did not establish that Williams was exposed to smoke.

The Hearing Officer noted that the evidence showed that Williams "at no time entered the burning building, but as Incident Commander, directed firefighting operations from the ground outside of the burning building." He also noted that Williams collapsed 6 minutes after he arrived at the scene; that Williams checked the apartments at the rear of the building where he encountered no smoke; and that Williams then proceeded to the other end of the building where the fire was being "knocked down," but was not completely

⁴⁰ The record also contains the transcript of a second deposition of Dr. D in which he again identified smoke inhalation as the trigger of Williams's cardiac arrhythmia.

extinguished, when he collapsed after taking two or three steps up an exterior stairway. The Hearing Officer also commented, "there is no testimony of any of the participating firefighters who testified at the hearing and were present at the scene of the fire that smoke was in the area where Captain Williams directed the firefighting operations." He therefore concluded that the evidence was insufficient to support a finding that Williams "died as the direct and proximate result' or an actual or presumed 'personal injury sustained in the line of duty,' under the PSOB Act and its implementing regulations."⁴¹

d. Director's Proposed Determination

Claimant sought review of the Hearing Officer's determination. Thereafter, the record was supplemented with a medical evaluation by Dr. F, a cardiologist and independent medical expert under contract with the PSOB Office. In the report, Dr. F noted that testing showed only trace amounts of carbon monoxide in Williams's blood and opined that Williams did not have an acute myocardial infarction, smoke inhalation, adult respiratory distress syndrome, or respiratory acidosis, but rather, Williams's ventricular fibrillation occurred spontaneously as a result of an extremely low level of serum potassium. Claimant subsequently submitted the transcript of a third deposition from Dr. D disputing Dr. F's findings and again identifying smoke inhalation as a substantial factor in Williams's death.

In a memorandum to OGC, BJA Director O'Donnell proposed that the claim be approved. She stated that while she appreciated the discussions she had with OGC and understood that OGC believed the claim should be denied, "after careful review of the record, and after weighing all of the evidence," she found that the claim should be approved. She identified the issue in dispute as whether Williams's heart attack was caused by a personal injury, specifically smoke inhalation. She noted that toxic gas inhalation can constitute an injury, and that such an injury "can be the 'direct and proximate cause' of a heart attack." O'Donnell stated that in determining if Williams suffered a personal injury, she had "conducted a thorough review of the entire record, including witness testimony from citizens and firefighters who describe the fire scene." She also had reviewed the medical reports considered by the Hearing Officer "as well as subsequent medical reports and relevant research regarding fire conditions (not available to the Hearing Officer) provided for [her] *de novo* review."

⁴¹ As noted by the Hearing Officer, pursuant to the Hometown Heroes Survivors Benefits Act of 2003, public safety officers who suffer heart attacks while engaging in non-routine, stressful, or strenuous physical activity while on duty, or within 24 hours of being on duty, are entitled to a presumption that they have sustained a line of duty personal injury, unless competent medical evidence establishes that the heart attack was unrelated to the officer's line of duty activity. However, the presumption is not applicable in this case because Williams's death occurred before the law went into effect on December 15, 2003. Additionally, there is no evidence — and claimants did not argue — that on the day of his death, Williams performed duties other than those routinely performed by an incident commander or that his activities required particularly significant physical exertion or an unusually-high level of alarm, fear, or anxiety.

In support of her initial conclusion that the claim should be approved, O'Donnell noted that "all of the witnesses testified that there was significant smoke coming from the front and side of the building where Captain [Williams] was present" and that firefighters on scene testified that there was "heavy smoke in the front of the building." She also noted that the neighbors who called 911 reported seeing smoke "'higher than the roof'" and that they saw the firefighters "'working on a guy'" and concluded that he "'probably got too much smoke.'" O'Donnell stated, "This first-hand account provides further background of the scene and substantiates that Captain [Williams] was indeed subjected to significant smoke."

With regard to the medical opinions, O'Donnell stated that she gave greater deference to the treating physician. O'Donnell noted that while Dr. F, an experienced cardiologist, reviewed Williams's file and concluded that Williams's heart attack was not caused by smoke inhalation, Dr. D, who is also an experienced cardiologist, concluded that it was. According to O'Donnell, Dr. D opined that the results of Williams's blood gas studies suggested that he suffered acidosis from smoke inhalation, that the level of carbon monoxide in Williams's blood may have been affected by the treatment he received from the EMTs, and that the low serum potassium levels were a result of Williams's heart attack, not the cause of it. Recognizing that "determining the cause of death can often be a complex medical issue," O'Donnell stated that she would "afford great deference . . . to the treating physician who has the benefit of making a face-to-face clinical assessment of the patient" and, in Dr. D's case, the added advantage of having treated Williams for 2 days.

O'Donnell commented that studies from medical journal articles showed that carbon monoxide and cyanide gasses are common in structure fires; that high concentrations of toxic gas can be fatal in as little as 1 minute; and that a number of studies showed that where carbon monoxide poisoning has been detected as very low, cyanide levels were found to be deadly. O'Donnell stated that she was "persuaded by the witness statements that the smoke was sufficiently robust to surround the air that Captain Williams breathed for the (albeit short) time he was on scene approaching the fire" and that he "suffered a heart attack as a direct and proximate result of a personal injury sustained in the line of duty." O'Donnell concluded the memo by requesting that OGC draft a Director Determination for her review and approval within the following 2 weeks.

e. OGC's Reply

OGC sent O'Donnell a 19-page memorandum arguing that O'Donnell's proposal to award the claim was not legally supported. The memorandum challenged O'Donnell's statement that OGC had "recommended" that O'Donnell deny the claim. It stated that the advice given (in several in-person briefings), rather, was that based "upon the record as currently constituted, the claim lawfully may not be paid."

The OGC memorandum criticized O'Donnell's analysis in three principal ways. First, it challenged her reliance on the speculative testimony of lay

witnesses to establish that Williams was indeed exposed to smoke.⁴² It pointed out that although the two firefighters who were at the scene testified that there was “heavy smoke at the front of the building,” their testimony was that the heavy smoke was present upon their initial arrival and that they did not describe the presence of heavy smoke at the time of Williams’s collapse. The memorandum noted that both men stated that they were at Williams’s side when he collapsed and that they had accompanied Williams, albeit separately, during his time at the scene. It also pointed out that although they could describe Williams’s facial expressions at the time of his collapse, claimants’ attorney did not ask if, nor did either volunteer that, Williams had been exposed to or breathed smoke. Rather, according to the memorandum, one firefighter testified that at the time of Williams’s collapse, the fire had already been “knocked down” and that the suppression of the fire had been “quick.”

Second, the OGC memorandum challenged O’Donnell’s suggestion that Williams had succumbed to carbon monoxide or cyanide poisoning. The author stated that he was “unaware of any testimonial or documentary evidence in the record raising the possibility of carbon monoxide poisoning or cyanide poisoning in connection with the death of the decedent,” noting that neither carbon monoxide nor cyanide poisoning were “even *suggested* as a potential cause of death by the [claimants or their] attorney or any physician who has opined in this case.” (Emphasis in original). The memorandum commented that the only references to carbon monoxide that OGC found in the record were those related to the laboratory testing conducted during Williams’s hospitalization. The results of those tests, including one for elevated carboxyhemoglobin levels, did not support a finding of smoke inhalation.

Third, the memorandum challenged O’Donnell’s reliance on Dr. D’s opinion, which according to the memorandum was based on a faulty factual assumption. Circling back to its first criticism, the memorandum argued that the factual predicate for Dr. D’s opinion — that Williams had been exposed to smoke — had not been established. The memorandum pointed out that the EMT’s records made no reference to smoke inhalation or the presence of heavy smoke at the scene. Rather, references to smoke inhalation were first noted in the hospital records and the basis for them was unclear. The memorandum noted that Dr. D’s testimony generally reflected a lack of knowledge of the facts surrounding Williams’s collapse, as Dr. D made several references to Williams being “found on the floor,” although Williams’s colleagues testified that he had collapsed while standing right next to them. It also noted that Dr. D stated in his deposition that he had reached his diagnosis that Williams’s ventricular fibrillation was caused by smoke inhalation solely by exclusion, after ruling out the other likely causes. The memorandum also expressed concern that Dr. D never addressed the low carboxyhemoglobin levels in Williams’s blood or

⁴² In a footnote, the memorandum also stated that although it did not appear to have impacted the substance of her testimony, one of the lay witnesses expressed bias and “testified that she was ‘protecting’ [the claimants] through her testimony and that she would ‘fight ‘til the day I die to see [that the claimants get what they deserve].’”

explained how they could be reconciled with a finding that Williams had inhaled a significant amount of smoke.

O'Donnell responded to the OGC memorandum about a month later. She informed OGC that she disagreed with its conclusion that the evidence was insufficient to support a determination that Williams's death was caused by smoke inhalation and that she believed it was "within [her] statutory responsibility to determine if the evidentiary basis exists for approving a claim." She stated that nevertheless, "in an effort to reach a resolution without further delay," she was referring the matter to a Hearing Officer to act as a Special Master and to collect additional medical evidence and make factual recommendations. In another memorandum, citing 28 C.F.R. § 32.54(c)(3), O'Donnell asked Hearing Officer Patrick O'Neal to evaluate the record, and any additional evidence he obtained, in order to recommend factual findings as to "what 'traumatic physical wound (or[] traumatized physical condition of the body[])' Mr. [Williams] suffered and what 'directly and proximately caused' such wound or condition."⁴³

f. The Special Master's Findings

O'Neal set forth his findings in a 12-page memorandum to O'Donnell. The memorandum explained the steps he took to gather and evaluate the evidence and to make his recommendations. These included reviewing the PSOB case file; conducting independent research into the issues of smoke inhalation and fire smoke generally; and traveling to the city where Williams worked to conduct unsworn, in-person interviews of the two firefighters who testified at hearing, two additional neighbors who witnessed the fire, and Dr. D. He identified the dispute and the focus of his analysis as "whether Captain [Williams] inhaled smoke at the fire scene sufficient to trigger a cardiac attack."

Among other things, O'Neal learned that most episodes of gas poisoning in fires occur in closed spaces; that the firefighters who testified observed no smoke except that venting upwards from the second floor apartment; and that the firefighters who testified at hearing were concerned about Williams's health because he had previously collapsed and lost consciousness while running to respond to a call. During his interview of Dr. D, O'Neal learned that Dr. D had focused on smoke because he recalled being told by unknown fire personnel that Williams had collapsed while fighting a fire. When he was told that the firefighters who were with Williams denied encountering significant smoke at the scene, Dr. D said that he nevertheless believed that smoke was a factor and suggested, alternatively, that Williams may have been subjected to a "low oxygen environment." However, Dr. D did not describe what would constitute a sufficiently "low-oxygen environment" to trigger a cardiac event. When asked about the low carboxyhemoglobin levels in Williams's blood, Dr. D stated that Williams may have had a "low threshold," but did not explain what he meant by

⁴³ Patrick O'Neal is a pseudonym. O'Neal is a former DOJ-OIG employee.

it. O'Neal said that he was unable to find any articles discussing circumstances in which people exposed to deadly levels of smoke physically processed it in a manner that resulted in near insignificant carboxyhemoglobin levels in their blood.

Based on his answers to these and other questions, O'Neal questioned the reliability of Dr. D's medical conclusions and recommended that Dr. D's opinion be given little weight. Although he viewed him as a capable, experienced cardiologist, O'Neal found Dr. D to be more interested in defending his original position than objectively considering additional evidence that might alter his initial conclusions. O'Neal also recommended a finding that Williams was not exposed to any significant smoke. In support, he cited the eyewitness testimony regarding the location of the smoke and Williams's activities at the scene, as well as the low carboxyhemoglobin levels in Williams's blood, which he described as "an objective independent factor." O'Neal concluded his memorandum by recommending a finding "that smoke inhalation was not shown to be a substantial cause of injury leading to Captain [Williams's] death."

g. O'Donnell's Final Determination

Two months after receiving O'Neal's memorandum, O'Donnell issued a decision denying benefits, stating, "I have no choice under the law, but to deny this claim." She referenced O'Neal's conclusions and recommendations and stated that she found them to be reasonable and supported by the record. O'Donnell stated that upon her review of the entire administrative record, she "cannot find that Captain [Williams] [was] exposed to smoke or toxic gases immediately prior to his collapse" and accordingly found Dr. D's opinion, "predicated as it was on an assumption of exposure to smoke and toxic gases," "not compelling." O'Donnell concluded, "The record in this case does not establish that Captain Williams died as 'the direct and proximate result of a personal injury' within the meaning of the PSOB Act. Accordingly, it is my determination that this claim must be, and hereby is, denied."

3. OIG Analysis

In her initial proposed findings approving the claim, O'Donnell confronted conflicting medical testimony and based her proposed findings in substantial part on the testimony of the treating physician, Dr. D.

Thereafter, O'Donnell responded to the OGC's concerns by referring the matter to a Special Master to develop additional evidence. Upon reviewing the Special Master's findings and recommendations, O'Donnell denied the claim. We find no basis to conclude, nor does the complaint allege, that O'Donnell's final determination was contrary to law, arbitrary and capricious, or unsupported by substantial evidence.

4. Conclusions Regarding Williams

We concluded that O'Donnell acted appropriately in referring the matter for the development of additional evidence and that her final determination was well supported.

D. Henry Sharp Claim

The Henry Sharp claim involved a state highway patrol officer who was struck by a steel boom apparatus while a vehicle was being pulled up a steep embankment by a wrecker.⁴⁴ The principal issue was whether the accident had rendered the officer permanently and totally disabled as defined by the Act. Although the claim was denied by the PSOB Office, it was approved by a Hearing Officer following the submission of a vocational expert's report and the testimony of the claimant and others at a hearing. O'Donnell reviewed the Hearing Officer's approval pursuant to 28 C.F.R. § 32.53(a) and determined that benefits should be awarded. OGC concurred with the approval of the claim. However, the complaint to the OIG alleged that O'Donnell approved the Sharp claim for payment without having reviewed the file.

1. Facts

Sharp (claimant), a state highway patrol officer, was struck in the head and shoulders by a steel boom apparatus while a vehicle was being pulled up a steep embankment by a wrecker following an accident. Rendered momentarily unconscious, he sustained closed head trauma with laceration to the scalp and several small contusions in the brain, as well as a small area of brain hemorrhage. Following the incident he suffered dizziness and diminished hearing, vertigo, and cognitive inefficiencies in the areas of speed, concentration, and endurance. Sharp was medically retired effective approximately 6 months after the incident.

Claimant filed a PSOB claim about 2 years later. The PSOB Office denied the claim, informing claimant of the denial via letter. Based in part upon the report of a cardiologist, Dr. G, who reviewed the record at the PSOB Office's request, the PSOB Office found that claimant had not established that he was totally and permanently disabled within the meaning of the Act; that is, that his injuries had rendered him incapable of performing any gainful employment. Claimant requested review by a Hearing Officer. Following a hearing and the submission of additional evidence, the Hearing Officer issued a determination over 2 years after the claim was filed, awarding the claim. The case was then ready to be sent to the BJA Director for review pursuant to 28 C.F.R. § 32.53(a), which states that the BJA Director shall review approvals by a Hearing Officer.

⁴⁴ Henry Sharp is a pseudonym.

In a series of e-mails, an OJP Deputy General Counsel (DGC) and a Senior Advisor (SA) to BJA Director O'Donnell discussed preparing the Director's Determination for the Sharp claim and another claim.

In the first e-mail, the SA told the DGC that O'Donnell "would like to affirm the Hearing Officer approvals" in Sharp and another claim; that "[O'Donnell] is just looking for 'Do Not Disturbs' here." The DGC responded that she had sent a hard copy of a "draft" for Sharp (presumably referring to a draft Director's Determination), but that she would need additional time to complete one for the other case. A few minutes later, the DGC wrote another e-mail to the SA, stating, "I have just learned to my surprise that we still have the Sharp file here in OGC. I thought it had been sent down to you last week. As it happens we worked very very closely with [the Hearing Officer] on this case and we were going to advise a "do not disturb" determination for the Director." The DGA also stated:

But I don't see on what basis [O'Donnell] could have reached a conclusion of approval without receiving our advice or reviewing the record. As you know, in the past other BJA Directors have relied on counsel's review of the record and advice in these instances. I know [O'Donnell] appears to have moved in a different direction in this regard, and I am puzzled how she could conclude that the HO determination is well-founded without having any idea of what the record may contain. Perhaps we should discuss? . . . (I am sending the file down meanwhile.)

The SA replied, "No worries! Things have been very hectic of late."

O'Donnell issued her Determination about 3 weeks after this e-mail exchange. Without summarizing the facts or providing an analysis, O'Donnell stated, "Having completed my review and because I agree with the findings and ultimate conclusion of the Hearing Officer, who considered the evidence before him thoroughly and carefully, I did not find cause to decide it differently. Accordingly this claim is approved."

The complaint to the OIG included the above-quoted e-mail communications between the DGC and the SA as an attachment. On the basis of this exchange, the complaint alleged that O'Donnell ordered that the Carpenter claim be paid "DESPITE NEVER HAVING REVIEWED THE FILE." (Emphasis in original).

2. OIG Analysis

Because OGC and O'Donnell concurred that the Sharp claim should be approved and the complaint did not allege that its payment was "in direct contravention of various statutory provisions that expressly forbid payment," the analytical construct that the OIG developed for this review is not strictly applicable to the Sharp claim. Our focus therefore, is on whether the assertion that O'Donnell approved this claim without reviewing the file has merit and, if

so, whether O'Donnell's action constituted an abuse of power or a failure to substantially comply with the statute or regulations. We do not believe that the complaint states a sufficient basis to require further investigation for several reasons.

First, the e-mails do not sufficiently evidence that O'Donnell made a final decision in the Sharp case without reviewing the file. The SA merely states that O'Donnell "would like to affirm the Hearing Officer approvals." This second hand, seemingly informal statement does not mean O'Donnell had yet made a final determination constituting an "order" that the claim be paid.

Second, O'Donnell did not issue her final determination until about 3 weeks after the DGC said she was sending the case file to O'Donnell. This was abundantly sufficient time for O'Donnell to review the case file. Nothing in the complaint suggests that she failed to do so before issuing her final determination.

Third, it is not clear from the regulation that O'Donnell was required to review the case file before affirming the Hearing Officer's decision. Section 32.53(a), addressing Director appeals, merely states, "Upon the filing of the approval (under subpart E of this part [by a Hearing Officer]) of a claim, the Director shall review the same." This language can reasonably be interpreted to require only that the Director review the Hearing Officer's decision and not necessarily review the entire file. In contrast, Section 32.43 (d)(1) provides that Hearing Officer review of a PSOB Office decision is "*de novo* (unless the Director should expressly prescribe otherwise)"

We reviewed the Hearing Officer's determination with an eye toward examining whether review of it alone would provide a sufficient basis for the Director's approval of an award. The Hearing Officer's 17-page determination appears well-reasoned. She provides a cogent statement of facts, identifies the applicable provisions of the statute, and appears to rationally apply the relevant portions of the statute to the facts in making her findings. Finally, the Hearing Officer offers a rational explanation for why she discounted certain aspects of Dr. G's opinion, upon which the PSOB Office relied heavily. She noted, for example, that the other physicians who treated claimant saw him for an additional 16 months after Dr. G completed his report and thus had a longer time frame over which to assess the claimant's injuries. Thus, on its face, the Hearing Officer's determination appears to reflect that she fully considered the relevant evidence and reached a logical conclusion, and this would provide a sufficient basis for O'Donnell's subsequent affirmance of that decision.

Finally, the evidence is clear that by the date of the e-mail exchange between the DGC and the SA, OGC had communicated to O'Donnell's office that it fully agreed with the Hearing Officer's decision; O'Donnell was undoubtedly aware of this agreement by the time she issued her final determination 3 weeks later. In light of the language of 28 C.F.R. § 32.53(a), it is not clear that O'Donnell was required to conduct further review of the case file under these circumstances. Such a review would have required the claimant – whose claim

had been pending for almost 3 years – to wait additional time for a result that was no longer in dispute.

3. Conclusions Regarding Sharp

We concluded that the information in the complaint and the case file did not support a conclusion that O'Donnell failed to perform her required functions as BJA Director with respect to the Sharp case and were insufficient to justify further OIG investigative activity.

V. Conclusion

The complaint submitted to the OIG accused BJA Director O'Donnell of failing to comply with the PSOB statute or regulations with respect to six identified claims. We found no basis to assess O'Donnell's actions with respect to two of the claims because her final decisions with respect to them are still pending. With regard to the remaining four claims, applying the analytical construct described above analogous to the deferential standard that would be used in a judicial appeal, we found that in one of the cases (Harper) O'Donnell granted a claim in a manner that was arbitrary and capricious and unsupported by "substantial evidence." In a second case, (Davis) we found there was sufficient support in the record for her decision to grant the claim. In a third case, (Williams) we found that O'Donnell ultimately rejected the claim after referring the matter to a Special Master and considering the findings thereof, which refuted any argument that she had granted the claim illegally. The final case (Sharp) involved an allegation that O'Donnell affirmed a Hearing Officer's determination without reviewing the associated case file. We found insufficient evidence to substantiate this allegation.

In conclusion, while we found that O'Donnell improperly decided to award benefits in one of the cases we reviewed, we found that her actions were not improper in the others and therefore concluded that O'Donnell had not systemically failed to follow the law in approving PSOB claims. We refer this report to the Department for its review and any appropriate action it deems appropriate.

APPENDIX A



U.S. Department of Justice

Office of Justice Programs

Bureau of Justice Assistance

Washington, D.C. 20531

Dear Assistant Inspector General Beckhard:

Thank you for affording me the opportunity to comment on the draft Report of the Office of the Inspector General (“OIG”), entitled “A Review of Certain Public Safety Officers’ Benefits [PSOB] Act Claim Determinations by the Director of the Bureau of Justice Assistance, Office of Justice Programs.” As I understand it, the draft Report grew out of a whistleblower’s allegation that I had systematically failed to follow the law in approving PSOB claims. I am appreciative that the OIG rejected that allegation. See Report at 3 (“we did not find evidence that O’Donnell had systematically failed to follow the law in approving PSOB claims”). The Report, however, found that in one instance -- the case of Officer Kurt Harper -- my decision to award benefits was “arbitrary and capricious” and “unsupported by ‘substantial evidence.’”¹ I respectfully disagree with that finding. As discussed below, I continue to believe that I reached the correct determination in the Harper case.

A. PSOB Background

During my almost five years as the Director of the Bureau of Justice Assistance (“BJA”), I have worked diligently to improve the PSOB program. The program, which became law in 1976, provides a federal benefit to eligible law enforcement officers, firefighters and other first responders (or their survivors) killed or catastrophically injured in the line of duty. Responsibility for its administration lies with BJA. As Director, I have taken that responsibility seriously. Indeed, strengthening the PSOB program to ensure that it fulfills its important purpose has been among my highest priorities.

When I became Director, I inherited a program that was subject to frequent criticism. One criticism was that claimants often had to wait extended periods to receive a final determination. Another criticism was that meritorious claims were being denied because of overly legalistic interpretations of the PSOB Act. Stakeholders also objected to the lack of deference given to the reports, certifications and testimony of public safety officials on issues such as whether an officer’s activities were “authorized” or “in the line of duty.” As law enforcement agencies saw it, BJA fact finders often failed to appreciate the dangers that public safety officers face and the split-second decisions that they must make in dangerous conditions.

¹ “Kurt Harper” is a pseudonym that OIG used to safeguard the privacy of the deceased officer and his family.

With the support of DOJ leadership, I have sought to address those concerns. In April 2013, then Attorney General Eric Holder directed that a new PSOB Legal Counsel Office be established within BJA to expedite the legal review process. I have worked hard to implement that directive. I have also worked with the Assistant Attorney General for the Office of Justice Programs to develop a new process by which the AAG could assist in resolving legal issues that have delayed the PSOB process. And I have worked to develop policies that give proper weight to the opinions of public safety agencies in cases involving possible officer misconduct or violations of departmental policies.

That is not all. In 2015, The OJP Assistant Attorney General directed a Business Process Improvement review of the PSOB Program, and I have been working with staff under an aggressive timeline to implement the review's recommendations. One component has been the development of a new on-line case processing system -- PSOB 2.0 -- which will be completed this November. Finally, I have initiated a comprehensive review of the PSOB regulations to address longstanding concerns that the regulations imposed unduly high burdens of proof and erected unnecessary procedural barriers, which frustrated fair and efficient claims processing. New regulations have been drafted which should result in a PSOB Program that better fulfills its purpose of providing benefits to officers and their families in the aftermath of tragedies.

In short, I am proud of what has been achieved during my tenure as BJA Director to improve the PSOB program.

B. Kurt Harper's Case

As BJA Director, I serve as the determining official for the third level of administrative review of PSOB claims. With the assistance of government and contract attorneys, I have attempted to reduce the backlog of PSOB Director Appeals. Since June 2011, I have issued approximately 140 determinations, awarding benefits in 75 cases and denying them in 65 cases. I have tried to give each case close attention and scrupulously follow the law.

The OIG draft Report finds that my determination in the Harper case was "arbitrary and capricious" and ran "counter to the evidence." I will not repeat here all of my reasons for awarding benefits. Nor would it be helpful to offer a point-by-point response to the Reports' 29-page analysis. I will focus instead on three issues.

1. Failure to Consider the Circumstances of Officer Harper's Accident

A central issue in the Harper case was whether Officer Harper was "voluntarily intoxicated at the time of his fatal or catastrophic injury," which would make him ineligible for PSOB benefits. 42 U.S.C. §3796(a)(2). The OIG draft Report faults me for "fail[ing] to consider an important aspect of the problem," namely the circumstances of the tragic accident that took Officer Harper's life. According to the draft Report, in finding that Officer Harper was not intoxicated, I ignored the "extraordinary" nature of the accident in which the officer "drove his car across two oncoming lanes of traffic, then travelled up onto a sidewalk, down an embankment, through a thicket of vegetation, up another embankment, became airborne, and finally fell into another parked car." Report at 21. That sequence, the Draft Report contends, shows that Officer Harper was intoxicated at the time.

I respectfully disagree. In reaching my determination, I was mindful of the fact that it takes only a second for a driver to become distracted and lose control of his vehicle. Many of us have had the experience of dozing off at the wheel only to awaken suddenly before anyone is harmed. The accident here occurred at 5:30 a.m. after a long night in which Officer Harper was carrying out his undercover role. Once Officer Harper's vehicle crossed over the oncoming lanes of traffic, it appears that in mere seconds it struck a utility pole, went down an embankment and became airborne. His ability to control the vehicle after it left the road was therefore non-existent. Tellingly, there were no eyewitnesses to the accident, and the accident report itself did not find that intoxication was the cause of the accident. (R601-604; 613-40). Moreover, neither of the two prior PSOB fact-finders -- the PSOB determining official and the Hearing Officer -- found that the circumstances of the accident proved intoxication. Like them, I did not find the point to be dispositive on the intoxication issue.

2. The Weight Given to the Statements of the Eyewitnesses

The draft Report also finds that I was wrong in failing to credit much of what the three witnesses who were at the bar with Officer Harper said occurred that night. I disagree on this point as well. I believe that the witnesses had a motive to exaggerate the degree of Officer Harper's intoxication to remove any suspicion that they might have had a role in his death. Moreover, one of the witnesses was a target of the investigation and had sold drugs to Officer Harper that very night, and the other two were the target's friends and, at a minimum, subjects of the investigation. Criminals and their associates can be truth-tellers, but I had ample reason to be skeptical of their stories. None was disinterested, which made them less than credible in my eyes.

Even assuming the witnesses were honest in reporting their perceptions that would not mean Officer Harper was intoxicated. The three men were observing a trained undercover appearing to be participating in heavy drinking to maintain his undercover role. Officer Harper did not go to the bar to have a good time, and he was not known to be a heavy drinker. (R798). He had no prior history of misconduct or alcohol abuse and was described by his supervisor as "one of the best" at his job. (R 804). Based on those facts, I thought it likely that if he appeared drunk, it was because he was convincingly playing his role in what has aptly been called "probably the most dangerous job" that a law enforcement officer can undertake. [R793].

Finally, it is true that I credited some of what the three witnesses said, but that is unsurprising. Juries are regularly instructed that they can accept some parts of what a witness says and reject others. I credited the witnesses' statements that they had offered Officer Harper a ride home and that he had declined the ride, and I saw his conduct as evidencing his presence of mind shortly before the accident. Had he accepted the ride, it would have disclosed the location of his undercover residence, which would have jeopardized his and others' safety.

I am surprised the draft Report seems to have accepted without question the statements of a target and subjects of a major narcotics investigation about the conduct of an undercover officer, whose job it was to appear to be something other than he was.

3. Weight Given to the Testimony of Law Enforcement Witnesses

The other legal issue in the Harper case was whether Officer Harper “was performing his duties in a grossly negligent manner at the time of his fatal or catastrophic injury.” 42 U.S.C. §3795(a)(1)-(3). I concluded that he was not grossly negligent, relying, in part, on the testimony of his supervisor and an expert law enforcement witness.

As the draft Report notes, the toxicology report indicated that Officer Harper had a .18 BAC shortly after the accident. That reading, however, was vigorously contested by the claimant’s expert, whose testimony I found compelling. I concluded that Officer Harper had a BAC level above the .10 threshold but that the .18% figure was “unreliable,” [Director’s Determination 4-6], a conclusion that the draft Report does not contest. I then gave considerable weight to the testimony of the Sheriff in charge of Officer Harper’s Department, who had put in place a policy allowing an undercover officer, “with the consent of [his] supervisor, [to] drink limited quantities of alcohol when necessary to accomplish the mission.” (R655). The Sheriff testified that Officer Harper’s BAC level did not indicate that he had exercised poor judgment:

Q. Does it indicate to you on this night, maybe, he did not exercise good judgment?

A. No ma’am.

Q. Why not?

A. Because when you’re put in a situation like he is in and you’re dealing with -- when you’re dealing with drug dealers, you have to act just like them. And if they’re in a club and they’re drinking and you don’t drink and if they’re there six hours and they’re drinking, you have to do the same thing they’re doing. If you don’t, they’re not going to accept you . . . so the fact that he was [above it] does not concern me at all because that shows he is out there actually doing his job To me it’s acceptable because I knew what he was doing. He was not out there partying. He wasn’t out there voluntarily getting drunk to have a good time. He was -- what he was doing that night was all in the line of duty because he was working. I know because I have done it myself, that’s what you had to do when you’re working undercover.

(R 795-96).

For me, the Sheriff’s testimony was persuasive. As a federal prosecutor for more than 15 years, I worked regularly with undercover officers and was impressed by their professionalism and courage. The best of them are extraordinarily public servants, who put their lives in danger to enforce our criminal laws. In deciding that Officer Harper was not grossly negligent, I gave weight to the fact that he was not out there to “get drunk to have a good time”

but “what he was doing that night was in the line of duty” -- that his safety would have been jeopardized if his true identity had been known.²

C. Conclusion

I recognize that reasonable people reviewing the record in the Harper case can reach different determinations. It is not an easy case. For my part, however, I found it difficult to conclude that the eyewitnesses did not have a motive to discredit Officer Harper, and, as a result, I gave their accounts only limited weight. Without their statements, I found that the evidence consisted of a questionable blood-alcohol test and the fact that a highly respected officer had lost control of his vehicle after leaving an undercover assignment at 5:30 a.m. That was not a record on which I was prepared to deny his family benefits. Officer Harper’s name has been entered on the wall of the National Law Enforcement Memorial because he died in the line of duty. I believe that he deserves that recognition and that his family is entitled to PSOB benefits.

I have many responsibilities as BJA Director, but managing the PSOB Program is an especially important one. I devote substantial hours, typically on evenings and weekends, to reviewing administrative records and deciding Director Appeals. I have given thoughtful consideration to each of the 140 determinations that I have made during my tenure. I am, of course, concerned for my reputation if my decision in one of those cases is labelled “arbitrary and capricious.” It is a characterization that suggests I acted in bad faith, when nothing could be less true. I am even more concerned about the impact that such a finding could have on my successors and on the PSOB officials who wrestle with complex cases on disputed facts and seek to apply the law faithfully. If any of us can be publicly faulted for making a good faith determination, then all of us carry out our responsibilities at our peril.

Thank you again for the opportunity to comment on the draft Report.

Sincerely,

Denise E. O’Donnell

Dated: May 16, 2016

² Notably, there was testimony that the target of the investigation had grown suspicious that Officer Harper might not be a fellow drug dealer. (R 595-96; 654). As for potential violence, it bears note that the target had previously sold Officer Harper a gun. (R 834).

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