

# Investigative Report of National Park Service Possible Destruction Of Evidence

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This is a version of the report prepared for public release.

## **SYNOPSIS**

In September 2014, the U.S. Department of the Interior (DOI) Office of Inspector General (OIG) received an inquiry from Congresswoman Jackie Speier, U.S. Representative for California's 14th Congressional District, requesting our assistance with resolving allegations surrounding the 2009 fatality of the Botell family's 9-year-old son at the National Park Service's (NPS) Lassen Volcanic National Park (LAVO) in Mineral, CA. We were referred to the Botell family's lawyer, who presented allegations of employee misconduct by LAVO staff for violating NPS policy and failing to preserve evidence following the 2009 fatality, which affected litigation of the family's original claim. Based on the request for assistance and information presented, we reopened our 2013 investigation of the fatal LAVO accident that addressed similar allegations, but was closed in an effort to not interfere with the civil lawsuit against the Government being litigated in U.S. District Court.

In 2013, the Botells filed a motion in the U.S. District Court seeking sanctions against the government based on allegations against NPS of spoliation of evidence. The District Court judge presiding over the lawsuit entered an order adopting the finding of the Magistrate that the government had intentionally removed the broken portion of the retaining wall and, as a sanction, should be deemed negligent in the death of the Botells' son, but otherwise deferred ruling on the motion or allegations. The lawsuit was settled in February 2014 without convening an evidentiary hearing to address the Botell's allegations of spoliation of evidence. A stipulation was incorporated into the settlement agreement, in which the Botells and other interested parties released the Government and its agents from any further claims or causes of action.

The civil lawsuit stemming from the 2009 fatality involved several U.S. Attorneys who represented the Government and Federal judges that presided over the matters, however, none of the alleged acts were referred for further investigation or action.

Our investigation into the alleged violations of NPS policy revealed that several of the claims referred to or cited policies and forms that had been superseded, replaced, or were no longer in circulation at the time of the fatal accident. Certain procedural aspects of NPS policy were not followed, but these actions did not appear to alter the outcome of NPS' investigation. Regarding the alleged destruction of evidence and documents, our investigation determined these actions were not intentional and stemmed from miscommunications between LAVO staff. Our investigation did not corroborate the allegations.

We briefed Congresswoman Speier's staff on the results of our investigation and referred our findings to the NPS Director for appropriate action.

## **BACKGROUND**

#### Lassen Volcanic National Park

The Lassen Volcanic National Park (LAVO), located 70 miles east of Redding, CA, encompasses over 100,000 acres of the Cascade Range in northeastern California. LAVO is home to Lassen Peak, one of the largest active dome volcanoes in the world. In October 1972, Congress designated nearly 75 percent of LAVO as the Lassen Volcanic Wilderness. The Wilderness Act of 1964 provides guidance to Federal agencies with respect to managing wilderness areas and restricts the construction of roads, buildings, and other manmade improvements, as well as the use of motorized vehicles within wilderness areas. All proposed improvements to wilderness areas require the initiative to undergo the processes established by the National Environmental Policy Act (NEPA) of 1969.

#### **Lassen Peak Trail**

In the 1930s, LAVO's Lassen Peak Trail was constructed from the original 1920s social trail (i.e., a trail caused by erosion from visitor foot traffic). Approximately 400,000 people visit LAVO annually, with 30,000 hikers climbing the peak trail, primarily during the 90-day summer season. During the summer season, up to 600 hikers climb the trail each weekend. Due to the volume of visitor traffic on the trail since its creation, the trail has undergone numerous rehabilitation and construction efforts spanning from the 1920s to present day. Most notably, the peak trail's original construction in the 1930s by the Civilian Conservation Corps, the construction of wet-mortared retaining walls in 1979 by the California Conservation Corps, and a \$3 million rehabilitation project from 2010 – 2014.

Despite the volume of visitors over the course of the trail's history, until 2009 there were no reported fatalities or injuries associated with failing retaining walls on the Lassen trail.<sup>6</sup>

#### **Prior Trail Assessments**

In 2002, U.S. Department of the Interior (DOI) National Park Service (NPS) conducted a Trail Condition Assessment Survey on LAVO's trail system. The survey found that heavy snow, water run-off, and the high volume of hikers short-cutting off the trail led to increased erosion and scarring of the concrete reinforced retaining walls along the peak trail. The surveyors, however, felt the retaining walls were "holding quite well" and listed the peak trail, among other sections, as priorities for rehabilitation projects. The 2002 survey offered no warnings nor identified hazards to visitors or park staff.

<sup>&</sup>lt;sup>1</sup> "Reach the Peak: Lassen Peak Trail Rehabilitation, Environmental Assessment." (EA) http://www.nps.gov/lavo/learn/management/upload/Lassen%20Peak%20Trail%20Rehabilitation%20Project%20En vironmental%20Assessment.pdf

<sup>&</sup>lt;sup>2</sup> Pub. L. No. 92-511

<sup>&</sup>lt;sup>3</sup> Pub. L. No. 88-577

<sup>&</sup>lt;sup>4</sup> 42 U.S.C. § 4321 et. seq.

<sup>&</sup>lt;sup>5</sup> EA

<sup>&</sup>lt;sup>6</sup> NPS Article Lassen Peak Accident - http://www.nps.gov/lavo/learn/news/botell-incident-3-15-10.htm

#### NPS Projects for the Lassen Peak Trail

In 2004, NPS' "Peak Protection Plan" campaign was initiated to discourage hikers from off-trail travel, which creates social trails like the one from which the peak trail originated. These social trails accelerate trail and rock wall deterioration by displacing material away from the base of the retaining walls.

LAVO's administrative files and historical trail documents revealed that the condition of the 100-year-old trail was in need of rehabilitation and maintenance. LAVO began internal scoping assessments in spring 2007, wherein LAVO's initial trail rehabilitation proposal was presented to NPS Pacific West Regional Mangers as a potential NPS Centennial Project. The proposal outlined the 5-year, \$3 million project. In 2008, LAVO launched a public campaign titled "Reach the Peak" with the goal of raising funds and awareness for the Lassen Peak Trail project. 7.

Based on the scope of the NPS' proposed rehabilitation efforts being within a wilderness area, NEPA required that an environmental assessment be conducted before proposed actions could be implemented. <sup>8</sup> The NEPA process requires all Federal agencies to document and evaluate potential impacts resulting from the proposed actions on lands under Federal jurisdiction, disclose the potential environmental consequences of implementing the proposed action, and identify reasonable and feasible alternatives. Based on the NEPA requirements, LAVO initiated formal meetings to develop alternatives for the proposed project beginning in July 2008, and the public scoping process began on August 1, 2008.

In February 2009, NPS published a "Findings of No Significant Impact" statement based on the environmental assessment and indicated the selection of Alternative C, "Modest Improvements in Lassen Peak Trail Visitor Experience," of the "Reach the Peak" project. These improvements included widening of the trails, adding turn outs and a loop around the summit, designating a route with stabilized tread, and adding a cable leading to the true summit. In December 2009, NPS' environmental assessment was finalized, which described the purpose and need for Alternative C.

#### 2009 Lassen Peak Trail Fatality

On July 29, 2009, a 9-year-old boy, Thomas Botell Jr., and his family were hiking the Lassen Peak Trail. While he and his siblings were sitting and resting on a wet-mortared rock retaining wall along the trail, the rock wall failed and fell away from the foundation. The dislodged portion of the retaining wall subsequently struck the Botell children, injuring them and ultimately leading to Thomas Botell Jr.'s death. The Botells, fellow hikers, and LAVO park rangers provided care for and coordinated the aerial evacuation of the injured children.

The LAVO park ranger who responded to the accident and helped to provide first-aid to the Botells was a seasoned ranger who had conducted several fatality investigations at the Grand Canyon National Park. He was also LAVO's lead investigator for this fatality. The LAVO park

Reach the Peak Public Campaign - https://www.youtube.com/watch?v=yIM5Xy5Mn3M Reach the Peak Video June 2009

rangers initiated their investigation immediately after the Botell children were evacuated, and the lead investigator documented the condition of the scene and gathered vital information and evidence from witnesses. The LAVO park rangers interviewed 57 witnesses, photographed the scene, and obtained hikers' photographs and videos of the scene.

LAVO staff notified their servicing NPS Investigative Services Bureau (ISB) representative/special agent of the fatal accident. The ISB special agent responded and assisted, but the LAVO park rangers retained and continued the investigation until LAVO management and rangers requested ISB's assistance. On August 24, 2009, LAVO rangers transferred the investigation to ISB. The ISB special agent completed the investigation and issued the final report of investigation in January 2010.

## **Botell Family's Administrative Claim and Federal Tort Claim**

According to LAVO's administrative files and court records, the Botell family's legal representative contacted NPS on August 18, 2009, via letter, requesting the accident scene and all evidence be preserved. In November 2010, the Botell family filed administrative claims (specifically, personal injury and wrongful death) with NPS, which NPS denied in May 2011. In June 2011, the Botells filed a complaint for wrongful death and personal injury with the U.S. District Court, Eastern District of California initiating the lawsuit under the Federal Tort Claims Act (FCTA) (28 U.S.C. § 1346(b)). The FCTA prescribes a uniform procedure for handling claims against the United States for damage, loss of property, personal injury, or death caused by the negligent or wrongful act or omission of a Government employee while acting within the scope of his or her employment. FCTA guidelines require claimants to submit an administrative claim to the appropriate agency within 2 years of the incident or file a suit within 6 months of an agency denial of the administrative claim.

## Civil Lawsuit, Findings, and Recommendations

In March 2013, U.S. Magistrate Judge Gregory G. Hollows, U.S. District Court, Eastern District of California, issued his findings and recommendations after presiding over the civil matter. Magistrate Judge Hollow's submitted findings and recommendations noting certain contradictory statements, but not determining whether or not LAVO's Superintendent Darlene M. Koontz perjured herself in depositions. The Magistrate also found that another LAVO employee had shredded trail-related documents that should have been maintained, and that NPS had failed to close Lassen's trail in 2009 for investigative purposes—and also that LAVO staff, at Koontz's behest, had knocked down, the remaining broken portion of the retaining wall responsible for the 2009 fatality. The Government objected to the matters submitted by Judge Hollows and requested the court conduct a de novo review (new review) of the record and reject the findings and recommendations. On May 13, 2013, U.S. District Judge Troy Nunley, Eastern District of California, adopted Magistrate Judge Hollows' findings and recommendations, but deferred ruling on the other allegations of spoliation until the court resolved the Botell's motions. Judge Nunley's order stated an evidentiary hearing regarding the spoliation of evidence would be held later if necessary.

#### The Office of Inspector General's Investigation

In March 2013, NPS' Office of Personnel Reliability referred Magistrate Judge Hollows' findings and recommendations to us, and we initiated an official investigation. We obtained copies of all the filings, orders, depositions, and records associated with the lawsuit from the U.S. Attorney's Office, Eastern District of California. We also obtained a copy of ISB's 2010 report of investigation and associated attachments and interviewed ISB's lead investigator about the investigation. The ISB special agent, who retired from NPS in 2011, reported the alleged destruction of the retaining wall was pursued, but was beyond the scope of ISB's investigation.

Based on this matter being litigated in the U.S. District Court, we did not interview any of the involved parties. Further, the judge presiding over the matter had not convened an evidentiary hearing to address the alleged misconduct by LAVO's staff. We attempted to interview Judge Hollows regarding the allegations listed in his findings and recommendations, but his legal assistant told us that the judge respectfully declined the interview to prevent affecting the active lawsuit. In addition, his legal assistant told us Federal judges have a duty to refer any criminal allegation of merit presented before them for further investigation.

## Lawsuit Settlement, Stipulations, and Evidentiary Hearing

On February 13, 2014, the Government and the Botell family reached a settlement agreement, which was accepted by Judge Nunley. The settlement was accompanied by a stipulation titled, "Stipulation for Compromise Settlement and Release of Federal Tort Claims Act." Section 4 of the settlement and stipulation states:

Plaintiffs and their guardians, heirs, executors, administrators, or assigns do hereby accept the cash sums set forth above in paragraph 3.a and the purchase of the annuity contract(s) set forth above in paragraphs 3.b and 3.c in full settlement, satisfaction, and release of any and all claims, demands, rights, and causes of action of whatsoever kind and nature, including any claims for fees, costs and expenses, arising from, and by reason of, any and all known and unknown, foreseen and unforeseen, bodily and personal injuries, death, or damage to property, and the consequences thereof, which the plaintiffs or their heirs, executors, administrators, or assigns may have or hereafter acquire against the United States, its agents, servants and employees on account of the same subject matter that gave rise to the above-captioned action. Plaintiffs and their guardians, heirs, executors, administrators, and assigns do hereby further agree to reimburse, indemnify and hold harmless the United States and its agents, servants, and employees from and against any and all such claims, causes of action, liens, rights, or subrogated or contribution interests incident to or resulting or arising from the acts or omissions that gave rise to the above-captioned action, including claims or causes of action for wrongful death.

U.S. District Court records indicate that the allegations the Botell's legal counsel presented to us in September 2014 were also presented to the court on February 7, 2013, in a document titled "Spoliation of Evidence and Bad Faith Acts Timeline." Judge Nunley deferred ruling on these

allegations, and the lawsuit was settled without the convening of an evidentiary hearing to address the allegations. We attempted to interview Judge Nunley regarding the allegations against NPS staff, but we were advised he respectfully declined to comment on the matter.<sup>9</sup>

The aforementioned claims and civil lawsuit involved several Assistant U.S. Attorneys, DOI Solicitors and Federal judges that presided over the matters, however, none of the alleged acts of misconduct were referred for further investigation or action.

## **DETAILS OF INVESTIGATION**

In September 2014, we received an inquiry from Congresswoman Jackie Speier, U.S. Representative for California's 14th Congressional District, who requested the OIG's assistance in resolving an outstanding issue pertaining to the 2009 fatality of 9-year-old Thomas Botell Jr. at LAVO. Congresswoman Speier's request pertained to the allegations of LAVO staff misconduct that were raised during the civil lawsuit court proceedings, specifically the allegations against Superintendent Koontz. Based on the congresswoman's request, we reopened our 2013 investigation in an effort to resolve outstanding issues pertaining to 2009 fatality.

In November 2014, Steven Campora of Dreyer, Babich, Buccola, Wood and Campora, LLP, sent us an inquiry regarding our investigation. Campora, who represented the Botell family during the civil lawsuit against the Government, offered his cooperation and information relevant to the allegations made against LAVO's staff. We contacted Campora, who provided us the "Spoliation of Evidence and Bad Faith Acts Timeline" complaint document that had been presented to the U.S. District Court on February 7, 2013, as part of the Botell's civil lawsuit. From November 2014 to February 2015, Campora sent us information, documents, and a copy of the NPS' January 1991 version of regulation NPS-50, "Loss Control Management," which was cited as the basis of the alleged LAVO staff misconduct and policy violations.

Campora alleged that LAVO park rangers mishandled the scene of the fatal accident and the subsequent investigation, which, he alleged, compromised ISB's investigation. He also alleged that LAVO staff violated NPS policy by failing to make the appropriate notifications or convene a post-incident board to address the event. The allegations further claimed that LAVO staff and the DOI Solicitor failed to issue a litigation hold or preserve NPS documents relevant to the fatality after NPS received a 2009 letter from the Botell's initial legal representative. In addition, Koontz allegedly failed to make the trail safe after becoming aware of perceived hazards prior to the 2009 accident, ordered the destruction of evidence (specifically, the trail retaining wall) and documents, and refused to be interviewed by ISB.

## NPS' Investigation of the Botell Fatality

According to Campora's complaint document, the LAVO park rangers' decision to conduct an "in-house" fatality investigation after allegedly dismissing ISB investigators was a violation of NPS policy and also compromised ISB's investigation by delaying its involvement. In addition, the LAVO park rangers who responded to and processed the accident scene allegedly failed to safeguard the scene by restricting public access to the trail after the accident.

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<sup>&</sup>lt;sup>9</sup> On June 9, 2015, Judge Nunley's assistant advised he respectfully declined to be interviewed.

We determined that from July 29, 2009, to August 24, 2009, the LAVO park rangers conducted the initial fatality investigation. During their investigation, they documented the conditions of the scene and obtained vital information and evidence from eyewitness interviews. According to NPS and ISB, ISB becomes involved in NPS investigations only when NPS site managers request their involvement, therefore LAVO's decision to retain the investigation did not violate NPS policy. According to ISB senior managers, LAVO park rangers conducted a thorough initial investigation and ISB's investigation was not compromised or affected by the ranger's initial investigative steps.

The complaint alleged that LAVO park rangers violated NPS policy regarding safeguarding incident scenes and investigating significant matters. The referenced NPS policy, however, had been superseded and the active NPS' law enforcement policies do not include specific instructions regarding which element of NPS law enforcement must conduct the investigation. In addition, NPS policy does not offer guidance for preserving a crime scene and offers only vague language for recommended initial actions associated to a serious crime. The details of our investigation are described below.

## NPS Investigative Authority

LAVO staff allegedly violated NPS policy by dismissing the ISB special agent on the day of the accident and subsequently not allowing ISB to investigate the fatality. In the complaint documents, Campora referred to NPS-50 and the ISB special agent's deposition (he was retired at the time of his deposition). We reviewed the January 1991 version of NPS-50 that Campora provided and the superseding NPS policies, finding that NPS-50 was NPS' former occupational health and safety guidance prior to the 2009 accident. In addition, NPS-50 contains no guidance for law enforcement functions, jurisdiction, authority, and incident scene management or preservation methods.

The NPS Deputy Chief of Law Enforcement Operations and Policy (DCLEOP) explained that NPS' law enforcement authority is derived from the Secretary of the Interior through the United States Code (U.S.C.) and is further described in DOI Departmental Manuals (DM) 205 and 446. NPS' law enforcement functions and roles are addressed in NPS Director's Order 9 and specific law enforcement operational guidance is covered in the May 2009 Law Enforcement Reference Manual 9 (RM-9).

RM-9 does not differentiate between park rangers and special agents, but rather Type 1 and 2 commissions. Type 1 commissioned employees are permanent personnel, whereas Type 2 commissions are for seasonal employees or staff awaiting formal training. RM-9 also states all Type 1 commissions have the same authority to perform law enforcement functions and conduct investigations. The policy does not require or specify that certain offenses or occurrences be investigated by either park rangers or special agents, but encourages collaboration and mutual cooperation. The DCLEOP further explained that Type 1 commissioned employees are not offered specialized fatality investigation training, and most full-time law enforcement officers gain experience through exposure or assisting on investigations.

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<sup>&</sup>lt;sup>10</sup> 16 U.S.C. §§ 1 – 6, "Law Enforcement Personnel within National Park System."

<sup>&</sup>lt;sup>11</sup> RM-9, Chapter 2, "Law Enforcement Authority," § 2, "Commissioned Employees."

RM-9 does not specify that the parks and sites must relinquish an investigation to ISB unless there are mitigating circumstances. <sup>12</sup> The policy states that rangers shall notify the appropriate special agent in charge for investigations of crimes involving—

- homicide or attempted homicide;
- sexual assaults:
- kidnapping, abductions, and missing persons (not including search and rescue);
- serial crimes;
- criminal organizations;
- armed robbery;
- drug distribution operations;
- assault of an officer involving injury;
- assault resulting in great bodily injury;
- arson:
- resource violations involving commercial interests;
- fee fraud or theft of monies from the fee program; or
- complex or severe civil investigations.

In addition, RM-9 does not list a visitor fatality as a circumstance in which a special agent or regional law enforcement specialist may be the preferred case agent.

The DCLEOP explained that national parks and sites are, however, required to contact and notify ISB when fatalities occur on NPS property. He related that ISB has less than 20 special agents nationwide and, in some cases, if a national park or site requested ISB's assistance it may take 2 to 3 days for them to respond. Based on this potential delay in response time, the park rangers (Type 1 commissioned employees) onsite are expected to process the scene of the incident, document the conditions, preserve evidence, and gather information surrounding the event. The DCLEOP reiterated that NPS views all Type 1 officers the same, but if NPS believes there is a potential for a claim, ISB's assistance may be requested. Requesting ISB's assistance, however, is not required.

Koontz told us that LAVO park rangers initiated and conducted the fatality investigation because they were Type 1 certified to perform complex investigations, which include fatality investigations. She expressed being comfortable with the park rangers' abilities. In addition, LAVO's lead investigator for the fatality was previously stationed at the Grand Canyon National Park, where he led several fatality investigations for NPS.

According to the 2012 deposition of the ISB special agent/lead investigator for ISB's investigation of the fatality, he became involved in the investigation shortly after the fatality occurred. The LAVO chief park ranger contacted the ISB special agent, briefed him on the circumstances, and requested that he meet with the coroner in Redding, CA. During his deposition, the ISB special agent did not mention that he was dismissed by LAVO, but he did report that LAVO park rangers made the decision to retain the investigation. The ISB special agent stated: "I advised my supervisory chain of command what had occurred, and they were of

 $^{12}$  RM-9, Chapter 15 "Law Enforcement Operations,"  $\S$  5.1, "Designation of Case Agents for Major Investigations."

the opinion, and I concurred, that a case of this magnitude was, pursuant to our policies and common practices, something that should be handled by Investigative Services Branch."

The ISB special agent told us that he had worked as an ISB special agent his entire career before retiring in December 2011. His last duty station was the Whiskeytown National Recreation Area in Shasta, CA, where a portion of his duties included providing law enforcement related training to park rangers aligned with NPS' RM-9. The ISB special agent personally trained the LAVO park rangers and worked with them to draft revisions of RM-9 prior to the incident in 2009.

ISB's Assistant Special Agent-in-Charge (ASAC), who supervised the ISB's lead investigator during the course of the 2009 fatality investigation, explained that NPS law enforcement regulations and policies do not differentiate between the different forms of Type 1 commissioned officers and their abilities. NPS park rangers are allowed and encouraged to perform all law enforcement related tasks. Park rangers, however, also have countless other assigned duties, which sometimes restricts their ability to pursue the various leads outside of the park that typical investigations generate. They possess the knowledge and skill to initiate an investigation and know how to preserve information, interview witnesses, and document all related matters. The ASAC stated that LAVO's lead investigator for the fatality was experienced in conducting fatality investigations.

ISB's former SAC, who supervised the ASAC during the 2009 fatality investigation, explained that NPS had more than 2,000 park rangers and fewer than 40 ISB agents nationwide. Therefore, it was standard practice for park rangers to initiate an investigation and either complete the case themselves, or to transfer the case to ISB at a later date. ISB's involvement in an investigation at an NPS site depends on whether or not ISB's assistance is requested by the park management, ISB's workload, and the severity of the matter to be investigated. An investigation is either ISB's to conduct or they have no involvement.

## Processing the Fatality Scene

LAVO park rangers allegedly failed to properly process and preserve the fatality scene. In the complaint documents, Campora refers to the ISB special agent's deposition and his response to the question of whether the LAVO staff failed to document or capture the condition of the scene before the LAVO trail crew dislodged the intact portion of the retaining wall. He answered:

It was documented insofar as [LAVO's lead investigator for the fatality] captured digital images of the site immediately after [the Botell's injured daughter] was medevaced. Tommy Botell was removed. And all of the first responders and members of the public, members of the family left the area, [LAVO's lead investigator] stayed behind and took photographs. [LAVO's lead investigator] and other National Park Service personnel were able to acquire digital imagery from park visitors who had also taken photographs there. That was how I was able to determine that the site, as it was when I arrived, was different from how it had been immediately following the event involving the Botell children. So there was documentation. It was my opinion, professional opinion, that it was necessary to more closely photograph, document, measure, capture global positioning system

coordinates of the site in order to preserve it in perpetuity as to the greatest extent possible. So some work had been done but not work to the level that I felt needed to be.

We reviewed the ISB 2010 report of investigation and found that it was derived from a combination of efforts by the LAVO park rangers and ISB investigators.

The report reflects that LAVO park rangers initiated their investigation immediately after the Botell children were airlifted out of the park. LAVO park rangers subsequently interviewed 57 witnesses as they departed the trail. The park rangers also obtained copies of the witnesses' photos and videos of the scene. In addition, LAVO's lead investigator for the accident documented the scene and captured 32 photos of the scene's condition, which included the point of origin for the failed portion the retaining wall as well as where the failed retaining wall had come to rest (approximately 700 feet downhill from the scene).

RM-9 establishes how park rangers or special agents should conduct investigations involving "serious crimes, complex long-term investigations." <sup>13</sup> RM-9 does not provide specific scene management guidance or instructions, but rather offers generic guidance for initial actions: "Respond to the scene to protect human life, preserve the crime scene, including evidence and the location of witnesses." RM-9 does not address the length of time a scene should be considered active. According to the DCLEOP, none of the NPS' law enforcement policies offer detailed incident scene management guidance and NPS has no templates or guides regarding how to process incident scenes. Each lead investigator processes scenes differently based on their experience and knowledge.

The ASAC recalled ISB's lead investigator commented that the LAVO park rangers had documented the accident scene "pretty well" and there were no issues that would have forced ISB to attempt to reconstruct the scene for processing. The ASAC related that the ISB special agent reviewed the LAVO park rangers' investigative work that had been completed prior to ISB's involvement and said that matters had been handled well. After the ISB special agent became involved, he began to conduct interviews and continue on with the investigation that the park rangers had initiated. According to the ASAC, the LAVO accident site was a difficult scene to process and manage because it was within a designated wilderness area and, therefore, governed by the restrictions to preserve wilderness areas.

The Assistant U.S. Attorneys (AUSA) who represented the Government in the lawsuit reported that the LAVO park rangers had thoroughly investigated and documented the scene of the accident in photos, notes, and videos.

Koontz told us that she was not a part of the conversations regarding how the scene of the accident was secured. Those conversations would have been led by LAVO's lead investigator, who never voiced any concerns to her regarding the need for additional time to process the scene of the accident or about preserving the scene. Koontz was under the impression the scene of the accident had been processed properly and was well documented.

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<sup>&</sup>lt;sup>13</sup> RM-9, Chapter 15, "Investigations Management."

#### Safeguarding the Accident Scene

LAVO park rangers allegedly violated NPS-50 by failing to safeguard the scene post-incident and before ISB assumed the investigation. The complaint documents referred to the deposition of the ISB special agent who led ISB's investigation of the fatality and his response to whether LAVO staff failed to secure and preserve the scene of the accident. The ISB special agent stated:

Correct. There was no -- aside from a barrier closing the trail, which consisted of some plastic safety fencing stretched between fence posts and a sign indicating that the area was closed to the public, there was no restriction otherwise within that area that would mark it as consistent with, for instance, a crime scene to preserve it and keep people out of it.

The fatality investigation was initiated by LAVO park rangers on July 29, 2009, and was actively conducted until August 24, 2009, when the investigation and associated documents were transferred to ISB. On approximately August 25, 2009, the ISB special agent reviewed the park rangers' investigative files and traveled to the site, where he noticed that the conditions of the scene differed from the photographs taken after the incident.

The ASAC explained that LAVO would be impossible to close off from the public and that same statement is true for most NPS trails. Investigators are always concerned that park visitors will walk around the temporary barrier closing the trail and access the hazardous portion of a trail.

Koontz told us the trail was closed immediately following the accident while she and her staff were focused on a contingency plan. Koontz and her staff discussed whether they should reopen the trail and eventually reached an agreement to open the trail, but restrict visitor access to the lower half of the trail. LAVO's trail was later reopened, keeping it open up to the 1.3 mile mark, allowing visitors a good experience but keeping them away from the accident site. Koontz explained there was no logistical way to completely close the trail because it ascended a volcanic mountain. Barriers were put in place at the 1.3 mile marker, but determined visitors could navigate around the temporary barriers and go to the hazardous accident site. In addition, LAVO's staff was not given instructions regarding how to treat the accident scene or whether or not to disturb remaining artifacts at the scene. Koontz stated that, in hindsight, some sort of announcement should have been sent out to her staff.

According to the DOI Regional Solicitor, any long-term decision to close a trail or restrict access to any NPS main attraction is not made at the local park leadership level. Any such related action would have required NPS regional leadership approval. LAVO's (former) chief of maintenance told LAVO's lead investigator during the 2009 investigation that "public enjoyment and the demands of the public have outweighed any idea of closing the trail. Removing or closing the trail would not keep people off the mountain, it would make conditions worse."

#### ISB's Investigation

LAVO staff's removal of the remaining portion of the retaining wall, allegedly "compromised" ISB's investigation. The complaint documents referred to the deposition of the ISB special agent

who led ISB's fatality investigation as the basis for the allegation. In his deposition, however, the ISB special agent made no statement or assertion that LAVO staff or their actions had compromised ISB's investigation.

The ISB special agent told us that, at the end of August 2009, he and LAVO's lead investigator for the accident traveled to the site after the investigation was transferred from LAVO's park rangers to ISB. During that visit, the ISB special agent noticed differences between the remaining portion of the rock wall and the photos captured during the initial investigation. ISB and LAVO park rangers later determined that LAVO trail crew members had dislodged the remaining loose portions of the retaining wall. The ISB special agent made no reference that any action by LAVO's park rangers or staff compromised his investigation or interfered with what he reported in the final report of investigation.

According to the ASAC, neither he nor the ISB special agent viewed the dismantling of the retaining wall as an action that compromised ISB's investigation. He explained that not much would have been gained by collecting the wall and they never viewed this act as tampering with the accident scene or destruction of evidence. They viewed the wall dismantling as the LAVO staff's attempt to mitigate further injuries and render the trail safe for the staff and future visitors. The ASAC and ISB special agent never considered the retaining wall to be evidence. It was not until the magistrate judge's 2013 findings and recommendations were made public that the idea of the wall as evidence was raised.

The SAC recalled being informed that a LAVO retaining wall had been dismantled and that the ISB special agent and ASAC were upset by the act. He reiterated that dismantling the retaining wall did not compromise ISB's investigation. The ISB special agent was frustrated that ISB inherited the investigation from LAVO weeks after the incident and felt "behind the curve" because the scene had been processed and the evidence collected. During the weeks that LAVO park rangers conducted their investigation, the ISB special agent was assigned other unrelated investigations.

The ISB special agent never voiced or elevated concerns to the SAC about the LAVO park rangers' ability, how LAVO conducted the investigation, or whether LAVO's actions compromised his investigation. The SAC told us that there were some personal differences in how the ISB special agent would have run the investigation, as he was a very detail oriented investigator who likely took issue with the way the LAVO park rangers conducted certain aspects of the investigation. While LAVO park rangers likely did things differently than the ISB special agent would have preferred, the SAC clarified that the rangers did nothing wrong; their actions were simply different from the ISB special agent's preferred method.

We interviewed the ISB agents involved in this investigation and found that none of the alleged acts warranted pursuit or referral for further action.

## **Alleged Violations of NPS Policy by LAVO**

According to Campora's complaints, LAVO staff allegedly violated NPS policy by failing to make the appropriate fatality notifications, file the proper documents, and convene a post-

incident board (Board of Inquiry or Board of Review) to address the event and make recommendations to mitigate future incidents.

We determined that LAVO immediately notified ISB—a branch of the Washington Support Office (WASO)—of the fatal accident and also completed incident documents. NPS policy, however, also required that the fatality be reported to the NPS' Emergency Incident Communication Center (EICC) and the DCLEOP. There were no recorded notifications in the EICC system, but EICC staff explained that not all notifications are recorded, therefore there was no definitive way to determine whether or not LAVO reported the fatality.

The complaint document refers to the superseded NPS-50 regarding the requirement for LAVO to convene a post-incident board (Board of Inquiry) and complete the associated Form DI-134, "Report of Accident/Incident." Campora told us that the NPS policies he referred to during depositions, in court documents, and in the complaint documents were the versions that he either downloaded from the NPS website or obtained from the AUSA. The AUSA stated that her office did not provide the Botells' lawyer with any Government policies, but recalled she had addressed the references to outdated policy with the Botells' lawyer.

The NPS policies and forms addressing visitor safety and post-incident boards underwent a series of modifications, updates, and partitions to specifically address each related NPS program. The policy referred to in the complaint documents had been superseded several times before the 2009 fatality and NPS' current policy on post-incident Boards of Review was not in effect until 2010. This gap in policy would result in guidance being sought from ascending policies, such as director's orders or DOI manuals, but would not revert back to superseded policies. Former NPS policies on convening post-incident boards stated that the boards are to be sensitive of and not interfere with ongoing investigations. In addition, the policies refer park managers to the DOI Solicitors Office for further guidance. The DOI Solicitor's Office informed us they advise against convening a Board of Review when the matter is being actively litigated. Based on the NPS policies at the time of the incident, there were no apparent violations of policy regarding convening a post-incident board. The details of our investigation are described below.

#### **Fatality Notifications**

RM-9 offers guidance to NPS law enforcement employees on how to report Level 2 incidents, which include "Visitor/Public Fatalities." This policy requires the park or site to report the fatality to the DCLEOP via email within 3 days and to call EICC and follow up with a written report.

The NPS EICC center manager explained that parks can notify EICC via a phone call, email, or the established Serious Incident Report System (SIRS). Written notifications are printed and filed at the EICC, but not all calls and emails are kept since EICC did not generate the documents. The center manager queried the SIRS for notifications associated to the 2009 LAVO fatality and found no record. The absence of a report in SIRS could be a result of either the park not notifying EICC, an EICC dispatcher neglecting to print and file the notification, or a dispatcher misfiling the notification. An absent report is not unusual, and it is also not unusual

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 $<sup>^{\</sup>rm 14}$  RM-9, Chapter 36, "Incident Notification Requirement and Procedures" Section 2.2

for parks to not report incidents to the EICC for various reasons.

During the deposition of LAVO's lead investigator for the accident and the special agent who was ISB's lead investigator for the accident, they were both presented with the 1991 version of NPS-50 and referred to sections that addressed notification Form DI-134s. Both employees were asked if DI-134s were generated for the fatality and whether a failure to generate a Form DI-134 would be a violation of NPS policy, to which they both responded that no DI-134 was generated.

We reviewed NPS-50 and superseding policy and found that the last reference to Form DI-134 was in the 1991 version of NPS-50 and newer versions referred to Standard Form 95 "Claim for Damage, Injury, or Death" to file claims.

NPS' Office of Risk Management (ORM), formerly known as WASO Loss Control Management, explained that Form DI-134 "Report of Accident/Incident" was the previous method to report and document accidents on public lands prior to the creation of SIRS. Form DI-134 was also used to capture data associated to potential worker's compensation claims filed by employees injured on duty. Form DI-134 was replaced by Standard Form 95 "Claim for Damage, Injury, or Death" and Form DI-570 "Employee Claim for Loss or Damage to Personal Property."

LAVO's administrative file contains a series of letters exchanged between LAVO and the Botells' lawyer. In a letter dated September 24, 2010, the LAVO chief park ranger provides the Botell family's lawyers with a Standard Form 95 and instruction to complete the claim.

#### Post-Incident Board

LAVO allegedly violated NPS-50 by not convening a post-incident Board of Inquiry for the fatality. Our investigation determined that the complaint documents referred to the superseded NPS-50 regarding the requirement for LAVO to convene a post-incident board.

In an effort to solidify the evolution of related NPS policy and the requirements that were in effect at the time of the incident, we coordinated with NPS Chief of ORM, ORM's Public Risk Management Program Managers, who were U.S. Public Health Service employees detailed to NPS. ORM explained that the policies receive their authority from executive orders or national-level policies. ORM's authority is derived from the Code of Federal Regulations (C.F.R.) "Basic Program Elements for Federal Employee Occupational Safety and Health Programs and Related Matters," which also includes serious accident processes and reporting requirements. DOI develops departmental manuals and regulations to ensure internal program are compliant with the C.F.R., such as Departmental Manual (DM) part 485, Chapter 7, "Incident/Accident Reporting/Serious Accident Investigations." Each DOI bureau also develops bureau-specific guidance, such as NPS Director's Orders and reference manuals. In the occurrence that there are gaps or items not addressed in bureau-specific guidance, staff seeks clarification from departmental manuals or the C.F.R.

NPS-50, "Loss Control Management," dates back to 1983 and was revised in 1991 and again in 1993. When in circulation, the policy addressed a wide variety of topics within the realm of

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<sup>15 29</sup> C.F.R. part 1960.

safety and occupational health matters for both NPS employees and the public. On December 21, 1999, NPS-50 was superseded by NPS Director's Order 50B, "Occupational Safety and Health," and Reference Manual 50B, "Occupational Safety and Health/Risk Management Program." The Director's Order explains how the new series of policy would be arranged:

The overall purposes of the NPS risk management program are to establish and implement a continuously improving and measurable risk management process that: (1) provides for the occupational safety and health of NPS employees; (2) provides for the safety and health of the visiting public; and (3) maximizes the utilization of NPS human and physical resources, and minimizes monetary losses through effective workers' compensation case management. The primary focus of this Director's Order 50B is the occupational safety and health of NPS employees. Visitor safety and health is the primary focus of Director's Order 50C (in preparation as of this writing); and worker's compensation case management is the primary focus of Director's Order 50A.

NPS Guideline NPS-50 is superseded and replaced by this Director's Order, and by Reference Manual 50B, which provides more detailed guidance on how the NPS will implement occupational safety and health management policies and procedures.

Special Directive 95-4 (governing automatic sprinkler and smoke detection requirements) is superseded and replaced by the policies, requirements, and responsibilities contained in this Director's Order, and by the Fire Safety section of Reference Manual 50B.

Figure 1. Director's Order 50B, 1999. Excerpt from the "Background and Purpose" section of the policy.

The 1999 versions of Director's Order and Reference Manual 50B further divide the areas once addressed by NPS-50 into two additional sections: Director's Order 50A, "Worker's Compensation Case Management," and Director's Order 50C, "Visitor Safety and Health." The 1999 version of NPS Reference Manual 50B §14, "Public Safety and Health," addresses post-incident requirements:

#### 14. PUBLIC SAFETY AND HEALTH

DIRECTOR'S ORDER #50C, AND THE RELATED REFERENCE MANUAL #50C, "PUBLIC SAFETY AND HEALTH," IS IN PREPARATION AS OF THIS WRITING, AND WILL PROIVDE DETAILED GUIDANCE ON PUBLIC SAFETY AND HEALTH POLICIES AND PROCEDURES.

#### 14.1 REQUIREMENTS

National Park Service (NPS) Operating Units' Risk Management Programs should address public safety, as applicable to each location, so as to minimize the potential for injury, illness, death, and/or property damage to the public while visiting NPS sites/facilities.

#### 14.2 INVESTIGATION/REPORTING RESPONSIBILITIES

A. It is vital that a complete investigation and documentation be made of all public accidents/incidents/fatalities. Any visitor injury resulting in death, occurring on property within Interior jurisdiction, should be reported by the operating unit manager to the Departmental Emergency Reporting System (1-8880581-2610), the appropriate Solicitor's Office, and a Technical Board of Investigation (TBI) should be appointed, within 24 hours.

B. The Technical Board of Investigation should investigate the accident and provide the NPS Risk Management Program Manager with an abstract of the incident and any recommendations that have servicewide application. The completed TBI Report will remain on file at the park and/or regional office.

Figure 2. Reference Manual 50B §14 excerpt, dated 1999.

The 1999 version of Director's Order and Reference Manual 50B were revised in September 2008, which would have been the active NPS policy at the time of the 2009 LAVO fatality. The 2008 versions offer no guidance for public safety or visitor fatalities and refer to Director's Order 50C for all public risk management matters. Director's Order and Reference Manual 50C were being drafted in 2009 and were finalized in May 2010, therefore Director's Order 50C was not an active policy at the time of the incident. The 2008 versions primarily address the safety and health of NPS employees or occupational safety and health and refers to Boards of Review when addressing an employee fatality.

The delay between the 2008 Director's Order 50B being published and the 2010 publication of Director's Order 50C created a gap in policy regarding Boards of Review. Guidance or clarification would therefore be sought from the next level of guidance: NPS management policies or departmental manuals. NPS' 2006 "Management Policies" briefly addresses visitor safety, but refers to Director's Order 50B and C for further guidance. DM part 485, Chapter 7 § J, "Accident Reviews" offers the following guidance:

Bureaus will establish appropriate procedures for review of accidents. For individual accidents, this will include second level management and/or safety management review of the [Safety Management Information System] Accident/ Incident Reports as they are entered into SMIS. Bureaus, at their discretion, should establish procedures for review of organization-wide accident information.

The terminology used to address post-incident boards in NPS policy underwent several revisions between 1991 and 2010:

- NPS-50 (1991): Boards of Inquiry required for all serious accidents (superseded).
- Director's Order 50B (1999): Technical Boards of Investigation should be convened post-incident to provide ORM with service wide recommendations.
- Director's Order 50B (2008): Post-incident boards are not addressed.
- Reference Manual 50B (2008): Boards of Review should be convened for serious accidents involving NPS employees. Serious accidents involving park visitors are not addressed.
- RM-9 (2009): Boards of Inquiry should be convened when employees are suspected of misconduct.

We reviewed NPS policies and guidance that specifically address post-incident boards following a visitor fatality and found that they contain nearly identical language in both the 1991 version of NPS-50 and the 2010 Reference Manual 50C: "NOTE: The [Board of Review] should be sensitive to the possibility of internal or criminal investigations by authorized authorities. In such cases, the [Board of Review] is not to interfere with any investigation of this kind." The policies also recommend park staff consult with DOI Solicitors before conducting a Board of Review.

The DOI Regional Solicitor told us that she would not have allowed a Board of Review to convene until after the statutes on the tort claim had expired or passed because of the potential for interference with NPS' investigation. Once litigation has begun, Boards of Review are not initiated for disclosure purposes. Once litigation has concluded, Boards of Review can be used to look at the situation in an attempt to mitigate or prevent the incident from reoccurring.

Koontz told us that LAVO did not conduct a formal post-incident board proceeding to ensure that her staff did not interfere with the ongoing investigation. Based on lessons learned during her 30-year career with NPS, Koontz avoided interfering with investigations or duplicating investigative efforts through a formal board process. Koontz and her staff did perform an informal After Action Report (AAR) to identify actions for immediate improvement and implementation. The AAR generated three immediate corrective actions that she and her staff identified: inspecting trails by physically pushing and pulling on retaining walls to look for movement; providing first-aid training and additional training for the LAVO visitor center staff; and stationing seasonal LAVO park rangers closer to both the trail and visitor center.

LAVO's administrative files contained a letter from LAVO's chief park ranger to the AUSA alerting the U.S. Attorney's Office that the Botells' lawyer was incorrectly referencing NPS-50, which the chief park ranger referred to as being obsolete. Campora indicated to us that he had found the policy on the NPS website or the AUSA emailed it to him. The AUSA told us that her office did not provide Campora with any Government policies.

## Alleged Failure to Preserve Records and Produce Discovery Information

According to Campora's complaint document, NPS staff, LAVO staff, and the DOI Regional Solicitor allegedly failed to act accordingly after they were contacted by the Botell's lawyer in

August 2009. They allegedly failed to issue preservation or litigation holds to preserve incidentand trail-related documentation related to the fatality. In addition, LAVO staff allegedly shredded relevant documents that were requested during the production and discovery period of the lawsuit.

We determined that NPS and the Solicitor's Office received a letter from the Botell family's former lawyer requesting that LAVO preserve evidence. The Solicitor viewed the letter from the Botell family's lawyer as a letter of representation and not an indication of intent to file a lawsuit. When the letter was received, the Botells had not filed a claim or indicated an intent to seek litigation for the fatality. The Solicitor's Office cannot issue a litigation hold without the intent to file or a filed lawsuit and does not instruct DOI bureaus to arbitrarily hold records without justification. The Solicitor was confident that the Government safeguards in place preserve the records during the allowable time a claimant has to file a claim or lawsuit.

The allegation that discovery documents were shredded surfaced after a LAVO clerk reported witnessing the LAVO chief park ranger shredding the documents they collected in response to a discovery request. The clerk's deposition, however, revealed that she was unable to observe what he shredded. The clerk subsequently retrieved the shredded pieces from LAVO and produced them during her deposition with the Botell's lawyers and the AUSAs. According to the AUSA who defended the Government during the lawsuit, she examined the shredded pieces in the presence of the Botell's lawyers and stated there appeared to be no original documentation or handwritten notes. The AUSA was confident that LAVO produced everything requested during the discovery process and explained no discovery instructions were provided to LAVO regarding the culling of documents. In his deposition, the LAVO chief park ranger stated he shredded duplicates and items that were deemed not relevant to the discovery requests. The details of our investigation are described below.

#### **Preservation Orders**

DOI allegedly failed to issue a preservation order or litigation hold following receipt of a letter from the Botell's legal representative. The Botell's initial law firm, Patrick W. Steinfeld & Associates, sent Koontz and the ISB special agent a letter dated August 12, 2009, stating that the Botells had retained the firm's services and requested a status of the investigation. In the letter, Steinfeld & Associates also requested that the firm's expert observe or participate if the investigation was ongoing and that "adequate measures to preserve evidence of the subject rock retaining" wall be implemented. In addition, the law firm stated in the letter that "spoliation of evidence may result in sanctions including monetary, issues and evidence as well as an inference that the evidence was adverse to your department's interests."

On August 18, 2009, the DOI Regional Solicitor responded in a letter to the Steinfeld & Associates' inquiry, stating that the investigation was ongoing and that "at this stage of the investigation there is nothing for your expert to observe as the site visits and interviews have concluded. You will be provided a copy of the accident report as soon as it is completed. The DOI Regional Solicitor's response further advised: "With respect to preserving evidence, the piece of retaining wall which dislodged fell approximately 1000 ft. below the trail, where it still lays. In addition, the section of trail at which the accident occurred is presently closed to

visitors." In the letter, the DOI Regional Solicitor also explained that the trail was frequently closed due to inclement weather and there was a trail renovation project pending. She then referred the Botell's lawyer to LAVO's secretary to make arrangements to view the accident site.

The Solicitor's response to the Steinfeld & Associates letter was allegedly "wholly untruthful" and meant to mislead the Botells' lawyer. According to the complaint, by August 18, 2009, the ISB special agent's investigation had not begun, preventing the Botells' lawyer and the law firm's expert from participating. Further, the Solicitor allegedly failed to mention that LAVO had dislodged the remaining portion of retaining wall.

The DOI Regional Solicitor told us that the intent of her response to the Steinfeld & Associates' letter was to update the Botells' lawyer on the status of the ongoing investigation, the status of the retaining wall, and to offer to make arrangements for the law firm's expert. She attempted to coordinate the law firm's experts' visit to LAVO because the area was approaching inclement weather months, which can make portions of the trail impassable. The DOI Regional Solicitor did not recall the Government ever receiving a response after she sent the August 18, 2009 letter or confirmation after the firm was provided a copy of ISB's report of investigation in January 2010. The next contact the Government received was when the tort claim was filed by the Botell's new law firm, Dreyer, Babich, Buccola, Wood LLP. <sup>16</sup> To her knowledge, no expert representing the Botells traveled to LAVO to inspect the site of the accident.

The DOI Regional Solictitor told us that the Steinfeld & Associate letter was viewed as a notification of representation and not a litigation hold or preservation notice. At that point, the Botells had not filed a claim or a lawsuit, therefore no litigation was pending that would have warranted the initiation of a litigation hold. Because no claim or lawsuit had been filed identifying the basis of the claim or which records needed to be preserved, the Government did not issue a preservation order. LAVO was not required to take any action aside from forwarding the letter to the Solicitor to verify the letter's authenticity and intent.

According to the DOI Regional Solicitor, the Government does not automatically preserve information after an accident because it would be unaware of a claimant's intentions until a claim or lawsuit is filed. Further, not all fatalities or injuries on public lands result in a claim or lawsuit. Records can be preserved on a case-by-case basis if the Government is made aware of the basis of the tort or lawsuit, claimants can file the claim up to 2 years from the date of the event. The DOI Regional Solicitor expressed that it is unrealistic for the Government to attempt to preserve all data for potential claims and there are established schedules for preserving and disposing of Government data. The DOI Regional Solicitor was not fearful of losing LAVO records or data pertaining to the incident, based on the cycle or scheduled destruction of Government records established by DOI and reinforced in the Federal Information System Security Awareness training for all DOI employees.

The DOI Regional Solicitor explained that records retention within DOI as a whole has been problematic in the past, partially due to the amount of time it takes for some claims or lawsuits to

<sup>&</sup>lt;sup>16</sup> According to the administrative file for this incident, Dreyer, Babich, Buccola, Wood LLP initiated contact with LAVO on September 21, 2010, regarding the process of filing a tort claim; the Botell's tort claim was filed in November 2010.

be filed. She did not see the 30-day auto delete email function as an issue at LAVO and explained that DOI's former email system, Lotus Notes, automatically archived emails making them accessible at a later date. After the Botells' lawsuit was filed against the Government, the U.S. Attorney's Office led the Government's defense efforts and all subsequent matters were addressed through the AUSAs. Once the litigation started, all litigation holds and preservation orders were routed directly to the Solicitor's Office or the AUSA for review and action.

According to the complaint, the absence of a preservation order led to the loss of relevant trail and safety documents when LAVO's former chief of maintenance destroyed his library of personal files before retiring.

During the former chief of maintenance's deposition, he said that he disposed of items in his personal library upon retirement in December 2009, while the remaining LAVO-related documents were left in his office. In addition, his retirement predated the Botell's claim and lawsuit.

Our Forensic and Analysis Unit captured and processed official DOI emails associated to this investigation, specifically searching for correspondences involving LAVO employees and the 2009 fatality. Based on the complainant's allegations, key word searches were conducted on the captured emails; the review generated no relevant correspondence.

#### **Discovery Documents**

LAVO staff, specifically the LAVO chief park ranger, allegedly shredded documents responsive to discovery requests. The alleged act was witnessed by a LAVO clerk, who helped him collect documents relevant to discovery requests.

According to her deposition, the clerk began assisting the chief park ranger gather and make copies of LAVO documents relevant to the 2009 fatality to fulfill production and discovery requests for the lawsuit. She collected documents, such as meeting minutes, notes, and emails, and provided them to the chief park ranger. In March 2012, she assisted in a second request for documents associated to a discovery request and again provided the documents to him. According to the clerk, the chief park ranger voiced concern over the documents she had gathered because he felt they were not relevant to the production request. The clerk recalled that the chief park ranger and Koontz had a meeting after she collected the LAVO documents. Upon returning from his meeting, he pulled documents from the collection and shredded the items. The clerk could not see which documents the chief park ranger shredded or the quantity, other than it appeared to be a stack of paper. She did not engage him to determine what he had shredded, but returned to work the following day and retrieved the shreds of paper from the waste bin. During her November 30, 2012 deposition, the clerk turned the shredded papers over to the court reporter.

The AUSA was present when the clerk presented the paper shreds. The AUSA reviewed the shredded papers during the clerk's deposition and in the presence of the Botell and LAVO clerk's lawyers. During her review, the AUSA did not find the alleged original documentation or handwritten notes. She believed no handwritten notes or agendas were located because of the nature of NPS culture in which the staff meet and communicate in person while out working in

the park. The AUSA was confident that LAVO produced everything requested during discovery. Her office did not provide LAVO with discovery instructions regarding culling procedures and all discovery requests were forwarded directly to LAVO for production.

Koontz recalled that the LAVO clerk assisted the LAVO chief park ranger in compiling documents requested for discovery. After the documents were compiled, Koontz, the chief park ranger, and Koontz' secretary, reviewed the compiled documents together and removed anything that was not relevant to the discovery request. She stated that LAVO produced everything pertinent to the accident, and she never gave any orders to shred or withhold information from discovery.

In the LAVO chief park ranger's deposition, he stated that the documents removed during production and later shredded were either duplicates or not relevant to the discovery requests. Koontz, her secretary and the chief park ranger culled through the collected documents and removed documents that they believed to be outside the scope of the discovery requests. The chief park ranger denied shredding any copy or original document bearing handwritten notes, but recalled removing an unsigned safety plan and LAVO financial documents that were not relevant to the discovery requests.

The AUSA explained that the preservation and retention of NPS records and records management was an issue during this lawsuit, but noted that related deficiencies occurred in several other Government departments and was not a LAVO- or NPS- specific issue. She reiterated being confident that the Government produced everything requested during discovery.

With regards to misconduct, the AUSA stated she was not presented with any evidence or information that led her to believe that any NPS employee had committed a crime. The AUSA expressed that the U.S. Attorney's Office has a duty to report merited misconduct for further action.

## Alleged Misconduct by LAVO's Superintendent

Koontz allegedly ordered the retaining wall destroyed and later refused to cooperate with ISB investigators. Koontz also allegedly had knowledge of LAVO's trail hazards prior to the 2009 fatality, failed to act accordingly, and removed "strong language" from an unrelated post-incident official report pertaining to the condition of the LAVO trail.

Witness testimony and LAVO staff statements to ISB revealed conflicting accounts regarding who ordered the trail crew members to dismantle the intact portion of the retaining wall. On July 29, 2009, the retaining wall responsible for the fatal accident was pushed off the trail tread and descended the volcano. The wall LAVO's trail crews allegedly destroyed was a portion that had remained intact on the trail until early August 2009 when trail crew members dislodged it due to unstable footing. None of the individuals interviewed or who provided testimony could attest that they received an order from Koontz to dismantle the intact portion of the retaining wall. Koontz denied ordering the destruction of the wall and stated that she learned of the event only after it happened. In addition, Koontz told both us and the DOI Regional Solicitor that ISB and NPS park rangers never attempted to interview her. While we found conflicting accounts regarding

whether ISB attempted to contact and interview Koontz, ISB was never under the impression Koontz refused to be interviewed.

The 2009 fatality was the first incident of its kind at LAVO, and Koontz had no reason to believe the trail's retaining walls would fail. She denied being previously advised by LAVO staff of the potential hazards or that the trail should have been closed prior to the fatality. The funding issues predated Koontz's time at LAVO, and LAVO's former chief of maintenance had fought for funding to rehabilitate the trail for more than 20 years. Because there was no evidence that the trail should be closed to the public, it remained open until the 2009 fatality and then was partially closed to restrict access to the site of the accident until the rehabilitation project was completed. Koontz had requested that certain statements made in a post-incident historic architectural inventory be removed because the comments in question were beyond the scope of the architectural inventory or the purpose of the report. The details of our investigation are described below.

## Retaining Wall

The retaining wall responsible for the fatal accident on July 29, 2009, came to rest approximately 700 feet below the site of the accident. Thomas Botell Sr. told the LAVO rangers he was able to move the failed portion of wall to gain access to his children, and the failed portion of wall then descended the volcano.

On approximately August 4, 2009, LAVO seasonal trail maintenance crew members hiked up the Lassen Peak Trail under the direction of the LAVO trails supervisor. The trails supervisor told them to assist the LAVO facility manager and an NPS historic landscape architect with a trail inventory. The trail crew members met with the facility manager near the site of the Botell accident, and the facility manager allegedly advised them to dislodge a portion of retaining wall that was "hanging" off the trail. The trail crew members used their legs to push the loose portion of retaining wall off the trail and down the slope of the volcano; the dislodged portion of retaining wall came to rest close to the portion that failed on July 29, 2009. According to the trail crew members, the facility manager and historic landscape architect continued on with the trail inventory, while the trail crew members went on to perform unrelated trail work, later reporting to the trail supervisor on their trail work for the day.

ISB's report of investigation and associated supplements revealed conflicting information from all of the LAVO staff involved in this matter, resulting in an unclear chain of events that led to the dislodging of the intact portion of the retaining wall. The facility manager reported that the trail crew members were acting under the guidance of either the trail supervisor's or the former chief of maintenance, while the former chief of maintenance reported he had no involvement or knowledge of the event. The trail supervisor confirmed he sent the trail crew to assist the facility manager with a trail inventory.

Koontz denied ordering the destruction of the intact portion of the retaining wall or being a part of any conversation with LAVO staff about removing the remaining portion of the wall. She only became aware of the event after it had occurred and immediately reported the event to the Solicitor. Koontz and her staff were mainly focused on ensuring the trail was safe and whether to

reopen the trail. Koontz was under the impression that the scene of the accident had already been processed and thoroughly documented by LAVO park rangers. Koontz and the LAVO park rangers never discussed releasing the scene or communicated to park staff that the accident scene was active or still being processed. Before to the matter was litigated, no questions were posed regarding whether the act of dismantling the retaining wall was a violation of law or NPS policy.

Due to conflicting accounts, the ISB special agent was unable to determine who ordered the trail crew to dislodge the intact portion of the retaining wall. The ISB special agent said that the order to dislodge the retaining wall had to have been given since it was not a task the trail crew would have performed on their own.

The ASAC reported that neither the remaining portion of the retaining wall nor the portion responsible for the fatal accident had any evidentiary value for ISB's investigation. It was only when the judge magistrate's findings and recommendations were released in 2013 that the idea the wall as evidence surfaced. Through the many conversations that the ASAC had with the ISB special agent about this investigation, the ISB special agent reported that the dismantling of the remaining portion of wall compromised ISB's investigation; The ASAC expressed that not much would have been gained by collecting or processing the wall as evidence.

## Koontz's Cooperation with ISB

According to the ISB special agent's deposition, Koontz declined to be interviewed by ISB, therefore he was unable to obtain clarification from her on several topics. The ISB special agent testified that Koontz had the right to decline an interview and explained the process and justification required to compel a witness to be interviewed. He discussed compelling Koontz to be interviewed with his ISB supervisors, but was unaware if ISB contacted Koontz's supervisor or regional director about the matter. The ISB special agent was unable to recall the details of how Koontz declined the interview, but recalled getting the response through his ISB chain of command:

I think I got that back from [the ASAC] verbally and in telephone conversation. But there is no question in my mind that she didn't wish to be interviewed by me pursuant to this investigation. I just don't recall specifically. I believe that came back through my chain of command. Either I spoke with [the SAC] or [the ASAC]. My best recollection is it was in a conversation with [the ASAC].

The ISB special agent told us that his requests to interview Koontz were made directly to Koontz's office and to the LAVO chief park ranger, but went unanswered. After receiving no response to his requests, he contacted his ISB supervisors, who subsequently contacted Koontz directly and reported back to the ISB special agent that Koontz did not want to comment on the incident.

The ASAC did not recall Koontz declining an interview. The SAC contacted Koontz during the investigation, but did so because they were personal friends (no further information). The ASAC did not recall ever discussing compelling Koontz to be interviewed by ISB; in hindsight, based on the magnitude of the matter, he felt that ISB should have pursued interviewing Koontz.

The SAC recalled the ISB special agent wanting to interview Koontz as part of the LAVO fatality investigation. The SAC was under the impression that the working relationship between ISB and LAVO was congenial and the investigation was moving forward. He was unable to recall talking to Koontz about being interviewed and did not remember Koontz declining to be interviewed. According to the SAC, the LAVO chief park ranger told the ISB special agent that Koontz did not want to be interviewed. He had no recollection of compelling Koontz to be interviewed ever being discussed and how that option would not have been warranted.

Koontz told us that neither the LAVO park rangers nor ISB attempted to interview her; she voiced her concern about not being interviewed to the DOI Regional Solicitor.

According to the ASAC, prior to the 2009 fatality, ISB conducted an unrelated theft investigation at LAVO that potentially affected how Koontz viewed ISB's involvement. Although the ISB special agent was not the case agent on the previous investigation, ISB managers were under the impression that their assistance was not welcomed at LAVO after the previous investigation. According to RM-9, ISB cannot investigate matters at the park level unless the parks and sites request assistance.

The ASAC recalled that the ISB special agent felt passionately that ISB should have led the 2009 investigation. The ISB special agent told ISB that LAVO park rangers also wanted ISB assistance with the fatality investigation, but the outcome of a previous ISB investigation at LAVO likely affected the park's decision to request ISB's involvement.

The SAC recalled that, during the 2009 ISB fatality investigation, there were several discussions between ISB and LAVO park rangers regarding investigative roles and responsibilities. He stated that the 2009 investigation caused a rift between Koontz and the ISB special agent, which he attributed to differences of opinion compounded by Koontz taking the LAVO chief park ranger's advice over the agent's (no further information). He explained that the ISB special agent was a detail oriented, "by-the-book" investigator and likely took issue with the way the LAVO rangers conducted certain aspects of the investigation. The SAC stated that the LAVO park rangers likely did things differently from the ISB special agent; he clarified that the park rangers did nothing wrong, their actions were just different.

## Knowledge of Trail Hazards

The ISB special agent told us that several LAVO employees informed him that they attended multiple meetings to discuss the condition of the trails prior to the 2009 fatality, during which witnesses, such as the facility manager and trail supervisor allegedly, voiced their concerns to Koontz that the trail was dangerous and should be closed. LAVO staff informed ISB that Koontz dismissed these concerns and the trail remained open to the public.

Koontz gave us a detailed explanation of the historical conditions of LAVO's 70-year-old trails and how LAVO staff had documented the well-known maintenance issues associated with the trails. The maintenance and funding issues predated her becoming LAVO's superintendent. According to Koontz, the former chief of maintenance continuously "fought" for funding during his 20-year career at LAVO. She and the now former chief of maintenance had countless

conversations about the trail's condition prior to the accidental death, but the topic of closing the trail was never discussed. Koontz said she would have closed the trail if presented with facts or evidence to support that decision.

During the former chief of maintenance's deposition, he clarified that the trails were in need of a structural retrofit, which was why he promoted the "Reach the Peak" project to raise awareness and funds for the trail rehabilitation project. The former chief of maintenance was never presented with any concerns and never personally observed any conditions that made the trail unsuitable for public visitors. The former chief of maintenance trusted the trail supervisor's judgement, but had no recollection of the trail supervisor advising him about the fissures the trail supervisor allegedly observed in the retaining walls or about various concerns and hazards along the trail before the 2009 fatality.

The historical concerns about inadequate footing for the 50 retaining walls along the Lassen trail and trail conditions were compounded by being built on a volcanic mountain, since the environment limited options to erect a stable footing to support the retaining walls and trail switchback. In addition, the pace of maintenance efforts could not keep up with the pace of the trail erosion, due to insufficient funding for trail crew members and rehabilitation efforts.

During the LAVO environmental compliance officer's (ECO) deposition, he said that he became aware of the trail's history and maintenance challenges upon his arrival to LAVO in 2008. He knew the mortared retaining walls were in poor shape in 2008, but denied knowing that the walls posed a safety hazard to visitors. He was unable to recall whether the trail supervisor ever voiced concerns that the trails were unsafe, but recalled the trail supervisor stating the retaining walls "needed work." The ECO did not recall the trails supervisor ever stating that LAVO management failed to listen to him regarding public safety.

LAVO staff members' depositions regarding the known hazards of the trail, as well as who informed Koontz of the issues and recommended trail closure, were conflicting. In the facility manager's interview with ISB, he stated in 2008 he observed trail hazards that should have required trail closure and reported his observances; in his 2012 deposition, he didn't recall providing that language to ISB but noted the trail was in need of rehabilitation. In the trail supervisor's 2012 depositions, he claimed to have advised Koontz of the trail hazards and recommended the trail be closed. The trail supervisor stated that he made Koontz aware of the hazards during a "Reach the Peak" meeting. The LAVO chief of resources' deposition revealed that she was unable to recall whether any LAVO staff voiced their concerns of hazards on the trail to her or LAVO management.

Koontz told us that she had no information or reason to believe additional signs were needed to address hazards other than the known issues associated with hiking the LAVO trails; there were no signs addressing the threat of failing retaining walls since that had never occurred prior to July 2009. There were various signs at the entrance of the trail and the visitor center covering various safety aspects for the public (e.g., environmental hazards of hiking the trail, recommended shoes, staying on the trail's tread, hydration, temperature changes and physical exertion), which were believed to be sufficient.

The LAVO trail is surrounded by wilderness area, which affects LAVO staff's ability to use machinery to repair and maintain the trail. <sup>17</sup> In addition, the steep trail adds difficulty to maintaining an already challenging trail. Further, Koontz said the trail receives a significant amount of snow, restricting trail crews to a narrow window to perform maintenance. The melting snow causes erosion of soil and footing along the trail. The trail is also constantly shifting because it was built on a volcano. Koontz estimated that LAVO experiences between one and three earthquakes per year, which contributes to the earth continuously shifting along the trail.

## NPS Historic Landscape Architect's Trail Inventory

In March 2009, LAVO requested assistance from an NPS historic landscape architect to conduct a LAVO trail inventory for historical significance and to offer technical assistance associated with the trail rehabilitation efforts, which consisted of guiding LAVO in the application of the laws and policies regarding the treatment of cultural resources. Due to scheduling conflicts, the historic landscape architect was unable to visit LAVO until August 2009. According to Koontz's and the ECO's deposition, the historic landscape architect was helping LAVO evaluate the historic integrity of the retaining walls along the trail to determine the trail's eligibility to become listed in the national register as a national historic trail.

According to Koontz, after the historic landscape architect conducted her inventory with the assistance of the ECO and facility manager, she wrote a draft report summarizing her observations, which included statements regarding the poor construction and condition of the LAVO retaining walls. The historic landscape architect provided her draft report to the ECO for review and comments. After reading the historic landscape architect's report, Koontz told the ECO to remove the statements from her report because they did not relate to the historic integrity of the walls. In her interview with ISB, the historic landscape architect recalled being advised by the ECO to "constrain" her comments to the historic preservation concepts associated with her visit. In the historic landscape architect's deposition, she did not recall the exact verbiage removed from her report, but recalled it pertained to the poor quality and construction of the walls.

According to depositions, no copies of the historic landscape architect's draft report were recovered because she edited over the draft, which later became the final version. In December 2009, the ISB special agent interviewed the historic landscape architect who told him that the LAVO trails were "quite the worst trail I'd ever seen in terms of poor condition and safety hazards." She also told him that after her visit in August 2009, she had recommended the trail be left closed until rehabilitation was completed

According to the ECO's deposition, the historic landscape architect felt that the peak trail retaining walls were in bad shape, but the ECO stated that the landscape architect was not there as a wall expert but as a cultural expert to determine the historical value of the trail. The historic

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<sup>&</sup>lt;sup>17</sup> Public Law 88-577, also known as the Wilderness Act, was signed into law by President Lyndon B. Johnson on September 3, 1964. This legislation not only protected over 9 million acres of Federal land throughout the United States, it also provided a legal definition for the term "wilderness" as "an area where the earth and its community of life are untrammeled by man, where man himself is a visitor who does not remain." Approximately 80,000 acres or 74 percent of LAVO is considered wilderness.

landscape architect's visit occurred 5 days after the fatal accident, thus LAVO's staff was already aware of the safety hazards associated to the retaining walls. The ECO recalled that Koontz told him that "some of the statements in this report do not deal with the cultural significance of the trail. Therefore, I don't feel they should be in a cultural report." The alleged strong language in the historic landscape architect's report that was subsequently removed pertained to redesigning the retaining walls. Koontz told the ECO that the historic landscape architect's recommendations were outside of her expertise and beyond the scope of her visit or historical significance of the trail.

In January 2010, the LAVO chief park ranger contacted the ISB special agent after he reviewed ISB's draft report of investigation on the 2009 fatality. The chief park ranger's email correspondence with the agent stated the historic landscape architect's comments "regarding the condition of the trail seem inappropriate for this report." The chief park ranger requested that the historic landscape architect's role be further clarified and for her comments to remain within the scope of her "knowledge and responsibility." The ISB special agent replied that the historic landscape architect's role and expertise were addressed in the report and the focus of the historic landscape architect's interview was to "gain insight into the trail history, construction methods, structural integrity and in process actions concerning the rehabilitation efforts" as well as the historic landscape architect's observations post-incident.

According to the ASAC, after the ISB special agent wrote his draft report of investigation, Koontz and the LAVO chief park ranger read the report and asked ISB to clarify certain aspects of the report. He recalled having a conversation with the agent about LAVO's request and asked him if everything in the report was factual. The ISB special agent assured him that the details in the investigative report were factual. Some of the LAVO staff's recollections, however, may not have been accurate, so the agent documented what each of the staff members reported to him. Based on this conversation, the ASAC advised the ISB special agent not to make any changes to the report of investigation and the report was finalized.

According to Koontz's deposition, LAVO was aware of the trail's condition prior to the historic landscape architect's comments and the 2009 fatality; Koontz stated LAVO's knowledge of the trail condition prompted their initiation of the environment assessment process in 2007 and 2008 and the request for funding to rehabilitate the trail. She denied requesting that the historic landscape architect's comments be removed because of the possibility of litigation, but rather to narrow the historic landscape architect's comments to the scope of the site visit.

#### SUBJECT(S)

National Park Service Lassen Volcanic National Park Mineral, CA

#### **DISPOSITION**

We briefed Congresswoman Speier's staff on the results of our investigation and referred our findings to the NPS Director for appropriate action.