

COMMONWEALTH OF MASSACHUSETTS

Middlesex, ss.

Division of Administrative Law Appeals

Maureen England,
Petitioner

v.

Docket No. CR-21-0263
Date Issued: June 12, 2026

Boston Retirement System,
Respondent

Appearance for Petitioner:

Maureen England, pro se

Appearance for Respondent:

Natacha Thomas, Esq.

Administrative Magistrate:

James Rooney

Summary of Decision

Widow of member who retired on accidental disability from PTSD and later died of heart failure sought death benefits under M.G.L. c 32, § 9(1). Retirement board's denial of a death benefit affirmed because, while PTSD likely was a contributing factor in his death, it was not the natural and proximate cause of his death.

DECISION

On June 30, 2021, Petitioner Maureen England timely appealed under M.G.L. c. 32, § 16(4) the June 15, 2021 decision of the Boston Retirement System denying her a death benefit under M.G.L. c. 32, § 9(1) for the death of her husband, Richard Flippin,

who had been retired on accidental disability. The Board denied her this benefit because the evidence before it did not show that Mr. Flippin's death was related to the post-traumatic stress syndrome (PTSD) for which he had been retired.

The parties each filed prehearing memoranda prior to a hearing scheduled for February 12, 2025. I mark Ms. England's memo as Pleading A and the Retirement System's as Pleading B. These filings contained 15 exhibits. I have added Ms. England's appeal as Exhibit 16, and the 2025 opinions of Christine Campbell Reardon, M.D., and Michael W. Kahn, M.D., as Exhibits 17 and 18 respectively. Prior to the hearing, the parties agreed to have this matter decided on the papers.

Findings of Fact

Based on the exhibits and reasonable inferences drawn from them, I make the following findings of fact:

1. Richard Flippin served in the Marine Corps in Vietnam. He earned a Purple Heart and suffered from PTSD after the truck he was in hit a mine, he was thrown from the truck, and the driver was burned. Mr. Flippin and Maureen England were married in 1987 and have two children. (Exs. 2, 5 and 11.)

2. Mr. Flippin worked as a special police officer in the traffic and parking Department of the Boston Police Department. His job was to place "Denver boots" on cars whose owners had failed to pay parking tickets. He was asked to investigate a fraudulent payroll scam at the Police Department. He told a psychiatrist who later examined him that he discovered that there was "a quota system in the traffic department" and "that people had been meeting their quota and going home early."

For reasons that are not entirely clear, following his report on this matter, in 1985 he was sent to work in a guard shack behind University Hospital for one year and given no duties. His sense that he was in solitary confinement and was being punished unfairly exacerbated his PTSD symptoms. In March 1986, he was hospitalized for three days at a Veterans Administration Hospital for PTSD and job stress. He was about to retire that June but was offered a position doing community relations in the Department of Veterans Services. In 1988, he gave a deposition in a labor dispute involving a fellow employee. To his surprise, he was questioned at the deposition about his dispute with his superiors in the traffic and parking department. He expressed concern to his new superiors about the direction the deposition had taken but found them unsupportive. Thereafter, he experienced restrictions on his job that he interpreted as retaliatory. Again, his PTSD symptoms were exacerbated. (Exs. 2, 5, and 8.)

3. Mr. Flippin applied for accidental disability retirement based on work-related trauma and PTSD. (Ex. 10.) A medical panel unanimously ruled in his favor, noting that his work conflicts had:

significantly aggravated his chronic Vietnam-related PTSD to the point that he is currently too symptomatic and disabled to work effectively. Given his numerous traumatic associations with City-related jobs and politics, we would advise that he should not return to either of his former jobs, which would likely reactivate those memories.

(Ex. 8.) Mr. Flippin was granted accidental disability retirement in 1990. (Ex. 3.)

4. Mr. Flippin's subsequent medical history was described by Christine Campbell Reardon, M.D., a pulmonologist who had been retained by the Boston Retirement Board to review Mr. Flippin's medical records and opine on whether his

death was related to PTSD. She stated:

Mr. Flippin's medical records from the VAMC [Veterans Administration Medical Center] indicate he was receiving medical care for diabetes, hypertension, hyperlipidemia, chronic kidney disease, gout and diverticulitis. Mr. Flippin's diverticulitis resulted in the development of a colovesicular fistula, and eventual colostomy placement.

Mr. Flippin was diagnosed with heart failure with reduced ejection fraction in 10/19. The etiology of heart failure was not clear, and thus [he] underwent a coronary artery catheterization to rule out ischemia. The catheterization showed single vessel disease and was not felt to explain his poor ejection fraction of 20 – 25%. He was noted to have a history of atrial fibrillation with rapid ventricular rhythm, so a tachy-mediated cardiomyopathy was entertained, along with the possibility of alcohol mediated cardiomyopathy.

Mr. Flippin presented to his primary care physician on 12/24/2019 and during this visit[] was noted to be severely short of breath, and was having difficulty walking without shortness of breath. Mr. Flippin noted that his breathing had been difficult for the preceding 5 days. He was admitted to the VAMC for decompensated heart failure. During this admission, Mr. Flippin's cardiac echo showed a further reduction in his cardiac function, with his left ventricular function down to 15-20%. During this admission, Mr. Flippin had episodes of atrial fibrillation with high ventricular rates. He was diuresed using a continuous infusion of Lasix, and his atrial fibrillation was control[led] with b[eta]-blockers and amiodarone. Mr. Flippin was also noted to have an abdominal wall abscess that was incised and drained at the bedside. Mr. Flippin had difficulty with hypotension that required stopping his b-blocker, and his atrial fibrillation became less well rate controlled. The medical team had ongoing discussion with the family, and during his admission, the decision was made to transition all measures to focus on Mr. Flippin's comfort. He died on 1/10/2020.

(Ex. 11.)

5. Mr. Flippin's death certificate listed his immediate cause of death as respiratory arrest. It listed PTSD as a contributory cause. (Ex. 4.)

6. Maureen England applied for a death benefit under M.G.L. c. 32, § 9(1), which provides that a retirement board shall provide a death benefit "upon receipt of proper proof," if it "finds that any member in service died as the natural and proximate

result of a personal injury sustained or a hazard undergone as a result of, and while in the performance of, his duties.” If the “member had previously been retired for accidental disability,” the beneficiary may receive a death benefit “if the board finds that such death was the natural and proximate result of the injury or hazard on account of which such member was retired.”

7. The Boston Retirement Board had Mr. Flippin’s medical records reviewed by Dr. Reardon and by Michael Kahn, M.D., a pulmonary and critical care specialist. (Ex. 11.)

8. Dr. Reardon’s opinion was that Mr. Flippin’s death:

was the direct result of decompensated systolic heart failure. He had progression of his heart failure with reduced ejection fraction over a few months from 10/19 to 12/19. This may have been related to atrial fibrillation with rapid ventricular rates causing tachy-mediated cardiomyopathy. Mr. Flippin’s death from decompensated heart failure is not related to post-traumatic stress disorder from which he was retired from his position as a Veterans’ Service agent in 1989.

(Ex. 11.)

9. Dr. Kahn informed the Board that he could not reach a definitive opinion.

He stated:

After reviewing the available records on Mr. Richard Flippin I am unable to opine on whether his death was causally related to what he was retired on.

(Ex. 11.)

10. The Board denied Ms. England’s application for accidental death benefits on June 15, 2021. It explained its denial by saying it relied on the medical records review by Drs. Reardon and Kahn, neither of whom determined that Mr. Flippin’s death was

related to his PTSD. (Ex. 11.)

11. Ms. England appealed.¹ (Ex. 16.) She later offered to the Board the opinions of two psychiatrists who had examined Mr. Flippin around the time he sought disability retirement. (Exs. 5 and 6.)

12. Gary Warstadt, M.D., first performed a psychiatric evaluation of Mr. Flippin in February 1990. At that time, Dr. Warstadt determined that Mr. Flippin was experiencing symptoms of PTSD that appeared to be related to his job difficulties. He concluded that:

there has been ample documentation of the extent to which Mr. Flippin's transfer to an isolated tow lot with no actual work responsibilities in 1985-1986 severely exacerbated his Vietnam-related chronic Post-Traumatic Stress Disorder to the point that he could no longer [work].²

(Ex. 5.)

13. When asked in 2024 to comment on whether PTSD played a role in Mr. Flippin's death, Dr. Warstadt stated:

Richard indeed suffered from PTSD, and it was very severe. It caused disability for him and prevented him from working. It caused a great deal of stress which may have contributed to his death.

¹ In her appeal, Ms. England pointed out that neither she nor her late husband qualified for Social Security. I assume as well that she is receiving no continuing retirement benefits after her husband's death because Option C, which would have provided her with a continuing benefit after Mr. Flippin's death, was not an available option when Mr. Flippin retired in 1990. It was not until 1996 that accidental disability retirees could elect Option C. *See* Acts 1996, c. 306, § 17. Ms. England may wish to consider filing a private bill with the legislature to seek relief.

² There appears to be a missing page after this quote from the doctor, as the next page does not align with what was written on the page that I quoted. The parties have searched in vain for the missing page.

(Ex. 1)

14. Bessel van der Kolk, M.D. examined Mr. Flippin in July 1989. The doctor researched PTSD starting in the 1970s. He served for a time as president of the International Society for Traumatic Stress Studies. (Exs. 5 and 6.) His impression of Mr. Flippin in 1989 was that:

While the sort of labor dispute which Mr. Flippin was engaged in with the Traffic Department would be extremely stressful for anyone, a person with PTSD, who is prone to hyperarousal, and to vengeful ruminations when not occupied with other matters, is likely to react to the sensory deprivation and virtual solitary confinement in which he was placed, with a sharp deterioration of his condition. It also is in line with the nature with the long term character changes that frequently accompany PTSD that such a matter would not be resolved once the situation had been solved, but that the patient would continue to be engaged in obsessional ruminations about the mental injuries and hardships experienced. While I believe that a careful examination of the records of the Boston VA where Mr. Flippin was hospitalized might give a more accurate picture of the degree of mental deterioration in the context of the labor dispute, it is a reasonable guess that the ostracism by the department is likely to have greatly contributed to Mr. Flippin's current sorry mental state.

(Ex. 6.)

15. After the appeal was filed, the Boston Retirement System asked Drs. Reardon and Kahn to comment on the opinions of Drs. Warstadt and van der Kolk and to review hospital records from Mr. Flippin's final hospitalization, including psychiatric notes. (Exs. 12 and 13.)

16. Dr. Reardon responded on May 30, 2023 that:

The psychiatric notes from the VA Medical Center 12-18-19 written by Drs. Alexander Chang and Cristina Montalvo report that Mr. Flippin had a history of heavy alcohol abuse ... the direct result of progressive heart disease which was likely multifactorial from tachy-mediated cardiomyopathy, along with the effects of alcohol abuse disorder, and ischemia. Post-traumatic stress disorder was not the primary cause of his death on 1-10-2020.

(Ex. 14.)

17. On April 23, 2023, Dr. Kahn again found that:

After reviewing the additional records on Mr. Richard Flippin I am unable to opine on whether his death was causally related to what he was retired on. I cannot say with a reasonable degree of medical certainty that his death was caused by PTSD.

(Ex. 15.)

18. Ms. England then asked for further comment from Dr. Warstadt and from a doctor who treated Mr. Flippin at the VA Hospital. Dr. Warstadt had treated Mr. Flippin until 2014. In his letter of May 2, 2024, he commented on the severity of Mr. Flippin's PTSD, focusing on 2004 when Mr. Flippin experienced a significant flashback. In the note he wrote at the time, Dr. Warstadt stated:

Patient has a well-documented history of PTSD. He has not had a flashback since 1981. His PTSD diagnosis was confirmed by Dr. Bessel van der Kolk years ago. The PTSD symptoms had been under good control for the past several years without any medications. Under stress of several veterans events, problems in Iraq, and struggles with the VA he had a flashback which was rather violent in nature.

(Ex. 1.) The doctor noted that flashbacks of this sort might happen decades apart. He prescribed Paxil, a selective serotonin reuptake inhibitor, to Mr. Flippin, but cautioned that while medications in this class worked well against many PTSD symptoms, they were "not particularly good at preventing flashbacks." *Id.*

19. Seema Chowdhury, M.D., is an anesthesiologist and intensivist at the VA hospital where Mr. Flippin died and appears from her letter to have been involved in Mr. Flippin's treatment at the end. Regarding the role PTSD played in Mr. Flippin's

death, Dr. Chowdhury stated in an April 23, 2024 letter that:

Mr. Flippin's immediate cause of death was respiratory failure after a long and complicated hospital course. Post traumatic stress disorder, which he had been diagnosed with many years before, was a significant contributor to the veteran's health status and to his death.

For example, Mr. Flippin's cardiac disorder (atrial arrhythmia and cardiomyopathy) and gastrointestinal disease were certainly exacerbated by PTSD. Mr. Flippin suffered from multiple intraabdominal infectious illnesses and associated hospital admission. PTSD diminished his ability to cope with his health changes and tolerate recommended care.

In fact, after the family decision was made to transition to comfort measures, some medications intended to provide symptom relief instead triggered flashbacks and caused significant distress. Medications were quickly adjusted, and in his last hours, Mr. Flippin appeared comfortable.

The above events have documented support in Mr. Flippin's medical records and in the available medical literature.

As documented in Mr. Flippin's death certificate and described above, PTSD was a significant contributor to his declining health status and present during his final days.

(Ex. 2.)

20. In 2025, Drs. Reardon and Kahn offered additional opinions. Dr. Kahn gave his first extended explanation of his opinion on whether PTSD caused Mr. Flippin's death. He stated that Mr. Flippin's

situation is a most unfortunate one. He seems clearly to have had severe PTSD, which quite possibly led to his poor self-care and overuse of alcohol.

PTSD by itself is not known to have a direct causal link to the kinds of medical conditions suffered by Mr. Flippin. He suffered multiple debilitating medical conditions which eventually led to his death.

His death certificate lists "respiratory arrest" as the "immediate cause of death." The death certificate also lists PTSD as an "Other significant contributing to death, but not resulting in underlying cause." I would agree with this assessment

insofar as PTSD may have contributed to poor self-care, which led to his getting inadequate treatment for his medical conditions.

The situation is far too complicated for me (or perhaps any physician) to state that his death was a direct result of PTSD.

(Ex. 18.)

21. Dr. Reardon's opinion was even more extensive. She thought Mr. Flippin died of untreatable end-stage heart failure. As for what role PTSD might have played, she observed:

There is literature published that patients with PTSD with underlying coronary artery disease had an increased risk of hospitalization for heart failure compared with patients without PTSD. In this study, there was not an increased risk of cardiovascular death. (Almuwaqqat Z. et al Posttraumatic Stress Disorder and the Risk of Heart Failure Hospitalizations among Individuals with Coronary Artery Disease. *Circulation: Cardiovascular Outcomes*, 20 November 2024). Another study by Roy et al. (*Am J Public Health* 2015, April: 105(4): 757-76) found an increased incidence of the development of heart failure in veterans with PTSD compared with veterans without PTSD. None of the studies determined the biological mechanism of this risk.

She concluded:

It remains my opinion that the cause of death for Mr. Richard Flippin was progression of end-stage congestive heart failure. The etiology of his heart failure appears to be multifactorial including coronary heart disease, tachycardia-mediated cardiomyopathy [a chronic disease of the heart muscle], toxic effects of alcohol causing a myopathy [a disease of muscle tissue], hypertension and diabetes. Although PTSD has been reported to increase the risk of the development of heart failure and the risk of hospitalization for heart failure, the mechanism is not known. Major risk factors for the development of heart failure included coronary artery disease, toxins such as alcohol, tachyarrhythmias, infections, valvular dysfunction, and hypertension. Other risk factors contributing to the development of heart failure include diabetes, chronic kidney disease, and obesity. It is my opinion that the medical issues of hypertension, diabetes, coronary artery disease, atrial fibrillations with rapid ventricular rates, and chronic alcohol use were the most likely to have caused his congestive heart failure than his history of post-traumatic stress disorder. It is my opinion that PTSD was less likely to have played a role in his death, specifically because the

Veterans' Administration psychiatric team who had had seen Mr. Flippin twice during the month he died specifically noted in their consultations that Mr. Flippin did not have signs of acute exacerbation of his PTSD. The progression of his heart failure was more likely a consequence of his atrial fibrillation than PTSD.

(Ex. 17.)

Discussion

The beneficiary of a public employee who took accidental disability retirement and died subsequently has the burden, when seeking a death benefit under M.G.L. c. 32, § 9(1), to show a causal connection between the member's death and the disability for which he was retired. *Robinson v. Contributory Ret. App. Bd.*, 20 Mass. App. Ct. 634, 639 (1985). To prove the cause of death, medical evidence is required because evidence of medical causation is beyond the common knowledge of the retirement board and the magistrate. *Id.*

The member's death "must have been the natural and proximate result of the injury or hazard on account of which such member was retired." *Reed v. Teachers' Ret. Bd.*, CR-94-010 (Contributory Ret. App. Bd., Apr. 6, 1998); *see also Cataldo v. Contributory Ret. App. Bd.*, 343 Mass. 312, 314 (1961). Showing merely the possibility or chance that the cause of the disability was also the cause of death is insufficient. *Tassinari's Case*, 9 Mass. App. Ct. 683, 686 (1980).

If the reason for the disability is the same as the cause of death, then a sufficient showing has been made. *See Standish v. Middlesex County Ret. Bd.*, CR-90-1312 (Div. Admin. L. App., August 15, 1992) (coronary artery disease caused disability then death); *Waring v. Bristol County Ret. Bd.*, CR-93-595 (Div. Admin. L. App., December 15, 1993)

(disability due to hypertension following a heart attack; died of cardiorespiratory arrest, as a consequence of a heart attack). Likewise, if the cause of death is similar to the cause of disability, a beneficiary may prevail. See *Gaudet v. Waltham Ret. Bd.*, CR-00-072, at *3 (Div. Admin. L. App., November 30, 2001) (retired under “Heart Law” presumption for mild hypertension and coronary artery disease; expert testified that death from congestive heart failure “may be a consequence of ... mild hypertension and ... coronary atherosclerosis”).³

If the injury or hazard that led to disability retirement also caused death even if the reason disability was granted differed from the cause of death, then a beneficiary may prevail. For example, a prison doctor who was severely beaten by an inmate suffered a disabling heart attack. A few years later, he died of a brain tumor. The Appeals Court remanded the matter for a determination whether the beating had also caused the brain tumor. *Namay v. Contributory Ret. App. Bd.*, 19 Mass. App. Ct. 456, 461-64 (1985). Beneficiaries have prevailed under this approach in a number of instances in which a disabled person later committed suicide. See *Morin v. Plymouth Ret. Bd.*, CR-04-169 (Div. Admin. L. App., April 13, 2005) (person disabled by cervical back pain that also aggravated his depression that led to suicide); *McLaughlin v. Hingham Ret. Bd.*, CR-03-9 (Div. Admin. L. App., March 29, 2004) (pain of disabling

³ Similarity may not always be enough. When a firefighter who was retired because of hypertension later died at 86 of a heart attack, recovery of a death benefit was denied because the evidence showed that the heart attack was related to atherosclerosis, which is a thickening of the artery walls, and there was no evidence that hypertension caused the atherosclerosis. *Gervais v. Lowell Ret. Bd.*, CR-09-578 (Div. Admin. L. App., July 26, 2013).

herniated disc led to suicide); and *Speer v. Public Emp. Ret. Admin.*, CR-93-1095 (Div. Admin. L. App., March 10, 1995) (police officer disabled by chronic back pain after he was injured by a robber; the confrontation with the robber also caused psychological injury and later suicide).

If none of these situations apply and the reasons for the disability and the cause of death appear different, it is possible for a beneficiary to challenge the listed cause of death and assert that the actual cause of death was the same as the reason the decedent was disabled. Who prevails in these instances depends upon which medical evidence convinces the magistrate. Compare *Hochowski v. Worcester Ret. Bd.*, CR-04-156 (Div. Admin. L. App., September 17, 2004) (disabled by heart disease; died of cancer; expert persuaded magistrate that medical records support finding that death caused by cancer, not by heart disease), with *Gorsuch v. Worcester Ret. Bd.*, CR-93-151 (Div. Admin. L. App., May 16, 1994) (disabled by heart disease; death certificate listed the cause of death as pulmonary aspiration, as a consequence of small bowel obstruction, that in turn was a consequence of metastatic carcinoma of the colon, i.e. death caused by cancer, but magistrate persuaded that sudden death caused by enlarged heart).

Efforts to prove that the disabling condition led to other health problems that then caused death have repeatedly failed. That is likely because prior decisions have held that “being an important contributing factor is not the same as being the ‘natural and proximate result of the injury or hazard on account of which such member was retired.’” *St. Michel v. State Bd. of Ret.*, CR-97-921 (Div. Admin. L. App., June 29, 1998;

affirmed by Contributory Ret. App. Bd., Oct. 16, 1998). In *St. Michel*, the decedent had been disabled by heart disease and later developed lung cancer. A bleed in his bronchial artery ultimately killed him. A doctor who treated him acknowledged that the bleed was caused by the lung cancer but opined that his heart disease was a “significant factor” in the man’s death because, had his heart been normal, he might have been able to survive the bleed. The magistrate accepted this testimony but concluded that identifying a significant factor was not the same as showing the proximate cause of death. DALA Decision at *7.

Similarly, when a man who retired because of a foot ulcer and later died of heart disease, his beneficiary sought to show a connection between the two. The foot ulcer was related to his diabetes that, according to his doctor, led to his diabetes worsening, that in turn led him to prematurely have a heart attack. The magistrate denied the claim after accepting the opinion of another doctor that diabetes is a progressive disease and the foot ulcer did not accelerate either his diabetes or heart disease. *Reed v. Teachers’ Ret. Sys.*, CR-94-010 (Div. Admin. L. App., December 31, 1997; affirmed by Contributory Ret. App. Bd., Apr. 6, 1998).⁴

⁴ For other instances in which beneficiaries failed to prevail when the cause of death and the reason for the disability differed see:

Hughes v. Melrose Ret. Bd., CR-21-0073 (Div. Admin. L. App., January 19, 2024) (disabled by hypertension and left ventricular hypertrophy; died of leukemia with congestive heart failure as a significant condition);

Palermo v. Revere Ret. Bd., CR-15-13 (Contributory Ret. App. Bd., August 14, 2015) (disabled by heart disease; died of abdominal sepsis; theory that heart disease made rotator cuff injury inoperable and led man to take ibuprofen that later caused him to

Here, there is no dispute that Mr. Flippin had a severe case of PTSD that was exacerbated by his negative work experiences and that caused troublesome flashbacks decades later. There is also no dispute that his PTSD was not the direct cause of his death but rather that he died from heart failure that led to respiratory arrest.

What role PTSD played in Mr. Flippin's death is not quite so clear. Dr. Kahn's opinion was that PTSD was not itself the cause of Mr. Flippin's many other health problems. Dr. Chowdhury did not dispute this, *per se*, but rather thought that his PTSD exacerbated his cardiac and gastrointestinal problems and thus was "a significant contributor to the veteran's health status and to his death." He pointed out that after efforts to battle Mr. Flippin's major health problems during his last hospitalization had not worked and he had been placed on comfort care, one of the pain medications he was given had induced PTSD flashbacks. Dr. Reardon thought PTSD played less of a role in Mr. Flippin's last hospitalization that preceded his death, pointing out that while

develop a stomach ulcer that led to sepsis was insufficient proof of natural and proximate cause);

Williams v. Waltham Ret. Bd., CR-11-36 (Div. Admin. L. App., November 16, 2012) (retired from low back pain; died from heart failure);

Paul v. Fall River Ret. Bd., CR-09-148 (Div. Admin. L. App., May 4, 2012) (disabled by hypertension and a cerebrovascular accident; died of cancer);

Ramshead v. New Bedford Ret. Bd., CR-05-854 (Div. Admin. L. App., January 5, 2006; affirmed by Contributory Ret. App. Bd., November 22, 2006) (retired from lumbar stenosis; died of heart disease); and

Young v. Public Emp. Ret. Admin., CR-97-629 (Div. Admin. L. App., April 18, 1997) (disabled by heart disease; died from Parkinson's).

studies had shown that PTSD increased hospitalization rates for veterans with PTSD and heart disease, it did not lead to more deaths, and that the “psychiatric team who had seen Mr. Flippin twice during the month he died specifically noted in their consultations that Mr. Flippin did not have signs of acute exacerbation of his PTSD.”

At best then, the evidence viewed most favorably to Ms. England’s claim shows that PTSD played a role in the deterioration of Mr. Flippin’s cardiac health, and this contributed to his death but was not an immediate cause of his death. As pointed out above in my discussion of the prior decisions concerning the death benefit provided by Section 9(1), proof that the disabling condition contributed to a member’s death is insufficient to warrant the grant of this benefit. What must be shown is that the death must have been the “natural and proximate result” of the injury or hazard on account of which such member was retired. Proof that Mr. Flippin’s death from heart failure and respiratory collapse was the natural and proximate result of his PTSD is lacking. Therefore, I must deny Ms. England relief and affirm the decision of the Boston Retirement System declining to grant her a death benefit under Section 9(1).

DIVISION OF ADMINISTRATIVE LAW APPEALS

James P. Rooney

James P. Rooney
Administrative Magistrate

Dated: June 12, 2026