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Contact List for Rulemaking Questions or Concerns

For questions or concerns regarding the Administrative Procedure Act or any of its components, consult with the agencies below. The bolded headings are typical issues which the given agency can address, but are not inclusive.

Rule Notices, Filings, Register, Deadlines, Copies of Proposed Rules, etc.
Office of Administrative Hearings
Rules Division
1711 New Hope Church Road (919) 431-3000
Raleigh, North Carolina 27609 (919) 431-3104 FAX
contact: Molly Masich, Codifier of Rules molly.masich@oah.nc.gov (919) 431-3071
Dana Vojtko, Publications Coordinator dana.vojtko@oah.nc.gov (919) 431-3075
Julie Edwards, Editorial Assistant julie.edwards@oah.nc.gov (919) 431-3073
Tammara Chalmers, Editorial Assistant tammara.chalmers@oah.nc.gov (919) 431-3083

Rule Review and Legal Issues
Rules Review Commission
1711 New Hope Church Road (919) 431-3000
Raleigh, North Carolina 27609 (919) 431-3104 FAX
contact: Joe DeLuca Jr., Commission Counsel joe.deluca@oah.nc.gov (919) 431-3081
Bobby Bryan, Commission Counsel bobby.bryan@oah.nc.gov (919) 431-3079

Fiscal Notes & Economic Analysis and Governor's Review
Office of State Budget and Management
116 West Jones Street (919) 807-4700
Raleigh, North Carolina 27603-8005 (919) 733-0640 FAX
Contact: Anca Grozav, Economic Analyst osbmruleanalysis@osbm.nc.gov (919) 807-4740
NC Association of County Commissioners
215 North Dawson Street (919) 715-2893
Raleigh, North Carolina 27603
contact: Rebecca Troutman rebecca.troutman@ncacc.org
NC League of Municipalities (919) 715-4000
215 North Dawson Street
Raleigh, North Carolina 27603
contact: Erin L. Wynia ewynia@nclm.org

Legislative Process Concerning Rule-making
Joint Legislative Administrative Procedure Oversight Committee
545 Legislative Office Building
300 North Salisbury Street (919) 733-2578
Raleigh, North Carolina 27611 (919) 715-5460 FAX
contact: Karen Cochrane-Brown, Staff Attorney Karen.cochrane-brown@ncleg.net
Jeff Hudson, Staff Attorney Jeffrey.hudson@ncleg.net

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## Filing Deadlines

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EXPLANATION OF THE PUBLICATION SCHEDULE

This Publication Schedule is prepared by the Office of Administrative Hearings as a public service and the computation of time periods are not to be deemed binding or controlling. Time is computed according to 26 NCAC 2C .0302 and the Rules of Civil Procedure, Rule 6.

GENERAL

The North Carolina Register shall be published twice a month and contains the following information submitted for publication by a state agency:

1. temporary rules;
2. notices of rule-making proceedings;
3. text of proposed rules;
4. text of permanent rules approved by the Rules Review Commission;
5. notices of receipt of a petition for municipal incorporation, as required by G.S. 120-165;
6. Executive Orders of the Governor;
7. final decision letters from the U.S. Attorney General concerning changes in laws affecting voting in a jurisdiction subject of Section 5 of the Voting Rights Act of 1965, as required by G.S. 120-30.9H;
8. orders of the Tax Review Board issued under G.S. 105-241.2; and
9. other information the Codifier of Rules determines to be helpful to the public.

COMPUTING TIME: In computing time in the schedule, the day of publication of the North Carolina Register is not included. The last day of the period so computed is included, unless it is a Saturday, Sunday, or State holiday, in which event the period runs until the preceding day which is not a Saturday, Sunday, or State holiday.

FILING DEADLINES

ISSUE DATE: The Register is published on the first and fifteen of each month if the first or fifteenth of the month is not a Saturday, Sunday, or State holiday for employees mandated by the State Personnel Commission. If the first or fifteenth of any month is a Saturday, Sunday, or a holiday for State employees, the North Carolina Register issue for that day will be published on the day of that month after the first or fifteenth that is not a Saturday, Sunday, or holiday for State employees.

LAST DAY FOR FILING: The last day for filing for any issue is 15 days before the issue date excluding Saturdays, Sundays, and holidays for State employees.

NOTICE OF TEXT

EARLIEST DATE FOR PUBLIC HEARING: The hearing date shall be at least 15 days after the date a notice of the hearing is published.

END OF REQUIRED COMMENT PERIOD
An agency shall accept comments on the text of a proposed rule for at least 60 days after the text is published or until the date of any public hearings held on the proposed rule, whichever is longer.

DEADLINE TO SUBMIT TO THE RULES REVIEW COMMISSION: The Commission shall review a rule submitted to it on or before the twentieth of a month by the last day of the next month.

FIRST LEGISLATIVE DAY OF THE NEXT REGULAR SESSION OF THE GENERAL ASSEMBLY: This date is the first legislative day of the next regular session of the General Assembly following approval of the rule by the Rules Review Commission. See G.S. 150B-21.3, Effective date of rules.
EXECUTIVE ORDER NO. 114

PROCLAMATION OF A STATE OF DISASTER FOR BURKE AND RUTHERFORD COUNTIES

WHEREAS, the North Carolina Emergency Management Act, Chapter 166A of the North Carolina General Statutes, authorizes the issuance of a proclamation defining an area as a disaster area as defined in N.C.G.S. § 166A-6 and categorizing the disaster as a Type I, Type II or Type III disaster; and

WHEREAS, on January 11, 2012, the counties of Burke and Rutherford in North Carolina were impacted by a series of severe weather incidents, including high winds, and tornadoes; and

WHEREAS, as a result of the severe weather and tornadoes, Burke County proclaimed a local state of emergency on January 11, 2012; and

WHEREAS, as a result of the severe weather and tornadoes, Rutherford County proclaimed a local state of emergency on January 11, 2012; and

WHEREAS, a joint preliminary damage assessment was done by local, state and federal emergency management officials on January 13, 2012; and

WHEREAS, I have determined that a State of Disaster, as defined in N.C.G.S. §166A-6, exists in the State of North Carolina, specifically in the counties of Burke and Rutherford; and

WHEREAS, pursuant to N.C.G.S. § 166A-6, the criteria for a Type I disaster are met if: (1) the Secretary of the Department of Public Safety has provided a preliminary damage assessment to the Governor and the General Assembly; (2) the counties of Burke and Rutherford declared local states of emergency pursuant to N.C.G.S. § 166A-8; (3) the preliminary damage assessment has met or exceeded the criteria established for the Small Business Disaster Loan Program pursuant to 13 C.F.R. Part 123; and (4) a major disaster declaration by the President of the United States pursuant to the Stafford Act has not been declared; and
WHEREAS, pursuant to N.C.G.S. § 166A-6.01, if a State of Disaster is proclaimed, the Governor may make State funds available for disaster assistance in the form of individual assistance and public assistance for recovery from those disasters for which federal assistance under the Stafford Act is either not available or does not adequately meet the needs of the citizens of the State in the disaster area.

NOW, THEREFORE, pursuant to the authority vested in me as Governor by the Constitution and the laws of the State of North Carolina, IT IS ORDERED:

Section 1. Pursuant to N.C.G.S. § 166A-6, a Type I State of Disaster is hereby declared for Burke County and Rutherford County.

Section 2. I authorize state disaster assistance in the form of individual assistance grants to eligible entities located within the disaster area that meet the terms and conditions under N.C.G.S. § 166A-6.01(b)(1).

Section 3. I hereby order this proclamation: (a) to be distributed to the news media and other organizations calculated to bring its contents to the attention of the general public; (b) to be promptly filed with the Secretary of the Department of Public Safety, the Secretary of State, and the clerks of superior court in the counties to which it applies; and (c) to be distributed to others as necessary to ensure proper implementation of this proclamation.

Section 4. This Type I Disaster Declaration shall expire 30 days after issuance unless renewed by the Governor or the General Assembly. Such renewals may be made in increments of 30 days each, not to exceed a total of 120 days from the date of first issuance.

IN WITNESS WHEREOF, I have hereunto signed my name and affixed the Great Seal of the State of North Carolina at the Capitol in the City of Raleigh, this eighteenth day of January in the year of our Lord two thousand and twelve, and of the Independence of the United States of America the two hundred and thirty-sixth.

[Beverly Eaves Perdue]
Governor

ATTEST:

[Elaine F. Marshall]
Secretary of State
Adam Mitchell, Esq.
Tharrington Smith
P.O. Box 1151
Raleigh, North Carolina 27602

Dear Mr. Mitchell:

This refers to the 2011 redistricting plan for the Craven County School District in Craven County, North Carolina, submitted to the Attorney General pursuant to Section 5 of the Voting Rights Act of 1965, 42 U.S.C. 1973c. We received your submission on November 16, 2011; additional information was received on December 5, 2011.

The Attorney General does not interpose any objection to the specified change. However, we note that Section 5 expressly provides that the failure of the Attorney General to object does not bar subsequent litigation to enjoin the enforcement of the change. Procedures for the Administration of Section 5 of the Voting Rights Act of 1965, 28 C.F.R. 51.41.

Sincerely,

[Signature]

T. Christian Herren, Jr.
Chief, Voting Section
U.S. Department of Justice  
Civil Rights Division

Lisa W. Overton, Esq.  
Assistant County Attorney  
1717 West 5th Street  
Greenville, North Carolina  27834-1696

Dear Ms. Overton:

This refers to the 2011 redistricting plan for the county commission and school board in Pitt County, North Carolina, submitted to the Attorney General pursuant to Section 5 of the Voting Rights Act of 1965, 42 U.S.C. 1973c. We received your submissions on October 31, 2011; additional information was received through November 30, 2011.

The Attorney General does not interpose any objection to the specified change. However, we note that Section 5 expressly provides that the failure of the Attorney General to object does not bar subsequent litigation to enjoin the enforcement of the change. Procedures for the Administration of Section 5 of the Voting Rights Act of 1965, 28 C.F.R. 51.41.

Sincerely,

[Signature]

T. Christian Herren, Jr.  
Chief, Voting Section
IN ADDITION

U.S. Department of Justice
Civil Rights Division

TCH:RSB:JR:RAK:tst
DJ 166-012-3
2011-4830

Voting Section - NWB
930 Pennsylvania Avenue, NW
Washington, DC 20530

January 12, 2012

Richard J. Rose, Esq.
Poyner Spruill
P.O. Box 353
Rocky Mount, North Carolina 27802-0353

Dear Mr. Rose:

This refers to the 2011 redistricting plan for the City of Rocky Mount in Edgecombe and Nash Counties, North Carolina, submitted to the Attorney General pursuant to Section 5 of the Voting Rights Act of 1965, 42 U.S.C. 1973c. We received your submission on November 16, 2011; additional information was received on December 2, 2011.

The Attorney General does not interpose any objection to the specified change. However, we note that Section 5 expressly provides that the failure of the Attorney General to object does not bar subsequent litigation to enjoin the enforcement of the change. Procedures for the Administration of Section 5 of the Voting Rights Act of 1965, 28 C.F.R. 51.41.

Sincerely,

[Signature]

T. Christian Herren, Jr.
Chief, Voting Section
Deborah R. Stagner, Esq.
Tharrington Smith
P.O. Box 1151
Raleigh, North Carolina  27602

Dear Ms. Stagner:

This refers to the 2011 redistricting plan for the Beaufort County School District in Beaufort County, North Carolina, submitted to the Attorney General pursuant to Section 5 of the Voting Rights Act of 1965, 42 U.S.C. 1973c. We received your submission on November 18, 2011.

The Attorney General does not interpose any objection to the specified change. However, we note that Section 5 expressly provides that the failure of the Attorney General to object does not bar subsequent litigation to enjoin the enforcement of the change. Procedures for the Administration of Section 5 of the Voting Rights Act of 1965, 28 C.F.R. 51.41.

Sincerely,

T. Christian Herren, Jr.
Chief, Voting Section
IN ADDITION

U.S. Department of Justice
Civil Rights Division

TCH:RSB:JBG:LJM:tst
DJ 166-012-3
2011-4943

January 10, 2012

R. Michael Cox, Esq.
County Attorney
P.O. Box 39
Elizabeth City, North Carolina 27907-0039

Dear Mr. Cox:

This refers to the 2011 redistricting plan for the board of commissioners for Pasquotank County, North Carolina, submitted to the Attorney General pursuant to Section 5 of the Voting Rights Act of 1965, 42 U.S.C. 1973c. We received your submission on November 21, 2011; supplemental information was received on December 22, 2011.

The Attorney General does not interpose any objection to the specified change. However, we note that Section 5 expressly provides that the failure of the Attorney General to object does not bar subsequent litigation to enjoin the enforcement of the change. In addition, as authorized by Section 5, we reserve the right to reexamine this submission if additional information that would otherwise require an objection comes to our attention during the remainder of the sixty-day review period. Procedures for the Administration of Section 5 of the Voting Rights Act of 1965, 28 C.F.R. 51.41 and 51.43.

Sincerely,

P. Christian Deffen, Jr.
Chief, Voting Section
IN ADDITION

U.S. Department of Justice
Civil Rights Division

TCH:RSB:MSR:ANA:tst
DJ 166-012-3
2011-4858

Voting Section - NWB
950 Pennsylvania Avenue, NW
Washington, DC 20530

January 11, 2012

Adam Mitchell, Esq.
Tharrington Smith
P.O. Box 1151
Raleigh, North Carolina 27602

Dear Mr. Mitchell:

This refers to the 2011 redistricting plan for the Town of Robersonville in Martin County, North Carolina, submitted to the Attorney General pursuant to Section 5 of the Voting Rights Act of 1965, 42 U.S.C. 1973c. We received your submission on November 17, 2011; additional information was received through December 29, 2011.

The Attorney General does not interpose any objection to the specified change. However, we note that Section 5 expressly provides that the failure of the Attorney General to object does not bar subsequent litigation to enjoin the enforcement of the change. Procedures for the Administration of Section 5 of the Voting Rights Act of 1965, 28 C.F.R. 51.41.

Sincerely,

[Signature]

T. Christian Herren, Jr.
Chief, Voting Section
TITLE 10A – DEPARTMENT OF HEALTH AND HUMAN SERVICES

Notice is hereby given in accordance with G.S. 150B-21.2 that the Commission for Public Health intends to amend the rule cited as 10A NCAC 41A .0205.

Link to agency website pursuant to G.S. 150B-19.1(c):
http://cph.publichealth.nc.gov/

Proposed Effective Date: June 1, 2012

Public Hearing:
Date: March 7, 2012
Time: 10:00 a.m.
Location: Cardinal Room, 5605 Six Forks Road, Raleigh, NC

Reason for Proposed Action: This proposed amendment is necessary to make permanent the temporary amendment to the TB Control Measures, which expires on April 10, 2012.

Background: Sputum specimens for acid-fast bacilli smears and mycobacterial culture are an important method of both assessing the infectiousness of persons with pulmonary tuberculosis and of monitoring the effectiveness of treatment. The current rule requires three consecutive sputum specimens for acid-fast bacilli to declare an individual "noninfectious" and discontinue airborne precautions. As a result, health departments routinely collect three sputum specimens every two weeks for acid-fast smear and mycobacterial culture, which are usually sent for testing to the North Carolina State Laboratory of Public Health (SLPH).

Issue: Centers for Disease Control and Prevention guidelines recommend collecting specimens at least monthly until two consecutive sputum specimens are acid-fast smear negative to discontinue respiratory isolation. The current NC guidelines are therefore excessive for local health department staff, patients, and the SLPH.

Proposed solution/benefit: The rule change will reduce the requirement to declare an individual "noninfectious" from three consecutive sputum specimens to two consecutive sputum specimens. This change will permit a more timely release of patients from respiratory isolation with fewer burdens on the patient and local health department staff.

The rule also proposes permitting use of interferon gamma release assays in place of tuberculin skin testing may increase expenditure on these assays while decreasing expenditure on the labor and materials for tuberculin skin testing. However, the rule only permits the use of these assays without mandating their use in any situation; thus, no new expenditure is required by any provider. The use of interferon gamma release assays may reduce the number of persons testing positive for tuberculosis infection because these assays are more specific than the tuberculin skin test (i.e. fewer false-positive tests). This greater specificity would result in reduced public health expenditures on further evaluation and treatment of persons with false-positive tuberculin skin tests.

The rule change has been deemed medically and programmatically appropriate by the North Carolina Tuberculosis Medical Director (Dr. Jason Stout) as well as by program staff at the Centers for Disease Control and Prevention.

Procedure by which a person can object to the agency on a proposed rule: Objections may be submitted in writing to Chris G. Hoke, JD, the Rule-Making Coordinator, during the public comment period. Additionally, objections may be made verbally and/or in writing at the public hearing for this rule.

Comments may be submitted to: Chris Hoke, 1931 Mail Service Center, Raleigh, NC 27699-1931; phone (919) 707-5006; email chris.hoke@dhhs.nc.gov

Comment period ends: April 16, 2012

Fiscal impact (check all that apply).

☒ State funds affected
☒ Environmental permitting of DOT affected
☒ Analysis submitted to Board of Transportation
☒ Local funds affected
☒ Date submitted to OSBM: January 12, 2012
☒ Substantial economic impact ($500,000+)
☒ Approved by OSBM
☒ No fiscal note required
CHAPTER 41 - HEALTH: EPIDEMIOLOGY

SUBCHAPTER 41A - COMMUNICABLE DISEASE CONTROL

SECTION .0200 - CONTROL MEASURES FOR COMMUNICABLE DISEASES

10A NCAC 41A .0205 CONTROL MEASURES – TUBERCULOSIS

(a) The local health director shall investigate all cases of tuberculosis disease and their contacts in accordance with the provisions of the Control of Communicable Diseases Manual which is hereby incorporated by reference including subsequent amendments and editions. Copies of this publication may be purchased from the American Public Health Association, Publication Sales Department, Post Office Box 753, Waldorf, MD 20604 for a cost of twenty-two dollars ($22.00) each plus five dollars ($5.00) shipping and handling. A copy is available for inspection in the Division of Public Health, 1931 Mail Service Center, Raleigh, North Carolina 27699-1931.

(b) The following persons shall be skin tested for tuberculosis: have a tuberculosis skin test (TST) or Interferon Gamma Release Assay (IGRA) and given appropriate clinical, microbiologic and x-ray examination in accordance with the "Diagnostic Standards and Classification of Tuberculosis in Adults and Children," published by the American Thoracic Society, "Targeted Tuberculin Testing and Treatment of Latent Tuberculosis," "Guidance for Preventing the Transmission of Tuberculosis in Health Care Facilities," "Prevention and Control of Tuberculosis in Correctional and Detention Facilities: Recommendations from the CDC," and the "Updated Guidelines for Using Interferon Gamma Release Assays to Detect Mycobacterium tuberculosis Infection—United States, 2010" published by the Centers for Disease Control and Prevention. The recommendations contained in these references shall be the required control measures for evaluation, testing, and diagnosis for tuberculosis patients, contacts and suspects, except as otherwise provided in this Rule and are incorporated by reference including subsequent amendments and editions:

1. Household and other high priority contacts of active cases of pulmonary and laryngeal tuberculosis. For purposes of this Rule, a high priority contact is defined in accordance with Centers for Disease Control and Prevention guidelines which are incorporated by reference in Rule .0201 of this Section. If the contact's initial IGRA or skin test is negative, and the case is confirmed by culture, a repeat IGRA or skin test shall be performed 8 to 10 weeks after the exposure has ended;

2. Persons reasonably suspected of having tuberculosis disease;

3. Inmates in the custody of, or staff with direct inmate contact in, the Department of Corrections upon incarceration, reincarceration, or employment, and annually thereafter;

4. Staff with direct inmate contact in the Department of Corrections upon employment, and annually thereafter. The two-step skin test method shall be used if the individual has not had a documented tuberculosis skin test within the preceding 12 months. A single skin test shall be given if the individual has had a single, documented, negative tuberculosis skin test within the preceding 12 months. A single IGRA may be used in place of the tuberculosis skin test; only one IGRA need be performed upon employment regardless of whether the individual has had a documented skin test within the preceding 12 months;

5. Patients and Staff in long term care facilities upon admission or employment. The two-step skin test method shall be used if the individual has not had a documented tuberculosis skin test within the preceding 12 months. A single skin test shall be given if the individual has had a single, documented, negative tuberculosis skin test within the preceding 12 months. A single IGRA may be used in place of the tuberculosis skin test; only one IGRA need be performed upon employment regardless of whether the individual has had a documented skin test within the preceding 12 months;

6. Residents upon admission to licensed nursing homes or adult care homes. The two-step skin test method shall be used if the individual is being admitted from any setting other than a hospital, licensed nursing home or adult care home in North Carolina without a documented tuberculosis skin test within the preceding 12 months. A single skin test shall be given if the individual is being admitted directly from any setting with only a single documented negative tuberculosis skin test within the preceding 12 months. If the individual is being admitted directly from another hospital, licensed nursing home or adult care home in North Carolina and there is documentation of a two-step skin test, the individual would not need to be retested. A single IGRA may be used in place of the tuberculosis skin test; only one IGRA need be performed upon admission regardless of whether the individual has had a documented tuberculosis skin test within the preceding 12 months;

7. Staff in adult day care centers providing care for persons with HIV infection or AIDS upon employment. The two-step skin test method shall be used if the individual has not had a documented tuberculosis skin test within the preceding 12 months. A single IGRA may be used in place of the tuberculosis skin test; only one IGRA need be performed upon admission regardless of whether the individual has had a documented tuberculosis skin test within the preceding 12 months; and

8. Persons with HIV infection or AIDS.
Persons with a prior positive tuberculin skin test or IGRA should be evaluated by an interview to screen for symptoms and a chest x-ray if they do not have a documented chest x-ray that was performed on the date of the positive test or later.

A copy of "Diagnostic Standards and Classification of Tuberculosis in Adults and Children" is available by contacting the Division of Public Health, 1931 Mail Service Center, Raleigh, North Carolina 27699-1931 or by accessing the Centers for Disease Control and Prevention website at http://www.cdc.gov/nchstp/tb/pubs/mmwrhtml/Maj_guide/cdc_at_guidelines.htm.

(c) Treatment and follow-up for tuberculosis infection or disease shall be in accordance with "Treatment of Tuberculosis," published by the American Thoracic Society. The recommendations contained in this reference shall be the required control measures for testing, treatment, and follow-up for tuberculosis patients, contacts and suspects, except as otherwise provided in this Rule and are incorporated by reference including subsequent amendments and editions. Copies of this publication are available by contacting the Division of Public Health, 1931 Mail Service Center, Raleigh, North Carolina 27699-1931 or by accessing the Centers for Disease Control and Prevention website at http://www.cdc.gov/nchstp/tb/pubs/mmwrhtml/Maj_guide/cdc_at_guidelines.htm.

(d) The attending physician or designee shall instruct all patients treated for tuberculosis regarding the potential side effects of the medications prescribed and prescribed medications, including instructions to promptly notify the physician or designee if side effects occur.

(e) Persons with active tuberculosis disease shall complete a standard multi-drug regimen, unless otherwise approved by the State Tuberculosis Medical Director or designee, and shall be managed using Directly Observed Therapy (DOT), which is the actual observation of medication ingestion by a health care worker (HCW).

(f) Persons with suspected or known active pulmonary or laryngeal tuberculosis who have sputum smears positive for acid fast bacilli are considered infectious and shall be managed using airborne precautions, including respiratory isolation, or isolation in their home, with no new persons exposed. These individuals are considered noninfectious and use of airborne precautions, including respiratory isolation or isolation in their home, may be discontinued when:

1. Appropriately obtained sputum specimens meet Centers for Disease Control and Prevention and North Carolina Tuberculosis Control guidelines for discontinuation of respiratory isolation;
2. They have three consecutive sputum smears collected at least eight hours apart which are negative; and
3. It has been at least seven days since the last positive sputum smear; and
4. They have been compliant on tuberculosis medications to which the organism is judged to be susceptible and there is evidence of clinical response to tuberculosis treatment.

(g) Persons with suspected or known active pulmonary or laryngeal tuberculosis who are initially sputum smear negative do not require respiratory isolation once they have been started on tuberculosis treatment. Treatment to which the organism is judged to be susceptible and there is evidence of clinical response to treatment.

Authority G.S. 130A-135; 130A-144.

TITLE 15A – DEPARTMENT OF ENVIRONMENT AND NATURAL RESOURCES

Notice is hereby given in accordance with G.S. 150B-21.2 that the NC Wildlife Resources Commission intends to amend the rules cited as 15A NCAC 10B .0113, .0116, .0219 and .0223.

Link to agency website pursuant to G.S. 150B-19.1(c): http://www.ncwildlife.org/About/MeetingsActions.aspx - Under "Regulatory Updates"

Proposed Effective Date: August 1, 2012

Public Hearing:
Date: March 20, 2012
Time: 7:00 p.m.
Location: Iredell County Agricultural Extension Center, 444 Bristol Dr., Statesville, NC 28677

Date: March 21, 2012
Time: 7:00 p.m.
Location: District Court #1, Buncombe County Courthouse, 60 Court Plaza, Asheville, NC 28801

Date: March 26, 2012
Time: 7:00 p.m.
Location: Bladen County Courthouse, 106 W. Broad Street, Elizabethtown, NC 28377

Date: March 28, 2012
Time: 7:00 p.m.
Location: Pitt Community College, Fulford Building, Room 153, 4381 County Home Road, Greenville, NC 27858

Date: March 29, 2012
Time: 7:00 p.m.
Location: Centennial Campus for Wildlife Education, 1751 Varsity Dr., Raleigh, NC 27606

Reason for Proposed Action:
15A NCAC 10B .0113 – The purpose of this rule is to remove a reference to "wild boar" which is no longer recognized by statute as an animal under the jurisdiction of the Wildlife Resources Commission.

15A NCAC 10B .0116 – The purpose of this rule is to delete "wild boar" from the list of animals that may be taken using archery equipment since State law no longer recognizes "wild
boar” as an animal under the jurisdiction of the Wildlife Resources Commission.

15A NCAC 10B .0219 – The purpose of this rule is to permit night hunting of coyotes with lights and electronic calls.

15A NCAC 10B .0223 – The purpose of this rule is to permit feral swine to be hunted day or night, and with the use of artificial lights.

Procedure by which a person can object to the agency on a proposed rule: Objections may be submitted in writing or via electronic mail during the comment period to C. Norman Young, Jr., NC Department of Justice, 9001 Mail Service Center, Raleigh, NC 27699-9001; email nyoung@ncdoj.gov.

Comments may be submitted to: Kate Pipkin, NC Wildlife Resources Commission, 1722 Mail Service Center, Raleigh, NC 27699-1722; phone (919) 707-0065; email kathryn.pipkin@ncwildlife.org

Comment period ends: April 16, 2012

Procedure for Subjecting a Proposed Rule to Legislative Review: If an objection is not resolved prior to the adoption of the rule, a person may also submit written objections to the Rules Review Commission after the adoption of the Rule. If the Rules Review Commission receives written and signed objections after the adoption of the Rule in accordance with G.S. 150B-21.3(b1), the Commission will receive written objections until 5:00 p.m. on the day following the day the Commission approves the rule. The Commission will receive those objections by mail, delivery service, hand delivery, or facsimile transmission. If you have any further questions concerning the submission of objections to the Commission, please call a Commission staff attorney at 919-431-3000.

Fiscal impact (check all that apply).
☐ State funds affected
☐ Environmental permitting of DOT affected
☐ Analysis submitted to Board of Transportation
☐ Local funds affected
☐ Date submitted to OSBM:
☐ Substantial economic impact ($500,000)
☒ Approved by OSBM
☐ No fiscal note required

CHAPTER 10 - WILDLIFE RESOURCES AND WATER SAFETY

SUBCHAPTER 10B - HUNTING AND TRAPPING

SECTION .0100 - GENERAL REGULATIONS

15A NCAC 10B .0113 BIG GAME KILL REPORTS
(a) Upon killing a bear, deer, wild boar, or wild turkey and before moving the animal from the site of kill, the successful hunter shall validate the Big Game Harvest Report Card furnished with the big game hunting license by cutting or punching out the validation box that correctly identifies the big game animal harvested. In lieu of the Big Game Harvest Report Card, antlerless deer may be recorded as outlined above on the Bonus Antlerless Deer Harvest Report Card acquired from the Wildlife Resources Commission or a Wildlife Service Agent.
(b) Before any harvested bear, deer, wild boar, or wild turkey is skinned, dressed, or dismembered for consumption and within 24 hours of the kill, the animal must be registered with a Wildlife Cooperator Agent or registered through the Electronic Big Game Reporting System. Deer harvested during the urban deer season specified in 15A NCAC 10B .0203(e) shall be registered through the Electronic Big Game Reporting System and shall not be registered with a Wildlife Cooperative Agent. The hunter may field dress the animal at the site of kill or before registering it by bleeding and removing the digestive, respiratory, and circulatory organs; but, the hunter may not mutilate the carcass in a manner that obscures its species identity, age, or sex. When the kill occurs in a remote area, which prevents the animal from being transported as an entire carcass, the animal may be skinned and quartered before being registered. When a hunter harvests a big game animal in a remote area and plans to remain in the remote area for longer than a day, the 24-hour time limit to register the kill is extended until the hunter leaves the area. Upon leaving the remote area, the hunter shall register the kill within 24 hours.
(c) When a hunter registers a kill with a Wildlife Cooperative Agent, the Wildlife Cooperative Agent shall issue an authorization number that includes the date of kill to the big game hunter. The hunter shall record the authorization number given by the Wildlife Cooperative Agent or obtained through the Electronic Big Game Reporting System in the space provided immediately adjacent to the validation box that has been cut or punched out on the Big Game Harvest Report Card or the Bonus Antlerless Deer Harvest Report Card. The record entered on the Big game Harvest Report Card or the Bonus Antlerless Deer Harvest Report Card shall thereafter constitute authorization for the continued possession of the carcass. Possession of a harvested bear, deer, wild boar, or wild turkey without the validated Big Game Harvest Report Card or Bonus Antlerless Deer Harvest Report Card where applicable, including the authorization number obtained from a Wildlife Cooperative Agent or through the Electronic Big Game Reporting System is unlawful.
(d) Persons who kill a big game animal and leave it unattended shall identify the carcass with their name, their hunting license number, and the date of kill. Once an unattended animal is registered the animal need only be identified with the authorization number received by registering the kill. It is unlawful for a person to possess a Big Game Harvest Report Card or Bonus Antlerless Deer Harvest Report Card on which the species validation box has been cut or punched out, but on which the authorization number received by registering the kill has not been recorded, unless the animal is in the person's possession or is identified as described in this Paragraph and not more than 24 hours have passed since the harvest.
(e) Persons who are by law exempt from the big game hunting license shall obtain a Big Game Harvest Report Card or Bonus Antlerless Deer Harvest Report Card for License Exempt
Hunters from a Wildlife Service Agent. Upon harvesting a bear, deer, wild boar, or wild turkey, the exempt person shall validate the Big Game Harvest Report Card or Bonus Antlerless Deer Harvest Report Card and register the kill as provided by this Rule.

(f) Persons who use special tags issued pursuant to G.S. 113-291.2(e) to validate the harvest of a deer shall follow the tagging and reporting requirements set forth by statute and are not obligated to take any action under this Rule.

Authority G.S. 113-134; 113-270.3; 113-276.1.

15A NCAC 10B .0116 PERMITTED ARCHERY EQUIPMENT

(a) Only longbows and recurved bows having a minimum pull of 40 pounds, compound bows having a minimum pull of 35 pounds and crossbows shall be used for taking game.

(b) Only arrows with a fixed minimum broadhead width of seven-eighths of an inch or a mechanically opening broadhead with a width of at least seven-eighths of an inch in the open position shall be used for taking bear, deer, wild boar or wild turkey. Blunt-type arrow heads may be used in taking small animals and birds including rabbits, squirrels, quail, grouse and pheasants. Poisonous, drugged, barbed, or explosive arrowheads shall not be used for taking any game.

(c) Crossbows shall have a minimum pull rated at least 150 pounds. Heads on bolts used with crossbows shall conform to those described for arrows in Paragraph (b) of this Rule.

Authority G.S. 113-134; 113-291.1(a).

SECTION .0200 - HUNTING

15A NCAC 10B .0219 COYOTE

(a) There is no closed season for taking coyotes by hunting. Coyotes may be taken by hunting anytime during the day or night.

(b) There are no bag limit restrictions on coyotes.

(c) Manner of Take. Hunters may use electronic calls, calls and artificial lights.

Authority G.S. 113-134; 113-291.1; 113-291.2.

15A NCAC 10B .0223 FERAL SWINE

(a) Open season. There is no closed season for taking feral swine by hunting. Feral swine may be taken by hunting anytime during the day or night.

(b) Bag limits. There are no bag limit restrictions. Restrictions on feral swine.

(c) Manner of take. Hunters may use artificial lights.

Authority G.S. 113-129; 113-134; 113-291; 113-291.1; 113-291.2.

Fiscal impact (check all that apply).

☐ State funds affected
☐ Environmental permitting of DOT affected
☐ Analysis submitted to Board of Transportation
☐ Local funds affected

Notice is hereby given in accordance with G.S. 150B-21.2 that the NC Wildlife Resources Commission intends to amend the rules cited as 15A NCAC 10F .0330 and .0354.

Link to agency website pursuant to G.S. 150B-19.1(c): http://www.ncwildlife.org/About/MeetingsActions.aspx - Under "Regulatory Updates"

Proposed Effective Date: July 1, 2012

Public Hearing:
Date: March 2, 2012
Time: 10:00 a.m.
Location: Wildlife Resources Commission, 1751 Varsity Drive, Raleigh, NC 27606

Reason for Proposed Action:
15A NCAC 10F .0330 – This rule would establish a "no-wake zone" in the waters of Carteret County at the Newport River Beach Access Boat Ramp in Morehead City north of the Highway 70 Bridge, and is necessary for public safety in a congested area (a)(14), as well as make several minor technical corrections.

15A NCAC 10F .0354 – This rule would repeal a no-wake zone currently in existence at the Seine Beach area of the Tar River in Pitt County that is no longer necessary for public safety.

Procedure by which a person can object to the agency on a proposed rule: Objections may be submitted in writing or via electronic mail during the comment period to C. Norman Young, Jr., NC Department of Justice, 9001 Mail Service Center, Raleigh, NC 27699-9001; email nyoung@ncdoj.gov.

Comments may be submitted to: Betsy Foard, NC Wildlife Resources Commission, 1701 Varsity Drive, Raleigh, NC 27699-1701; phone (919) 707-0013; email betsy.foard@ncwildlife.org

Comment period ends: April 16, 2012

Procedure for Subjecting a Proposed Rule to Legislative Review: If an objection is not resolved prior to the adoption of the rule, a person may also submit written objections to the Rules Review Commission after the adoption of the Rule. If the Rules Review Commission receives written and signed objections after the adoption of the Rule in accordance with G.S. 150B-21.3(b2) from 10 or more persons clearly requesting review by the legislature and the Rules Review Commission approves the rule, the rule will become effective as provided in G.S. 150B-21.3(b1). The Commission will receive written objections until 5:00 p.m. on the day following the day the Commission approves the rule. The Commission will review those objections by mail, delivery service, hand delivery, or facsimile transmission. If you have any further questions concerning the submission of objections to the Commission, please call a Commission staff attorney at 919-431-3000.
PROPOSED RULES

PORT OF MOREHEAD CITY

Date submitted to OSBM: January 6, 2012 (15A NCAC 10F.0330); January 7, 2012 (15A NCAC 10F.0354)

- Substantial economic impact (≥$500,000)
- Approved by OSBM
- No fiscal note required

CHAPTER 10 - WILDLIFE RESOURCES AND WATER SAFETY

SUBCHAPTER 10F - MOTORBOATS AND WATER SAFETY

SECTION .0300 - LOCAL WATER SAFETY REGULATIONS

15A NCAC 10F .0330 CARTERET COUNTY

(a) Regulated Areas. This Rule applies to the following waters in Carteret County:

1. The waters of Money Island Slough beginning at the east end of Money Island near the Anchorge Marine Basin and ending at the west end of Money Island where Brooks Avenue deadends at the slough;
2. The waters of Taylor Creek located within the territorial limits of the Town of Beaufort;
3. The waters of Pelletier Creek beginning at the entrance to Pelletier Creek at the Intracoastal Waterway and ending at U.S. Highway 70;
4. The waters of Bogue Sound Harbor Channel in Morehead City between Sugar Loaf Island and the seawall on the south side of Evans, Shepard and Shackleford Streets and bounded on the east by the State Ports Authority and on the west by the eastern right-of-way margin of South 13th Street extended;
5. The waters of Gallant's Channel from the US 70 crossing over the Grayden Paul bridge to Taylor's Creek;
6. The waters of Cedar Island Bay and Harbor from U.S. 70 N.C. Highway 12 to Cedar Island Bay Channel Light 8;
7. The waters of the small cove on the west side of Radio Island immediately south of the B & M Railroad and US 70 Bridges across the Intracoastal Waterway in which Radio Island Marina and Morehead Sports Marina are located as delineated by appropriate markers; south of Old Causeway Road;
8. The waters of the Newport River beginning at the north side of the Beaufort Drawbridge and ending at marker #6;
9. The waters of Spooners Creek within the territorial limits of the Town of Morehead City as delineated by appropriate markers;
10. The waters of Taylor's Creek from the eastern end of the current no wake zone eastward to Channel Marker #1A;
11. The waters of the Newport River at Bogue Sound including all waters surrounding the Port of Morehead City to Brandt Island as delineated by appropriate markers; and
12. The waters of Morgans Creek as delineated by appropriate markers;
13. The waters of Cannonsgate Marina and the Cannonsgate Marina Channel, beginning at its intersection with Bogue Sound at 34.70163 N, 76.98157 W as delineated by appropriate markers; and
14. The waters of the Newport River at the Newport River Beach Access Boat Ramp, north of the Highway 70 bridge, beginning from the shore at a point at 34.72141 N, 76.68707 W, west to a point at 34.72128 N, 76.68893 W, north to a point at 34.72376 N, 76.68911 N, then east to the shore at 34.72371 N, 76.68631 W.

(b) Speed Limit. It is unlawful to operate a motorboat or vessel at a speed greater than no-wake speed while on the waters of the regulated areas designated in Paragraph (a) of this Rule.

(c) Placement and Maintenance of Markers. The Board of Commissioners of Carteret County, with respect to the regulated areas designated in Subparagraphs (1), (3), (5), (6), (7), (8), (10), (12) and (13) of Paragraph (a) of this Rule, and the Board of Commissioners of the Town of Beaufort, with respect to the regulated area designated in Subparagraph (2) of Paragraph (a) of this Rule, and the Board of Commissioners of Morehead City, with respect to Subparagraph (4) and (4), (9), (14) of Paragraph (a) of this Rule, and the North Carolina State Ports Authority, with respect to the regulated area designated in Subparagraph (11) of Paragraph (a) of this Rule are designated as suitable agencies for placement and maintenance of the markers implementing this Rule, subject to the approval of the United States Coast Guard and the United States Army Corps of Engineers.

Authority G.S. 75A-3; 75A-15.

15A NCAC 10F .0354 PITT COUNTY

(a) Regulated Areas. This Rule applies to the waters described in this Paragraph:

1. The entire inlet of Hardee Creek from the Tar River in Pitt County; and
2. The Seine Beach area of the Tar River beginning at Chicod Creek and extending to the east side of the Grimesland Bridge as marked by appropriate markers; and
3. That portion of Tranters Creek beginning at a line, shore to shore, from a point at 35.56925 N, 77.09138 W and ending at a line, shore to shore, to a point at 35.56703 N, 77.08981 W as delineated by appropriate markers.

(b) Speed Limit. No person shall operate a motorboat or vessel at greater than no-wake speed within the regulated areas described in Paragraph (a) of this Rule.

(c) Placement and Maintenance of Markers. The Board of Commissioners of Pitt County is designated a suitable agency for placement and maintenance of markers implementing this Rule.
Authority G.S. 75A-3; 75A-15.

TITLE 21 – OCCUPATIONAL LICENSING BOARDS AND COMMISSIONS
CHAPTER 10 - BOARD OF CHIROPRACTIC EXAMINERS

Notice is hereby given in accordance with G.S. 150B-21.2 that the NC Board of Chiropractic Examiners intends to repeal the rules cited as 21 NCAC 10 .0405, .0603, .0607-.0608, .0611 and .0707.

Link to agency website pursuant to G.S. 150B-19.1(c): http://www.ncchiroboard.com

Proposed Effective Date: July 1, 2012

Public Hearing:
Date: March 8, 2012
Time: 10:00 a.m.
Location: Office of the Board of Chiropractic Examiners, 174 Church Street N., Concord, NC 28025

Reason for Proposed Action: All the rules set for repeal are simply references to the relevant statutes; the rules have no substantive text.

Procedure by which a person can object to the agency on a proposed rule: Written objections may be filed with Carol Hall, Executive Secretary of the Board, at P.O. Box 312, Concord, NC 28026.

Comments may be submitted to: Carol Hall, NC Board of Chiropractic Examiners, P.O. Box 312, Concord, NC 28026

Comment period ends: April 16, 2012

Procedure for Subjecting a Proposed Rule to Legislative Review: If an objection is not resolved prior to the adoption of the rule, a person may also submit written objections to the Rules Review Commission after the adoption of the Rule. If the Rules Review Commission receives written and signed objections after the adoption of the Rule in accordance with G.S. 150B-21.3(b2) from 10 or more persons clearly requesting review by the legislature and the Rules Review Commission approves the rule, the rule will become effective as provided in G.S. 150B-21.3(b1). The Commission will receive written objections until 5:00 p.m. on the day following the day the Commission approves the rule. The Commission will receive those objections by mail, delivery service, hand delivery, or facsimile transmission. If you have any further questions concerning the submission of objections to the Commission, please call a Commission staff attorney at 919-431-3000.

Fiscal impact (check all that apply).
☐ State funds affected
☐ Environmental permitting of DOT affected
☐ Analysis submitted to Board of Transportation
☐ Local funds affected
☐ Date submitted to OSBM:
☐ Substantial economic impact (≥$500,000)
☐ Approved by OSBM
☐ No fiscal note required

SECTION .0400 – RULE-MAKING PROCEDURES

21 NCAC 10 .0405 TEMPORARY RULES
The power of the Board of Examiners to adopt temporary rules and the procedure by which such rules are put into effect are governed by G.S. 150B-13.

Authority G.S. 150B-13.

SECTION .0600 - CONTESTED CASES

21 NCAC 10 .0603 NOTICE OF HEARING: ANSWER
(a) The contents and manner of service of notice of hearing in a contested case shall be as prescribed in G.S. 150B-38(b) and (c).
(b) Any party who has been served with notice of hearing may file a written response as prescribed in G.S. 150B-38(d).

Authority G.S. 150B-38.

21 NCAC 10 .0607 LOCATION OF HEARING
The location of the hearing in a contested case shall be as prescribed in G.S. 150B-38(e).

Authority G.S. 150B-38.

21 NCAC 10 .0608 INTERVENTION
The intervention of persons not initially parties to a contested case is governed by G.S. 150B-38(f). Petitions or motions to intervene must be in writing. The Board shall promptly determine whether to grant or deny intervention and shall so notify the petitioner and all parties in writing.

Authority G.S. 90-142; 150B-38.

21 NCAC 10 .0611 SUBPOENAS
The authority of the Board to issue or revoke subpoenas in preparation for, or in the conduct of, contested cases is governed by G.S. 150B-39. If a subpoena is issued at the request of a party and not on the Board's own motion, that party shall bear the cost of service.

Authority G.S. 90-142; 150B-39.

SECTION .0700 - HEARINGS IN CONTESTED CASES

21 NCAC 10 .0707 DECISION OF BOARD
(a) The form and content of the Board's decision in a contested case shall be as prescribed by G.S. 150B-42(a), and its decision shall be served upon the parties in a manner consistent with said statute.
(b) The official record of the hearing in a contested case shall contain those items specified in G.S. 150B-42(b).

Authority G.S. 150B-42.

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CHAPTER 42 - BOARD OF EXAMINERS IN OPTOMETRY

Notice is hereby given in accordance with G.S. 150B-21.2 that the NC State Board of Examiners in Optometry intends to repeal the rules cited as 21 NCAC 42B .0104; and 42D .0103-.0106, .0108.

Link to agency website pursuant to G.S. 150B-19.1(c): http://www.ncoptometry.org/rules_and_regs.shtm

Proposed Effective Date: June 1, 2012

Instructions on How to Demand a Public Hearing: (must be requested in writing within 15 days of notice): A public hearing may be demanded by contacting: John D. Robinson, O.D., Executive Director, NC State Board of Examiners in Optometry, 109 North Graham Street, Wallace, NC 28466; phone (910) 285-3160 or (800) 426-4457; email exdir@ncoptometry.org.

Reason for Proposed Action: These rules were identified as being subject to repeal pursuant to the NC State Board of Examiners in Optometry's Internal Review of Rules process that was requested by the Governor's Executive Order 70 on Rules Modification and Improvement. These rules are obsolete and are no longer necessary.

Procedure by which a person can object to the agency on a proposed rule: Persons may object to the proposed rule changes by contacting: John D. Robinson, O.D., Executive Director, NC State Board of Examiners in Optometry, 109 North Graham Street, Wallace, NC 28466; phone (910) 285-3160 or (800) 426-4457; email exdir@ncoptometry.org.

Comments may be submitted to: John D. Robinson, O.D., Executive Director, NC State Board of Examiners in Optometry, 109 North Graham Street, Wallace, NC 28466; phone (910) 285-3160 or (800) 426-4457; email exdir@ncoptometry.org

Comment period ends: April 16, 2012

Procedure for Subjecting a Proposed Rule to Legislative Review: If an objection is not resolved prior to the adoption of the rule, a person may also submit written objections to the Rules Review Commission after the adoption of the Rule. If the Rules Review Commission receives written and signed objections after the adoption of the Rule in accordance with G.S. 150B-21.3(b2) from 10 or more persons clearly requesting review by the legislature and the Rules Review Commission approves the rule, the rule will become effective as provided in G.S. 150B-21.3(b1). The Commission will receive written objections until 5:00 p.m. on the day following the day the Commission approves the rule. The Commission will receive those objections by mail, delivery service, hand delivery, or facsimile transmission. If you have any further questions concerning the submission of objections to the Commission, please call a Commission staff attorney at 919-431-3000.

Fiscal impact (check all that apply).

- State funds affected
- Environmental permitting of DOT affected
- Analysis submitted to Board of Transportation
- Local funds affected
- Date submitted to OSBM: Substantial economic impact ($500,000)
- Approved by OSBM
- No fiscal note required

SUBCHAPTER 42B - LICENSE TO PRACTICE OPTOMETRY

SECTION .0100 - LICENSE BY EXAMINATION

21 NCAC 42B .0104 APPLICATION FOR LICENSURE BY RECIPROCITY

Requests for application for licensure under the provisions of G.S. 90-118.5 shall be accompanied by the appropriate fee and shall be made on Form BEO-1 supplied by the Board. The application and supporting documents required by G.S. 90-118.5 must be received in the Board office 60 days prior to the date of the clinical practicum examination for which the application is being made.

Authority G.S. 90-117.5; 90-118.5.

SUBCHAPTER 42D - OPTOMETRIC ASSISTANT AND TECHNICIAN

SECTION .0100 - LICENSE BY EXAMINATION

21 NCAC 42D .0103 APPLICATION

Application for registration of an optometric assistant or an optometric technician shall be made upon Form BEO-6 supplied by the Secretary and shall be submitted by the prospective registrant or the optometrist for whom the optometric assistant or optometric technician will work.

Authority G.S. 90-115.1(6); 90-117.5.

21 NCAC 42D .0104 REGISTRATION

Before being approved for registration by the Board to perform as an optometric assistant or as an optometric technician an applicant must submit an application, the registration fee, and give evidence of qualification of training as recognized by the Board under Rule .0006 of this Subchapter. Registration will be effective until January 31 of the year following approval and thereafter be annually renewed.

Authority G.S. 90-115.1(6); 90-117.5.

21 NCAC 42D .0105 ANNUAL RENEWAL

Registered optometric assistants and optometric technicians will be required to apply for annual renewal of registration not later
than January 31 of each year. Renewal will be made by application on Form BEO-10 supplied by the Secretary and accompanied with the annual renewal fee.

Authority G.S. 90-115.1(6); 90-117.5.

21 NCAC 42D .0106 ACCREDITATION OF TRAINING PROGRAMS

Application for recognition of an optometric technician or optometric assistant training program by the Board shall be made by letter with supporting documents from the director of the program. The training program must be sponsored by an institute, college, university recognized by the American Optometric Association, the North Carolina Optometric Society, or by an entity affiliated with one of the foregoing. There must be evidence that the program has education as its primary orientation and objective. The program must be under the supervision of a qualified director, who has at his disposal the resources of competent personnel adequately trained in the optometric field. The prescribed program must provide adequate instruction in the field of optometry as related to an optometric assistant or a prescribed course in optometric technician. Recognition of a program may be withdrawn when, in the opinion of the Board, the program fails to maintain the educational standards recommended by the Council on Optometric Education.

Authority G.S. 90-115.1(6); 90-117.5.

21 NCAC 42D .0108 TERMINATION OF REGISTRATION

The approval of an optometric assistant or an optometric technician shall be terminated by the Board when, after due notice and hearing, it shall find:

(1) that the assistant or technician has held himself out or permitted another to represent him to be an optometrist;

(2) that the assistant or technician in fact has performed otherwise than at the direction or under the supervision of an optometrist licensed by the Board or has been delegated and has performed a task or tasks beyond his competence;

(3) that the assistant or technician is a habitual user of intoxicants or drugs to such an extent that he is unable to perform as an assistant or technician to an optometrist;

(4) that the assistant or technician has been convicted in any court, state or federal, of any felony or other criminal offense involving moral turpitude;

(5) that the assistant or technician has been adjudicated as mentally incompetent, or suffers from a mental condition rendering him unable to safely perform as an assistant or technician to an optometrist;

(6) that the assistant or technician failed to pay the registration fee or renewal fee.

Authority G.S. 90-115.1(6); 90-117.5.
Note from the Codifier: The rules published in this Section of the NC Register are temporary rules reviewed and approved by the Rules Review Commission (RRC) and have been delivered to the Codifier of Rules for entry into the North Carolina Administrative Code. A temporary rule expires on the 270th day from publication in the Register unless the agency submits the permanent rule to the Rules Review Commission by the 270th day. This section of the Register may also include, from time to time, a listing of temporary rules that have expired. See G.S. 150B-21.1 and 26 NCAC 02C .0500 for adoption and filing requirements.

TITLE 19A – DEPARTMENT OF TRANSPORTATION

Rule-making Agency: NC Department of Transportation

Rule Citation: 19A NCAC 02E .0210-.0211, .0602-.0603, and .0608-.0611

Effective Date: March 1, 2012

Date Approved by the Rules Review Commission: January 19, 2012

Reason for Action: The effective date of a recent act of the General Assembly. The General Assembly enacted SL 2011-397, which establishes certain statutory standards for selective vegetation removal within the rights-of-way of the highway system and standards for denial of a permit for proposed and for revocation of permits for outdoor advertising. In addition, in Section 10 of SL 2011-397, the Department of Transportation is directed to adopt temporary rules to administer the act. NCDOT adopted the proposed temporary rules to comply with the legislative change.

CHAPTER 02 - DIVISION OF HIGHWAYS

SUBCHAPTER 02E - MISCELLANEOUS OPERATIONS

SECTION .0200 - OUTDOOR ADVERTISING

19A NCAC 02E .0210 REVOCATION OF OUTDOOR ADVERTISING PERMIT

The appropriate district engineer shall revoke a permit for a lawful outdoor advertising structure based on any of the following:

1. mistake of facts by the issuing District Engineer for which had the correct facts been known, he would not have issued the outdoor advertising permit;

2. misrepresentations of any facts made by the permit holder or sign owner and on which the District Engineer relied in approving the outdoor advertising permit application;

3. misrepresentation of facts to any regulatory authority with jurisdiction over the sign by the permit holder or sign owner, the permit applicant or the owner of property on which the outdoor advertising structure is located;

4. failure to pay annual renewal fees or provide the documentation requested under Rule .0207(c) of this Section;

5. failure to construct the outdoor advertising structure except all sign faces within 180 days from the date of issuance of the outdoor advertising permit;

6. a determination upon initial inspection of a newly erected outdoor advertising structure that it fails to comply with the Outdoor Advertising Control Act or the rules in this Section;

7. any alteration of an outdoor advertising structure for which a permit has previously been issued which would cause that outdoor advertising structure to fail to comply with the provisions of the Outdoor Advertising Control Act or the rules adopted by the Board of Transportation pursuant thereto;

8. alterations to a nonconforming sign or a sign conforming by virtue of the grandfather clause other than reasonable repair and maintenance as defined in Rule .0225(c). For purposes of this subsection, alterations include, but are not limited to:

   a. enlarging a dimension of the sign facing, or raising the height of the sign;

   b. changing the material of the sign structure's support;

   c. adding a pole or poles;

   d. adding illumination;

9. failure to affix the emblem within as required by Rule .0208 of this Section or failure to maintain the emblem so that it is visible and readable from the main-traveled way or controlled route;

10. failure to affix the name of the person, firm, or corporation owning or maintaining the outdoor advertising sign to the sign structure in sufficient size to be clearly visible as required by Rule .0208 of this Section;

11. destruction or cutting of trees, shrubs, or other vegetation located on the state owned or maintained right of way where an investigation by the Department of Transportation reveals that the destruction or cutting:

   a. occurred on the state owned or maintained right of way within 500 feet on either side of the sign location along the edge of pavement of the main traveled way of the nearest controlled route;
was conducted by a person or persons other than the Department of Transportation or its authorized agents or assigns, or without permission from the Department of Transportation; and

c) was conducted by one or more of the following: the sign owner, the permit holder, the lessee or advertiser employing the sign, the owner of the property upon which the sign is located, or any of their employees, agents or assigns, including, but not limited to, independent contractors hired by the permit holder/sign owner, the lessee/agents or advertiser employing the sign, or the owner of the property upon which the sign is located.

11. unlawful destruction or illegal cutting of trees, shrubs or other vegetation within the right-of-way of any State-owned or State-maintained highway as specified in G.S. 136-133.1(i); unlawful use of a controlled access facility for purposes of repairing, maintaining or servicing an outdoor advertising sign where an investigation reveals that the unlawful violation:

(a) was conducted actually or by design by the sign owner, permit holder, the lessee or advertiser employing the sign, the owner of the property upon which the sign is located, or any of their employees, agents, or assigns, including, but not limited to, independent contractors hired by any of the above persons; and

(b) involved the use of highway right of way for the purpose of repairing, servicing, or maintaining a sign including stopping, parking, or leaving any vehicle whether attended or unattended, on any part or portion of the right of way, way except as authorized by the Department of Transportation, including activities authorized by the Department for selective vegetation removal pursuant G.S. 136-131.1, G.S. 136-131.2 and G.S. 136-133.4. Access from the highway main travel way shall be allowed only for surveying or delineation work in preparation for and in the processing of an application for a selective vegetation removal permit; or

(c) involved crossing the control of access fence to reach the sign structure, structure, except as authorized by the Department, including those activities referenced in Sub-Item (12)(b) of this Rule:

13. maintaining a blank sign for a period of 12 consecutive months;

14. maintaining an abandoned, dilapidated, or discontinued sign;

15. a sign that has been destroyed or significantly damaged as determined by Rules Rule .0201(8) and (29) of this Section;

16. moving or relocating a nonconforming sign or a sign conforming by virtue of the grandfather clause which changes the location of the sign as determined by Rule .0201(27) of this Section;

17. failure to erect, maintain, or alter an outdoor advertising sign structure in accordance with the North Carolina Outdoor Advertising Control Act, codified in G.S. 136, Article 11, and the rules adopted by the Board of Transportation, pursuant thereto; and

18. willful failure to substantially comply with all the requirements specified in a vegetation removal permit if such willful failure meets the standards of G.S. 136-133.1(i) as specified in G.S. 136-133.4(e).

History Note: Authority G.S. 136-93; 136-130; 136-133; 136-133.1(i), 136-133.4(e);
Eff. July 1, 1978;
Amended Eff. August 1, 2000; May 1, 1997; November 1, 1993; March 1, 1993; October 1, 1991; December 1, 1990; Temporary Amendment Eff. March 1, 2012.

19A NCAC 02E .0211 DENIAL OF PERMIT

(a) Should the appropriate district engineer determine that a proposed outdoor advertising structure would not conform to the standards of outdoor advertising as set out in the Outdoor Advertising Control Act or the rules in this Section, the district engineer shall refuse to issue a permit for that proposed outdoor advertising structure.

(b) When such noncompliance of the Outdoor Advertising Control Act or these Rules has been determined, the district engineer shall notify the permit applicant by certified mail, return receipt requested, in the form of a letter setting forth the factual and statutory or regulatory basis for the denial, and include a copy of the Act and rules.

(c) The Department of Transportation shall not issue permits for new outdoor advertising signs at a sign location (as defined by Rule .0201 of this Section) as follows:

(1) for a period of five years where the unlawful destruction or illegal cutting of vegetation has occurred within 500 feet on either side of the proposed sign location, and as measured along the edge of pavement of the main traveled way of the nearest controlled route. For purposes of this paragraph only:
(A) "Unlawful destruction or illegal cutting" is the destruction or cutting of trees, shrubs, or other vegetation on the state-owned or maintained right of way which was conducted by a person or persons other than the Department of Transportation or its authorized agents or without the permission of the Department of Transportation;

(B) The Department of Transportation's investigation shall reveal some evidence that the unlawful destruction or illegal cutting would create, increase, or improve a view to a proposed outdoor advertising sign from the main traveled way of the nearest controlled route;

(C) The five-year period shall run from the date on which the Department of Transportation has actual knowledge of the unlawful destruction or illegal cutting to be documented by the appropriate district engineer;

(D) The five year prohibition period for a new sign permit shall apply equally to all sign locations including the following examples:

(i) sign locations where the unlawful destruction or illegal cutting of vegetation occurs prior to the time the location becomes a conforming location;

(ii) sign locations where a revocation of an existing permit has been upheld and a sign has been removed;

(iii) sign locations where the unlawful destruction or illegal cutting occurs prior to receipt of an outdoor advertising permit application; and

(iv) sign locations where the unlawful destruction or illegal cutting occurs following receipt of an outdoor advertising permit application, but prior to final issuance of the permit by the Department of Transportation.

(2) Where existing trees, if they were to reach the average mature size for that species, would make the proposed sign faces, when erected, not completely visible from the viewing zone.

For purposes of this subsection only:

(A) "Existing trees" are those trees four inches or greater in diameter measured six inches from the ground;


(C) Viewing Zone is the area which is 500 feet as measured along the edge of the main traveled way of the controlled route on each side of the proposed sign structure which will have a sign face.

(3) Where the zoning is not part of comprehensive zoning or was zoned primarily to permit outdoor advertising structures or constitutes spot zoning or strip zoning as defined in 19 NCAC 2E .0201(4)(b)(iii).

(4) For a period of 12 months prior to the proposed letting of a new construction contract that may affect the spacing or location requirements for an outdoor advertising structure until the project is completed.

(5) On a route designated as a scenic byway.


SECTION .0600 - SELECTIVE VEGETATION REMOVAL POLICY

19A NCAC 02E .0602 REQUESTS FOR PERMITS FOR A BUSINESS FACILITY

(a) Applications for selective vegetation thinning, pruning, or removal (exclusive of grasses) at a business facility shall be made by the owner of the business facility or advertisement to the appropriate Division Engineer of the North Carolina Department of Transportation, Division of Highways. Applications with all required documentation shall be submitted in both printed and electronic form. A non-refundable fee of two hundred dollars ($200.00) must accompany each application.

(b) Selective vegetation thinning, pruning, or removal shall be permitted only for the Permittee's facilities adjacent to highway right of way at locations where such facilities have been constructed. The provisions shall not be used to provide visibility to undeveloped property.

(c) Applications must be accompanied by a sketch showing the requested limits of the selective thinning, pruning, or removal of vegetation. For commercial, industrial, institutional and office facilities, the limits of selective clearing or thinning shall be
restricted to the area of right-of-way immediately adjacent to
frontage property of the facility but not to exceed 1,000 linear
feet.
For outdoor advertising displays, these limits shall be restricted
to a maximum cutting area for each sign face which shall be
determined as follows:

1. The point located on the edge of the right-of-way which is the closest point to the center
line of the sign face shall be point A;
2. The point located 100 feet down the right-of-way line in the direction of the sign viewing
zone shall be point B;
3. The point on the edge of pavement of the travelway (not paved shoulder) which is the
closest to the center line of the sign shall be point C;
4. The point 50 feet down the edge of pavement in the direction of the sign viewing zone from
point C shall be point D;
5. The point 250 feet down the edge of pavement in the direction of the sign viewing zone from
point C shall be point E; and
6. Lines drawn from point A to point D and from point B to point E shall define the limits of the
cutting area (see diagrams that follow as examples of the application of this subsection).

The Department of Transportation shall determine compensatory
planting to be performed by the sign owner as a result of the
ABED removal zone versus the previous 125-foot rectangular zone. Compensatory tree planting is required to
replace trees removed in the new portion of the ABED zone.
This replanting shall be one inch for one inch based on the caliper inches of
trees removed in the ABED zone which are four inches and
greater measured six inches above the ground. Location of
replanting shall be areas of old 125-foot zone now not allowable
to be cut by new ABED zone and locations within right of way
on same route within one mile as designated by the Department
where sign faces are blocked or will be blocked by existing trees
in the 125-foot zone the ABED removal zone shall not be
implemented. For commercial, industrial, institutional and
office facilities, the limits of selective clearing or thinning shall
be restricted to the area of right-of-way immediately adjacent to
frontage property of the facility but not to exceed 1,000 linear
feet.

Applications for permits for vegetation cutting to be
performed on State Highway right of way must be accompanied
by written authorization(s) by the underlying fee owner(s) of all
property upon which cutting is to take place, provided that where
the right of way was secured in fee simple by the Department,
such authorization shall not be required. The application must
also be accompanied by written authorization of all owners of
property abutting the area to be cut.

The selective vegetation control request shall be investigated
on site by Maintenance and Roadside Environmental personnel
and a representative of the applicant.

If the application for vegetation cutting is for a site located
within the corporate limits of a City or Town, the applicant shall
deliver the application to the municipality at least 30 days prior
to submitting the application to the Department, so that local
officials shall be given the opportunity to review the application
if the City or Town has previously advised the Division
Engineer of their desire to review such applications.

History Note: Authority G.S. 136-18(5); 136-18(7); 136-
18(9); 136-18.7; 136-93; 136-130;
Temporary Rule Eff. April 13, 1982 for a Period of 48 Days to
Expire on June 1, 1982;
Eff. June 1, 1982;
Amended Eff. November 16, 1991; December 1, 1990; August 1,
1985; June 2, 1982;
Temporary Amendment Eff. November 16, 1999;
Amended Eff. August 1, 2000;

19A NCAC 02E .0603 ISSUE OR DENIAL OF
PERMIT FOR A BUSINESS FACILITY
(a) Within 30 days following receipt of the application,
application for a selective vegetation removal permit for a
business facility, including the fee and all required
documentation, the Division Engineer shall approve or deny the
application. [However, if the proposed site is located within
the corporate limits of a municipality, the municipality shall be
given 30 days ("the Municipal Review Period") to review and
provide comments on the application if the municipality has
previously advised the Department in writing of the desire to
review such applications and the name of the local official to
whom notice of such application should be directed. In that
case, after the requesting municipality has provided comments or
after the Municipal Review Period expires, the] The applicant, as
part of the application, shall state in writing the date [the] that he
has delivered a copy of the application with required attachments
to a municipality which has previously advised the Department
in writing that it seeks to review such applications. The
applicant shall deliver the application to the municipality at least
30 days prior to submitting the application to the Department.

The Division Engineer shall have 30 days to approve or deny the
application. If the application is denied, the Division Engineer
shall advise the applicant, in writing, of the reasons for denial.

(b) The application shall be denied by the Division Engineer if:

1. It requires removal of trees that were in
existence before the business or advertisement
was established. An existing tree shall be one
that is four inches, or larger, in diameter as
measured six inches from the ground.
2. The application is for the opening of view to a
business sign or which has been declared
illegal or is currently involved in litigation
with the department.
3. It is determined that the facility or
advertisement is not screened from view.
4. The application is for the opening of view to
an outdoor advertising sign which was
obscured from view at the time of erection of
the sign.
5. Removal of vegetation will adversely affect
the safety of the traveling public.
Trees, shrubs, or other vegetation of any sort were planted in accordance with a local, State, or Federal beautification project.

Planting was done in conjunction with a designed noise barrier.

The applicant has not performed satisfactory met all permit requirements for work on previous requests under the provisions of the Rules in this Section (this Section. This is not may not be cause for denial if the applicant engages a landscape contractor to perform the work.

It involves opening of views to junkyards.

The application is contrary to ordinances or rules and regulations enacted by local government, within whose jurisdiction the work has been requested to be performed.

The applicant fails to provide all documentation required by statute and rule.

History Note: Authority G.S. 136-18(5); 136-18(7); 136-18(9); 136-93; 136-130;
Temporary Rule Eff. April 13, 1982 for a Period of 48 Days to Expire on June 1, 1982;
Eff. June 1, 1982;
Amended Eff. August 1, 2000; November 1, 1991; December 1, 1990; August 1, 1985; June 2, 1982;

19A NCAC 02E .0609 ISSUANCE OR DENIAL OF SELECTIVE VEGETATION REMOVAL PERMIT FOR OUTDOOR ADVERTISING
(a) Within 30 days following receipt of the application for a selective vegetation removal permit for outdoor advertising, including the fee set out in G.S. 136-18.7 and all required documentation set out in G.S. 136-133.2, the Division Engineer shall approve or deny the application. [However, if the proposed site is located within the corporate limits of a municipality, the municipality shall be given 30 days ("the Municipal Review Period") to review and provide comments on the application if the municipality has previously advised the Department in writing of the desire to review such applications and the name of the local official to whom notice of such application should be directed. In that case, after the requesting municipality has provided comments or after the Municipal Review Period expires, the] The applicant, as part of the application, shall state in writing the date [the] that he has delivered a copy of the application with required attachments to a municipality which has previously advised the Department in writing that it seeks to review such applications. The applicant shall deliver the application to the municipality at least 30 days prior to submitting the application to the Department. The Division Engineer shall have 30 days to approve or deny the application. If written notice of approval or denial is not given to the applicant after this time, then the application shall be deemed approved. If the application is denied, the Division Engineer shall advise the applicant, in writing, of the reasons for denial, and the fee shall be returned.

(b) The application shall be denied by the Division Engineer if:

(1) The application is for an outdoor advertising location where the outdoor advertising permit is less than two years old pursuant to G.S. 136-133.2.

(2) The application is for the opening of a view to a sign which has been declared illegal or whose permit has been revoked or is currently involved in litigation with the Department.

(3) Removal of vegetation will adversely affect the safety of the traveling public.

(4) The application is for the removal of vegetation planted in accordance with a local, State, or Federal beautification project unless a mitigating replanting plan as set forth in 19A NCAC 02E .0611 except for the provisions in Paragraph (d) and Subparagraph (g)(11), is approved by the applicant, the Department, and if applicable, the Federal Highway Administration.

(5) The application is for the removal of vegetation planted as part of a designed noise barrier project unless a mitigating replanting plan as set forth in 19A NCAC 02E .0611 except for the provisions in Paragraph (d) and Subparagraph (g)(11), is approved by the applicant, the Department, and if applicable, the Federal Highway Administration.

History Note: Authority G.S. 136-18(5); 136-18(7); 136-18(9); 136-18.7; 136-129(4); 136-129(5); 136-130; 136-133.1; 136-133.2.
19A NCAC 02E .0610 CONDITIONS OF SELECTIVE VEGETATION REMOVAL PERMIT FOR OUTDOOR ADVERTISING OR PERMIT REQUIREMENTS

The following apply to the conditions of selective vegetation removal permit for outdoor advertising or permit requirements:

(1) Selected vegetation, as defined in 136-133.1(b) may be allowed to be cut, thinned, pruned or removed in accordance with the standards set out in G.S. 136-133.4.

(2) The permittee shall indemnify and hold harmless the North Carolina Department of Transportation, its employees, attorneys, agents, and contractors against any and all claims or causes of action, and all losses therefrom, arising out of or in any way related to permittee's operation.

(3) The permittee shall furnish a Performance and Indemnity Bond or certified check or cashier’s check made payable to North Carolina Department of Transportation for the minimum sum of two thousand dollars ($2,000). The bond, certified check or cashier’s check shall cover any all restoration of the right of way to the original condition prior to the occurrence of the damage caused by the permittee or the permittee's agent, if damage occurs during the permitted selective vegetation removal. The bond or certified check or cashier's check is required before each permit to cut vegetation is issued. The bond shall run concurrently with the permit. The bond shall be released after a final inspection of the work by NCDOT reveals that all work provided for and specified by the permit is found to be completed, and all damages to the right of way, including damage to fencing and other structures within the right-of-way, have been repaired or restored to its original condition prior to the occurrence of the damage caused by the permittee or the permittee's agent.

(4) Companies that plan to apply for two or more permits may provide continuing bonds for a minimum of one hundred thousand dollars ($100,000) and this type of bond shall be kept on file by the Department.

(5) If the work is to be performed by any entity other than the sign owner or permittee, whether the permittee or the other entity must furnish the required bonding as described in this Section, for all work provided for and specified by the permit. Required forms for all bonds are available upon request from the Department. Bonds are to be furnished with the Selective Vegetation Removal application form to the appropriate official assigned to receive selective vegetation removal applications at the local NCDOT Division of Highways Office.

The permittee shall also provide proof of liability insurance of a minimum coverage of five million dollars ($5,000,000). Whoever performs the work, the permittee, his contractor or agent shall maintain all legally required insurance coverage, including, but not limited to, worker’s compensation and vehicle liability in the amounts required by law. The permittee, or his contractor or agent is liable for any losses due to the negligence or willful misconduct of his agents, assigns, and employees. The permittee or other entity shall name the Department as an additional insured on its general liability policy and provide the Department with a copy of the certificate showing the Department named as an additional insured policy.

(6) If there are existing trees requested to be removed, before any work can be performed under a selective vegetation removal permit the permittee must:

(A) Submit the reimbursement to the Department pursuant to G.S. 136-93.2 in a cashier's or certified check;

(B) Fully disassemble two non-conforming outdoor advertising signs and their supporting structures and return the outdoor advertising permits tags to the Department;

(C) Obtain Departmental approval for the replanting plan in accordance with 19A NCAC 02E .0611.

(7) After a tree is removed and the applicant or the Department discovers, based on the number of rings in the tree stump, an error in the tree survey report or site plan, the Department shall request an amendment to the tree survey report.
or site plan, and a redetermination pursuant to G.S. 136-133.1(d) and (e) shall be made by the Department and the applicant shall be subject to that redetermination.

(9)(7) A Division of Highways Inspector may be present while work is underway. The presence or absence of a Division of Highways inspector at the work site does not lessen the permittee's responsibility for conformance with the requirements of the permit and all applicable General Statutes and rules. Should the inspector fail to point out work that does not conform with the requirements, it does not prevent later notification to the permittee that the work is not in compliance with the permit.

(10)(8) Selective vegetation removal permits. Permits may be issued for multiple sites; however, a selective vegetation removal permit must be secured for each applicable outdoor advertising site prior to performing any vegetation removal work.

(11)(9) Should the Division Engineer ("Engineer") or his representative observe unsafe operations, activities or conditions, he shall suspend work. Work shall not resume until the unsafe conditions or activities have been eliminated or corrected. Failure to comply with any of the requirements for safety and traffic control of this permit shall result in temporary suspension of work.

(12)(10) The applicant must certify that he or she has permission from the adjoining landowner(s) to access their private property for the purpose of conducting activities related to the selective vegetation removal permit application.

(13)(11) The Permittee or its contractor or agent must have a copy of the Selective Vegetation Removal Permit on the work site at all times during any phase of selective vegetation cutting, thinning, trimming, pruning, removal, or planting operations.

(14)(12) The permittee shall provide to the appropriate Department official, a 48-hour notification before entering the right-of-way for any work covered by the conditions of the permit. The permittee shall schedule all work with the appropriate Department official. The permittee shall notify the Department in advance of work scheduled for nights, weekends and holidays. The Department reserves the right to modify the permittee's work schedule for nights, weekends, and holidays. When the Department restricts construction in work zones for the safety of the traveling public, the Department shall deny access to the right-of-way for selective vegetation removal.

(15)(13) If work is planned in an active work zone, the Permittee shall receive written permission from the contractor or the Department (if the Department's employees are performing the work). The Permittee shall provide the Division Engineer with a copy of the written permission.

(16)(14) Sites with vegetation not presenting a hazard from falling tree parts and follow-up work shall be restricted to individual and manually operated power equipment and hand-held tools.

(17)(15) The Department may allow use of power-driven vegetation removal equipment (such as excavator-based land clearing attachments, skid-steer cutters, and bucket trucks) and access from the private property side to the right-of-way. Tree removal, which presents a hazard from falling tree parts, shall be performed in accordance with International Society of Arboriculture standards. Written authorization must be obtained from the Department for use of power-driven vegetation removal equipment as well as for access to move resources from the private property side to the right-of-way. Applicant The applicant must provide information on the permit application for which type(s) of equipment and access is requested. The applicant shall also provide contractor qualifications for the Department.

(18)(16) The Department shall determine the traffic control signage that is required. The permittee shall furnish, erect, and maintain the required signs as directed by the Department.

(19)(17) The height of stumps remaining after tree removal shall not exceed four inches above the surrounding ground level. The work site shall be left in a clean and orderly appearance at the end of each workday.

(20)(18) Upon completion of all work, the Roadside Inspector Department shall notify the Division Engineer who shall notify the Permittee in writing of acceptance, terminate the permit, and return the Performance and Indemnity Bond or certified or cashier's check to the permittee.

(21)(19) Pursuant to 136-133.4(e), willful failure to substantially comply with all the requirements specified in the permit, unless otherwise mutually resolved, shall result in immediate and summary revocation of the selective vegetation removal permit and forfeiture of any or all of the Performance and Indemnity Bond or check as determined by the Division Engineer based on conditions stated in Item (2) of this Rule.

History Note: Authority G.S. 136-18(5); 136-18(7); 136-18(9); 136-93; 136-130; 136-133.4; Temporary Adoption Eff. March 1, 2012.
TEMPORARY RULES

19A NCAC 02E .0611 REQUIREMENTS FOR BEAUTIFICATION AND REPLANTING CONDITIONS OF SELECTIVE VEGETATION REMOVAL PERMIT FOR OUTDOOR ADVERTISING

(a) For the purpose of the rules in this section, each sign face shall be evaluated separately for beautification and replanting requirements.

(b) Except as provided in Paragraph (c) of this Rule,

(a) Any site qualifies for a beautification and replanting plan if the Department’s investigation of the applicant’s initial site plan and tree tagging requirement reveals that 60 percent or more of the total number of trees (including existing trees as defined in G.S. 136-133.1(b), and other trees) within the maximum limits of the vegetation removal zone are requested to be removed. For the purposes of the rules in this section, other trees are defined as those trees not including existing trees measured four inches or greater in diameter at six inches from the ground at the time of the selective vegetation removal application.

(c) Notwithstanding Paragraph (b) of this Rule, the Department may determine, in consultation with any applicable local government representatives and the applicant that a site which would otherwise not meet the standards for compensatory replanting in Paragraph (d) of this section does qualify for a beautification and replanting plan.

(d) The determination of which sites qualify for compensatory replanting shall be based on the initial site plan and tree tagging requirement under G.S. 136-133.1(e).

(e) After the initial selective vegetation removal request is made for a site, all subsequent selective vegetation removal requests shall revert to the initial site plan and tree tagging requirement for purposes of determining the percent of the quantity of trees (including existing trees and other trees) that are requested to be removed. When cumulative tree removal equals or exceeds 60 percent, the location qualifies for a beautification and replanting plan.

(f) For a period of five years after a beautification and replanting plan is approved and the initial installation is accepted by the Department, no selective vegetation removal permit for removal of replanted materials or existing trees as defined in G.S. 136-133.1(b) or other trees as defined in the rules in this section are allowed. For future selective vegetation removal applications at replanted sites, replanted materials may only be removed if may be removed only if partially blocking the view to a sign face. In this case, the Department will require plant substitutions on a one for one basis, except for a site where any replanted materials are partially blocking the view to a sign face and the permittee requests approval through the Department for plant substitutions on a one for one basis. All requests for plant substitutions shall be approved by the Department and installed according to the rules in this Section.

(g) Submittal of a selective vegetation removal application shall be in accordance with G.S. 136.133.1(c).

(h) The applicant may employ the services of a North Carolina licensed landscape architect or an arborist certified by the International Society of Arboriculture to submit a comprehensive report under seal to comprise all the requirements of G.S. 136-133.1(e) for the initial selective vegetation removal application, including a site plan of existing trees, tree tagging requirements, and a tree survey of existing trees. If the applicant chooses to submit a comprehensive report, which includes the criteria listed below and in Paragraph (d) of this Rule, the report will conclusively resolve any dispute concerning existing trees:

(1) The site plan includes a site map of quantity and dimensions and separate inventory lists of all existing trees and all other trees, within the maximum limits of the vegetation removal zone. The lists shall include all trees present that are four inches and larger in diameter measured at six inches above ground at the time of the selective vegetation removal application, and shall identify all trees requested to be removed. The lists of existing trees and other trees shall be categorized to include quantity, species, and caliper inch diameter size at six inches above ground. All trees (existing trees and other trees) requested to be removed shall also be tagged with highly visible orange material or flagging.

(2) The tree survey of existing trees includes the year that the tree had a diameter of four inches or measured six inches from the ground and the age of any tree within the maximum vegetation removal zone that existed at the time the sign was erected. Such tree survey is not required for subsequent applications to remove trees that have been previously permitted.

(i) Any dispute relating to information on the site plan, tree tagging requirement, and the tree survey under the rules in this section shall be conclusively resolved by information in the comprehensive report.

(j) After the initial selective vegetation removal permit, subsequent applications do not require a new comprehensive report, but shall identify all trees (including existing trees and other trees) requested to be removed based on the initial comprehensive report.

(k) The caliper inches of existing trees from the applicant's site plan shall equal the caliper inches to be replanted and maintained by the applicant at the outdoor advertising site from which existing trees are requested to be removed. If the caliper inches of existing trees from the site plan exceed the density of the Departments replanting site design, the excess caliper inches of trees shall be delivered by the applicant to the Department according to limitations the schedule described in Subparagraph (m)(g)(6) of the this Rule. If plant material other than trees is proposed, the Department shall approve any consideration such substitution for the required caliper inches. The excess trees shall be planted and maintained by the Department at sites to be determined by the Department.

(l) If other trees are requested to be removed, the following apply:

(1) The total number of other trees, based on the applicant’s tree tagging requirement, shall equal the total number of trees to be replanted.
and maintained by the applicant at the outdoor advertising site.

(2) If the total number of other trees from the tree-tagging requirement exceeds the density of the Department's replanting site design, the excess quantity of trees to be replanted shall be delivered to the Department by the applicant according to limitations described in Subparagraph (m)(6) of this Rule.

(3) For other trees removed, the minimum size of each replanted tree shall be 1.5 caliper inches in diameter. If plant material other than trees is proposed, the Department may approve such substitution to the required 1.5 caliper inch tree. The excess trees shall be planted and maintained by the Department at sites to be determined by the Department.

(e)(k) For sites that qualify according to the replanting criteria described in this Rule, the Department shall consult with the applicant and any local government that has requested to review and provide comments on selective vegetation removal applications pursuant to G.S. 136-93(d) or has notified the Department of its desire to review and provide comments on beautification and replanting plans for outdoor advertising sites. If the local government does provide comments on a beautification and replanting plan, the Department shall take the comments into consideration. If the local government does not make appropriate request for a review, the criteria stated in the rules in this Section shall be followed for replanting determination. If a site qualifies for a replanting, the Department may require one of the compensatory options set forth in G.S. 136-133.1(d).

(f) In consideration of differences in outdoor advertising sign structure heights, the Department shall maintain on file regionalized landscape design plans and plant lists as a guide for applicants. The applicant may submit one of the Department's plans or a proposed beautification and replanting plan prepared and sealed by a North Carolina licensed landscape architect; within 60 days of notification that the site qualifies for a beautification and replanting plan. Such designs must be approved by the Department in writing. The Department's written approval, based on the American Standard for Nursery Stock, of the beautification, replanting, and maintenance plan will allow the applicant to proceed with requested vegetation cutting, thinning, pruning or removal of existing and other trees at the outdoor advertising site.

(g)(m) The approved beautification and replanting plan becomes a part of the selective vegetation removal permit pursuant to G.S. 136-93(b) and 136-133.1(e). All applicable requirements of the permit, including the performance bond and insurance, shall continue to apply until all replanting and establishment requirements are satisfied and accepted in writing by the Department. The Department shall approve the replanting portion of the selective vegetation removal permit in writing detailing the requirements of the beautification and replanting plan. The requirements include the following:

(1) The work for initial plantings and all future replacements must be adhered to by the permittee or any of their employees, agents, or assigns according to International Society of Arboriculture standards except as stipulated in the rules in this section. Initial and replacement planting will be considered acceptable when the plants have been placed in the plant hole, backfilled, watered, mulched, staked, and guyed. All plants of one species, which are shown on the plans to be planted within a bed, shall be planted concurrently and the entire group shall be completed before any plant therein is considered acceptable. Replacement planting consists of replacing those plants which are not in a living and healthy condition as defined in these rules.

(2) The permittee must adhere to erosion control requirements, according to North Carolina General Statutes, Article 4, Chapter 113A entitled: Sedimentation Pollution Control Act of 1973.

(3) All plant materials shall be pre-approved in writing by the Department prior to arrival at the outdoor advertising site or prior to excess trees being furnished and delivered to the Department. The approval shall be based on the American Standard for Nursery Stock.

(4) All work is subject to NCDOT Division of Highways inspection and shall be scheduled with the Department. A minimum 48-hour notification shall be provided to the Department by the permittee before entering the right-of-way for any beautification and replanting plan requirements.

(5) Grinding of all cut stumps (to a minimum depth of four inches below ground level) must be completed in the area of replanting during the preparation of the site, prior to initial planting.

(6) All initial and replacement plantings shall be installed during the first planting season between (November 1 and March 15) following the selective vegetation removal. If replanting cannot be completed by the March 15 deadline, the replanting shall occur during the next planting season. The same dates (November 1 to March 15) apply when the permittee provides the Department with excess plant material at a site where either existing caliper inches or quantity of trees exceeds the site design capacity.

(7) The permittee shall contact the Department to schedule a final replanting acceptance inspection upon completion of any plant material installation. For one year from the date of the initial planting acceptance for the entire replanting plan, the permittee must establish all plant materials according to these provisions. Establishment for all initial or replacement plants shall begin immediately after they are planted. The permittee shall be
responsible for the area around plantings for a
distance of six feet beyond the outside edges
of the mulch. Establishment shall include
cutting of grass and weeds; watering;
replacement of mulch; repair or replacement of
guy stakes, guy wires, and water rings; and
other work to encourage the survival and
growth of plant material. The permittee shall
remove and dispose of dead plants from the
replanting plan site during the establishment
period. Prior to the end of the one-year
establishment period, the permittee is
responsible for contacting the Department to
schedule a site meeting with Departmental
officials to identify plants to be replaced that
are not in a living and healthy condition.
Plants do not meet the living and healthy
condition requirement and need replacement if
25 percent or more of the crown is dead, if the
main leader is dead, or if an area of the plant
has died leaving the character of its form
compromised, lopsided, or disfigured. The
permittee shall replace, during the planting
period, plant material needed to restore the
planting to the original quantity, size, and
species of plant material. Any desired changes
in plant material proposed by the permittee
must be requested in writing to the
Department. The Department shall notify the
permittee in writing of the replacement
plantings.

(8) At the conclusion of the one-year
establishment period the Department shall
issue a written acceptance of the permittee's
work and release the applicable bond. Then a
one-year observation period shall begin in
which the permittee or sign owner shall
maintain stability of the original and
replacement plantings to promote their
continued livability and healthy growth. The
sign owner is responsible for replacement of
plants not meeting the living and healthy
condition requirement during the observation
period and in accordance with the dates of
planting as stated in the rules in this section.

(9) After the one-year observation period
concludes, the Department shall notify the
sign owner if the permit requirement conditions
have been met successfully.

(10) After the conclusion of the initial five
year period as set out in Paragraph (f) of this Rule,
the permittee may not remove any tree or other
plant that was installed or replaced according
to a replanting plan unless, due to replanted
materials blocking the view to a sign face,
plant substitutions are proposed on a one for
one basis. All requests for plant substitutions
must be approved by the Department and
installed, observed, and maintained according to the rules in this
section. Additional replanting, subject to the
requirements of the rules in this section, shall
be required if a permittee requests additional
selective vegetation removal.

(11) Replanted materials may be pruned according
to the International Society of Arboriculture
standards; however, topping of trees or other
vegetation is not allowed.

(12) Excess plants or trees furnished and delivered
to the Department, shall receive care and
handling in accordance with the following: In
digging, loading, transporting, unloading,
planting, or otherwise handling plants, the
permittee shall exercise care to prevent
windburn, injury to or drying out of
the trunk, branches, or roots; and to prevent
freezing of the plant roots. The solidity of the
plant ball shall be carefully
preserved.

(13) Should the outdoor advertising structure
related to the selective vegetation permit be
sold or transferred, the new owner or permit
holder is subject to the requirements in the
General Statutes and rules in this Section,
including those regarding planting,
establishment, replacement or renovation
plantings, minimum living and healthy
condition, and observation.

(14) Willful failure to substantially comply with the
requirements of Paragraph (m) of this Rule
for the beautification and replanting plan shall
subject the permittee to penalties prescribed in
G.S. 136-133.4.

History Note:  Authority G.S. 136-93; 136-130; 136-133.4;
This Section contains information for the meeting of the Rules Review Commission on Thursday January 19, 2012 10:00 a.m. at 1711 New Hope Church Road, RRC Commission Room, Raleigh, NC. Anyone wishing to submit written comment on any rule before the Commission should submit those comments to the RRC staff, the agency, and the individual Commissioners. Specific instructions and addresses may be obtained from the Rules Review Commission at 919-431-3000. Anyone wishing to address the Commission should notify the RRC staff and the agency no later than 5:00 p.m. of the 2nd business day before the meeting. Please refer to RRC rules codified in 26 NCAC 05.

RULES REVIEW COMMISSION MEMBERS

Appointed by Senate
Addison Bell
Margaret Currin
Pete Osborne
Bob Rippy
Faylene Whitaker

Appointed by House
Ralph A. Walker
Curtis Venable
George Lucier
Garth K. Dunklin
Stephanie Simpson

COMMISSION COUNSEL
Joe Deluca (919)431-3081
Bobby Bryan (919)431-3079

RULES REVIEW COMMISSION MEETING DATES
February 16, 2012 March 15, 2012
April 19, 2012 May 17, 2012

RULES REVIEW COMMISSION
January 19, 2012
MINUTES

The Rules Review Commission met on Thursday, January 19, 2012, in the Commission Room at 1711 New Hope Church Road, Raleigh, North Carolina. Commissioners present were: Addison Bell, Margaret Currin, Garth Dunklin, George Lucier, Pete Osborne, Bob Rippy, Stephanie Simpson, Curtis Venable, Ralph Walker and Faylene Whitaker.

Staff members present were: Joe Deluca and Bobby Bryan, Commission Counsel; Dana Vojtko, Julie Edwards and Tammara Chalmers.

The meeting was called to order at 10:05 a.m. with Judge Walker presiding. He reminded the Commission members that they have a duty to avoid conflicts of interest and the appearances of conflicts as required by NCGS 138A-15(e).

APPROVAL OF MINUTES
Chairman Walker asked for any discussion, comments, or corrections concerning the minutes of the December 15, 2011 meeting. There were none and the minutes were approved as distributed.

FOLLOW-UP MATTERS
10A NCAC 09 .0102, .2819, .2820, .2822 – Child Care Commission. The Commission approved the rewritten rules submitted by the agency.

The Commission received more than 10 written letters of objection to 10A NCAC 09 .0102, .2819, .2820, .2822. These rules, along with the rules that were created from breaking these rules into multiple rules for clarity, are now subject to legislative review and a delayed effective date.

10A NCAC 10 .0203 – Social Services Commission. No action was taken.

15A NCAC 10B .0223 - Wildlife Resources Commission. The Commission approved the rule based on the repeal of 15A NCAC 10B .0204.
21 NCAC 14T .0614-.0701 - Board of Cosmetic Art Examiners. The Commission approved rewritten Rule .0614 submitted by the agency. 21 NCAC 14T .0614 was approved contingent on receiving a technical change. The technical change has been subsequently received.

Lynda Elliot from the board addressed the Commission.

21 NCAC 32C .0102, .0105, .0106, .0109 - Medical Board. No action was taken.


2012 Mechanical Code – Sections 313.1 and 313.2 – Building Code Council. The Commission approved the rewritten rule submitted by the agency.


2009 Residential Code – Sections 313.1.1 and 313.1.2 – Building Code Council. The Commission approved the rewritten rule submitted by the agency.

2012 Residential Code – Sections 311.1 and 311.2 – Building Code Council. The Commission approved the rewritten rule submitted by the agency.

Barry Gupton with the Building Code Council was present to address any questions from the Commission.

LOG OF FILINGS
Chairman Walker presided over the review of the log of permanent rules.

Alcoholic Beverage Control Commission
All rules were approved unanimously with the following exceptions:

04 NCAC 02S .1008 - The Commission objected to this rule based on ambiguity in accordance with G.S. 150B-21.10. In Part (b)(1)(D), it is not clear what additional exceptions will be granted in the case of corporate names or franchise trade names. If this simply means that the use of corporate names or franchise trade names is allowed on all outside signage, the rule should say that. If it means something else, that is not clear.

Child Care Commission
10A NCAC 09 .0604 was approved unanimously.

10A NCAC 09 .1725 was withdrawn by the agency.

Sheriffs Education and Training Standards Commission
All rules were approved unanimously.

Alarm Systems Licensing Board
All rules were approved unanimously.

Marine Fisheries Commission
All rules were approved unanimously.

Sedimentation Control Commission
15A NCAC 04B .0132 was approved unanimously.

Wildlife Resources Commission
15A NCAC 10B .0204 was approved unanimously.

Water Treatment Facility Operators Certification Board
All rules were approved unanimously with the following exception:
15A NCAC 18D .0309 was withdrawn by the agency.
Commissioner Osborne was not present during the vote.

**Certified Public Accountant Examiners, Board of**
All rules were approved unanimously.

Commissioner Osborne was not present during the vote.

**Medical Board**
Thom Mansfield from the Board addressed the Commission.

All rules were approved unanimously.

Commissioner Venable was not present during the vote.

**Podiatry Examiners, Board of**
Penney DePas from the Board was present to address any questions from the Commission.

21 NCAC 52 .0208 was approved unanimously.

**Real Estate Commission**
Prior to the review of the rules from the Real Estate Commission, Commissioner Dunklin recused himself and did not participate in any discussion or vote concerning these rules because he regularly practices before the Real Estate Commission.

Prior to the review of the rules from the Real Estate Commission, Commissioner Currin recused herself and did not participate in any discussion or vote concerning these rules because she possesses an inactive real estate broker's license.

All rules were approved unanimously.

The meeting recessed at 11:00 a.m. and reconvened at 11:10 a.m.

**TEMPORARY RULES**
Chairman Walker presided over the review of the log of temporary rules.

**Department of Transportation**
Ryke Longest from the Duke Environmental Law & Policy Clinic, Harry Phillips, private citizen, and Ken Moore, private citizen, addressed the Commission in opposition to these rules.

Craig Justus from the Van Winkle Law Firm addressed the Commission in favor of these rules.

Betsy Strickland representing the Department addressed the Commission.

Commissioner Venable moved to accept the staff recommendation to approve the rules from the Department of Transportation. The motion was approved with Commissioners Venable, Simpson, Osborne, Rippy, and Currin voting for the motion and Commissioners Dunklin, Lucier and Bell voting against the motion.

Prior to the review of the rules from the Department of Transportation, Commissioner Walker recused himself and did not participate in any discussion or vote concerning these rules because his family owns property in Burke County which have billboards.

Commissioner Whitaker recused herself and did not participate in any discussion or vote concerning these rules because she has billboards rented.

**2012 State Medical Facilities Plan**
The Commission found that the Department of Health and Human Services and the State Health Coordinating Council had complied with G.S. 131E-176(25) in the adoption of the 2012 Plan.

**COMMISSION PROCEDURES AND OTHER BUSINESS**
The Commission adopted amended rule 26 NCAC 05 .0108 and rule 26 NCAC 05 .0114 with an effective date of February 1, 2012.

Staff discussed the new OSBM guidelines.
The Commission elected officers. The Commission’s Bylaws require that elections be held at the January meeting.

Judge Walker was re-elected Chairman.

Margaret Currin was re-elected 1st Vice-Chairman.

George Lucier was re-elected 2nd Vice-Chairman.

The meeting adjourned at 1:12 p.m.

The next scheduled meeting of the Commission is Thursday, February 16 at 10:00 a.m.

Respectfully Submitted,

________________________________
Julie Edwards
Editorial Assistant

Minutes approved by the Rules Review Commission.
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<td>Norman Porn</td>
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<td>Robert Sym</td>
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<td>Renee Hutcherson</td>
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### Rules Review Commission

#### Meeting

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<td>Lisa Martin</td>
<td>WC Home Builders Assoc</td>
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LIST OF APPROVED PERMANENT RULES
January 19, 2012 Meeting

ALCOHOLIC BEVERAGE CONTROL COMMISSION
Notice of Alleged Violation 04 NCAC 02R .0802

CHILD CARE COMMISSION
Definitions 10A NCAC 09 .0102
General Safety Requirements 10A NCAC 09 .0604
Education Standards for a Two Component Rated License for... 10A NCAC 09 .2819
Education Standards for Lead Teachers for a Rated License... 10A NCAC 09 .2820
Education Standards for Teachers for Rated License for Ch... 10A NCAC 09 .2821
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**OFFICE OF ADMINISTRATIVE HEARINGS**

*Chief Administrative Law Judge*

**JULIAN MANN, III**

*Senior Administrative Law Judge*

**FRED G. MORRISON JR.**

**ADMINISTRATIVE LAW JUDGES**

- Beecher R. Gray
- Selina Brooks
- Melissa Owens Lassiter
- Don Overby
- Randall May
- A. B. Elkins II
- Joe Webster

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On March 28 and 29, 2011, Administrative Law Judge Melissa Owens Lassiter conducted a contested case hearing in this case. At the conclusion of the hearing, the undersigned held the record open for to allow the undersigned and the attorneys to view the Amtrak videotape of the collision that is the focus of this contested case, and for the deposition of the train engineer, Richard Todd Harris. On April 1, 2011, the undersigned and the attorneys viewed the videotaped evidence in this case. On April 7, 2011, the undersigned ordered the videotaped evidence from the onboard camera sealed in the record.

On April 26, 2011, Mr. Richard Harris was deposed. On August 11, 2011, the parties filed their respective proposed Decisions with the Office of Administrative Hearings. On August 18, 2011, a transcript of Harris' deposition was filed with the Office of Administrative Hearings. Chief Administrative Law Judge Julian Mann III extended the deadline for the filing of the Decision in this case until October 7, 2011.

APPEARANCES

For Petitioner: Cody R. Hand
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For Respondent: John Barkley
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ISSUE

Whether Respondent properly classified decedent's death as a suicide based upon the Chief Medical Examiner's opinion as to the manner of death?
APPLICABLE STATUTE AND RULES


EXHIBITS ADMITTED INTO EVIDENCE

The parties stipulated to the admission of all exhibits:

For Petitioner: A – E
For Respondent: 1A - 1N, 2 – 7

FINDINGS OF FACT

Parties

1. At approximately 11 a.m. on June 9, 2009, an Amtrak passenger train collided with a Toyota Solara automobile on the railroad tracks at the Royal Street railroad crossing near Hillsborough Street in Raleigh, North Carolina. Mr. Jack Daniels was the driver of the car, and was killed in the crash.

2. Ms. Nanette B. Daniels (hereinafter “Petitioner”) is the widow of Mr. Jack Daniels (hereinafter the “decedent”).

3. Pursuant to N.C. Gen. Stat. § 130A-377 et seq, Respondent Chief Medical Examiner’s Office conducts postmortem medicolegal examinations to determine the cause and manner of a person’s death in this State.

Procedural Facts

4. Mr. Daniels’ body was taken to the Medical Examiner’s office, and examined by Dr. Theresa Kent, medical examiner for Orange County. Dr. Kent classified the manner of Mr. Daniels’ death as an “accident.” In her report, Kent noted that Mr. Daniels’ car was “struck by a train while he was driving around the gates across the tracks... Cause of death is consistent with multi-trauma secondary to MVC versus train.” (Resp. Exh. 2)

5. In July 2009, Respondent received information from the Raleigh Police Department (“RPD”) that Mr. Daniels’ car was stopped on the tracks, instead of attempting to drive around the gates, that RPD considered Daniels’ death a “suicide,” and that Daniels’ family disagreed with RPD’s suicide determination. Chief Medical Examiner Dr. John D. Butts revisited this case.

6. After reviewing additional information, Dr. Butts placed a notation on the medical examiner’s report explaining his review, and classifying the manner of death as
"suicide." On August 3, 2009, Dr. Butts filed a supplemental death certificate showing the Medical Examiner's opinion as to the manner of death as "suicide."

7. On September 17, 2009, Petitioner filed a petition for a contested case hearing appealing Dr. Butts' classification of Mr. Daniel's death as a suicide. In that petition, Petitioner alleged that Mr. Daniels' death does not fit the pattern of suicide, and that Mr. Daniels suffered from diabetes and severe cramping that often made him unable to move his legs. Petitioner contended that Respondent acted improperly and failed to follow proper procedure by failing to perform an autopsy to determine if Mr. Daniels suffered from complications of his diabetes, and by failing to examine Daniels' vehicle for mechanical failure.

**Decedent, Jack M. Daniels**

8. The decedent, Jack M. Daniels, owned and operated the Jack Daniels Deli ("the store") in Raleigh, North Carolina for more than 30 years. He and his wife worked together on a daily basis in their business. The store was open from 7:00 am until 8:00 pm. (T p.10-11)

9. Mr. Daniels was an outgoing, gregarious individual who regularly befriended service workers, employees and others who came to his business. (T p. 80). He enjoyed engaging them in lengthy conversations not directly related to work. (T p. 80) Friends and family described Mr. Daniels as optimistic, reliable and dependable. (T p. 34, 64, 80) Family described Daniels' as a thinker and a planner, who carefully thought through and planned events and activities in his life. (T p. 35)

10. Physically, Mr. Daniels had some medical issues. (T p. 22) He was almost deaf in one ear, due in part to his service as a door gunner in Vietnam. (T p. 32) His eyesight was diminished due to age and diabetes. (T p. 33) He also suffered from diabetes. Although Mr. Daniels' diabetes was generally under control, Daniels' would occasionally skip meals, and then have blood sugar issues. (T p. 22)

11. The Daniels' business had gone through some financial stresses in 2009. (T p. 12) However, there is no evidence in the record proving those financial stresses were so significant that either the business or Mr. Daniels personally were losing large amounts of money, in danger of defaulting on a loan, or in danger of bankruptcy. Similarly, there is no evidence in the record showing the financial stresses on the Daniels' business were significantly affecting Mr. Daniels' mood, emotional state, behavior or demeanor.

12. The evidence at hearing showed that Mr. Daniels was close to his wife. They often planned "date nights," and had planned a "date" for the evening of the day he died. (T p. 17)

13. Mr. Daniels was also very close to the Daniels' only child, Kara Daniels Hand, an attorney. (T p. 40,41) When Kara attended Cary High School, there were a number of student suicides. Because of concerns related to those suicides, Mr. Daniels and Kara discussed the issue of suicide at some length (T p. 49) During that conversation, Mr.
Daniels told Kara that, "Suicide was the most selfish thing that you could do. It separates you from family and from God." (T p. 49)

14. In the spring of 2009, and in the weeks leading up to his death, Mr. Daniels did not display any signs of serious or prolonged depression. (T p. 53, 53, 73) The preponderance of the evidence at hearing showed that Mr. Daniels was excited about his future, and had made plans for that future.

a. The day before Mr. Daniels died, he and Ms. Daniels had an appointment to meet with a buyer for the store. (T p. 12) The buyer was unable to make that appointment due to a medical issue, but they agreed on a meeting time later that week. (T p. 12) The Daniels intended to sell the store, spend a few months straightening out some medical issues, and then see the country. (T p. 33). Mr. Daniels was considering an alternative career path. (T p. 11)

b. In early June 2009, Mr. Daniels was so excited about the upcoming June 14, 2009 christening of his granddaughter that he had already selected his suit and taken it to a dry cleaner to be picked up the following Friday morning. (T p. 34) Mr. Daniels was actively involved in the planning of the christening party for Emmie Reed set for the day of the christening, and had volunteered to arrange for the BBQ for the guests. (T p. 33)

15. Mr. and Mrs. Daniels had a regular routine of opening the store early in the morning, then leaving to pick up and care for their granddaughter Emmie for part of each morning. (T p. 15)

The morning of June 9, 2009

16. On the morning on June 9, 2009, Mr. and Mrs. Daniels followed their usual routine. (T p. 14) They arose at 4:30 am, and took showers. At about five o’clock, Mr. Daniels threw up in the bathroom after getting out of the shower. (T p 14) They drove to the store, prepared breakfast, and other jobs, then opened the store at 7:00 am. (T p 15) They discovered the walk-in cooler was broken, and not operating.

17. Around 8:00 am, Kara Bond, an employee and sister-in-law of Mrs. Daniels, arrived for work. The Daniels and Ms. Bond moved food out of the walk-in cooler. Around 8:25 am, Mr. and Mrs. Daniels left the store to pick up their granddaughter Emmie at their daughter’s law office. (T p. 15) Mr. Daniels drove Mrs. Daniels and Emmie to their home, so Mrs. Daniels could care for Emmie there. (T p. 16)

18. Around 9:30 am, Mr. Daniels returned to the store to assist with the lunch hour rush, and to meet the cooler repairman. (T p. 17; Pet Exh C) Ms. Bond observed Mr. Daniels enter the store. She observed that he was "red-faced, and slightly out of breath." (Pet Exh C) Ms. Bond asked Daniels if:

[H]e had eaten that morning. He said no and I offered to make him breakfast. He replied that he would get something later.
(Pet Exh C) Bond offered Mr. Daniels food on a regular basis, but normally he was good about keeping himself fed. (T p. 70)

19. At the store, Mr. Daniels met with repairman David Sanders about the broken cooler. (T p. 15, 65) Sanders and Daniels engaged in a good bit of friendly conversation unrelated to the cooler. (T p. 80, 82) They discussed the cooler, its current maintenance issue, the history of prior problems, and repairs to the cooler. After discussing options, with Sanders, regarding repairing or replacing the cooler, Mr. Daniels decided to replace the cooler. (T pp 80-82)

20. Mr. Daniels went across the street to a rental house he and Mrs. Daniels owned, and stayed approximately 20-30 minutes. (Pet Exh C) Mr. Daniels stored the Solara at the rental house, and drove the Solara back to the store. (T p. 21)

21. When Mr. Daniels returned to the store, Ms. Bond informed him that they were out of cups, and Mountain Dews. (T p. 67; Pet Exh C) Ms. Bond noticed that Mr. Daniels "responded slowly, like his mind was on something else or he didn't comprehend what I was saying. He was in a daze." (Pet Exh C) Daniels walked to the back of the store, and spoke with David Sanders. (T p 67-69; Pet Exh C)

22. It was not unusual for Mr. or Mrs. Daniels to make a quick run to Raleigh Wholesale or Sam's Club to pick up the needed supplies. (T p. 71) It typically took no more than 1/2 hour to 45 minutes to make such a run for supplies. (T p. 71) Mr. Daniels volunteered to go to their regular supplier Raleigh Wholesale to buy the supplies. (T p. 68)

23. Mr. Daniels commented about it being late, and close to lunchtime. Mr. Daniels told Ms. Bond, "I'll be right back." (T p. 70) and left the store to go to Raleigh Wholesale a little before 11:00 am. (Pet Exh C)

24. The route Mr. Daniels regularly drove from the store to the supplier took Daniels along Beryl Road in Raleigh, and across the railroad tracks owned by the CSX rail company at Royal Street. (T p. 19) There are two parallel sets of tracks at that railroad crossing. The road that crosses the tracks is a two-lane road with no dividing line. (T p. 117) The train often travels on the opposite set of tracks as it traveled on June 9, 2009. (Deposition, p. 43)

25. Shortly before, 10:55 am, an Amtrak train traveling about 79 miles per hour rounded the Beryl Road curve. Its engineer, Richard Todd Harris, could not tell that there was a vehicle on the tracks until after he rounded the Beryl Road curve. (Deposition, p. 20) Harris described the scene as follows:

I was coming around the curve. I was going about 79 mph. That is how fast trains go in town. I was heading east bound. When I rounded the curve, I saw a grey vehicle sitting in the middle of the tracks. It looked like a Saab.
The track arms were down. When I realized that the car wasn’t going to move I hit the brakes. When I got close I could see a white male in the driver’s seat. The car was facing north. He just kind of looked at me and that was it. I didn’t have time to stop before I got to him.

(Respondent’s Ex. 1E) The crossing arm was down when Harris first saw Mr. Daniels’ car. (Deposition, p. 20). Harris blew the horn, the train struck Mr. Daniels’ vehicle, and caused Mr. Daniels’ death.

26. On the morning of June 9, 2009, Benjamin Marks, III was hanging out with friends behind Raleigh Wholesale. Mr. Marks indicated he had an unobstructed view of the railroad crossing at Royal Street and saw the front of Mr. Daniels car as it drove onto the tracks. When he saw Mr. Daniels drive onto the tracks, the crossing guard arms went up, and when Daniels got on the railroad track, the arms dropped down. (T p. 118). Marks opined that the arms appeared to be malfunctioning, as he had frequently observed happen before that morning. Marks was not the only eyewitness. (T p. 103).

27. On June 9, 2009, the RPD was notified of the collision and arrived on the scene to investigate the crash. The Crash Reconstruction Unit (CRU) of RPD was also called to investigate the crash. The CRU consists of officers trained in crash investigation and crash reconstruction who respond to all fatal crashes or serious crashes that may ultimately result in a fatality. The CRU officers investigate the crash scene, and coordinate the onsite investigation by the other officers in gathering the necessary information to determine what caused the crash, what happened during the crash, and other pertinent information related to the crash.

28. On or about June 9, 2009, Sgt. Robert Strickland was the Sergeant in command of the CRU. (T. p. 124-125) Sgt. Strickland is a 23 year veteran of the RPD, and has had extensive training and experience in the crash investigations and crash reconstructions, including two courses specifically concerning train-car collisions (see Respondent’s exhibit, Sgt. Strickland’s CV). He has attended and taught numerous continuing education courses on crash investigation and reconstruction. He has conducted 117 crash reconstructions and investigated 972 traffic crashes.

29. Sgt. Strickland was in charge of the CRU for 4 years, and during that time the CRU investigated an average of 50 crashes a year, with approximately 50% of the crashes resulting in fatalities. At the time of the decedent’s death, Strickland had previously investigated 5-6 car-train collisions. Based on his training and experience, the undersigned qualified Sgt. Strickland as an expert in crash investigation and crash reconstruction at hearing. (T. p. 124-137) Since then, Sergeant Strickland has been promoted to Lieutenant, and is currently, the watch commander for B Squad of the RPD.

30. When Sgt. Strickland arrives on the scene, he always looks at the pavement first, for signs of gouges or tire marks, because there’s always damage to pavement when there is a collision. He looks at where the train stops, because that indicates braking or slowing of the train based on the weight of the train, including the number of cars being pulled. He also looks at the debris field from the crash, because debris goes out in a cone
from the crash, and that indicates the location of the vehicle at the time of impact.

31. In this case, Sgt. Strickland arrived at the scene of the crash on June 9, 2011, and gathered officers together to advise him about the basic synopsis of the call reporting the crash, and what had been done on scene to that point. Sgt. Strickland assigned duties to various officers to conduct the investigation. He assigned Officer Winston, who was also a certified crash deconstructionist, to investigate Petitioner's car. He assigned CRU officers Sweden and Bradford, along with Officer Harrelson, to investigate the train. He assigned Officer Conners, who was an intermediate crash investigator, to prepare a field diagram and take measurements, such as distance of the car and train to final resting places, length of tire marks and gouges, and other related measurements. He assigned Sergeant Trueheart to notify the decedent's next of kin. Other officers were assigned to canvas the area to attempt to find any possible witnesses.

32. Sgt. Strickland looked at the pavement at the point of impact. He immediately noticed there were gouges and tire marks on the road, and noticed they were on the "wrong side," meaning the left side, of the road. This indicated to him that the car was driving on the wrong side of the road, or had gone around the train warning gates. He also noticed that the marks were angled, indicating that the car was at a slight angle across the tracks. He noticed that these gouges were deep, which indicated the point of impact. These observations confirmed to him that the car was on the wrong side of the road at the time of impact.

33. Officer Bradford observed tire marks and gouge marks on the road surface at the crossing, and determined that the marks indicated that the car was on the wrong side of the road for its direction of travel at the time of the crash. (Resp. Exh. 1-I)

34. Officer Bradford asked railway workers, who had arrived at the scene, to check the control box for the gates and warning lights and bells. The railway workers tested the gates, and observed that the gates went down and stayed down, the lights were flashing, and the bells were ringing. Another railway worker arrived later to examine the control box. He determined from the computer records in the box that the signal had been functioning properly at the time of the crash. The train engineer stated that the gate arms were down and appeared to be functioning properly. Based on this information, Sgt. Strickland concluded that the warning devices were all working appropriately at the time of the collision.

35. Sgt. Strickland observed the damage to Petitioner's car, and the location where the car finally came to rest. He observed a massive impact to the driver's door area that was "square-on" to that area. In his opinion, that showed an impact that was straight into the car, and was consistent with the car being stopped on the track. The fact that Petitioner's car came to a rest off to the side of the track, 75 feet from impact, also indicated that Petitioner's car had been stopped on the track. The cone of the debris field also supported that the car was stopped.

36. Normally, in a train-car collision, the car is trying to speed across the track and attempting to beat the train. In such circumstances, the speed of the car forces
the car off in a different trajectory from the train. However, in this case, the car went straight down the track with the train until it fell off to the side. This indicated that the car was in a stopped position on the tracks. If the car had been moving, the car would have been further out from the train, and the cone of debris would have gone with the angle of the impact, instead of straight down the track with the train. Here, the debris field followed the straight path, and was consistent with the car being stopped. (Sgt. Strickland testimony)

37. Sgt. Strickland thought that the distance of the train, from impact to resting point, demonstrated that significant braking had taken place. In other words, the engineer saw the car in the road, and had a longer opportunity to attempt to stop the train. Had the car been speeding across the track, the engineer would not have seen the car until later, and would not have been able to do the same amount of braking. Lastly, the tire and gouge marks were consistent with the damage to the car, showing that the car was stopped on the tracks at impact. These marks would have been different had the car been moving at the time.

38. Officer Harrelson obtained a statement from the engineer, Richard Harris, at the scene. (See Resp Exh 1-E; noted above)

39. RPD found no eyewitnesses other than the engineer. However, Mr. Arch Altman heard the crash. Mr. Altman worked nearby, and was used to hearing the short horn blasts as trains came through. Shortly before the crash, Mr. Altman heard a prolonged horn blast, instead of short blasts, and then heard a "thump." His coworker ran out, and saw the arms were going up just as he ran out. (T p. 149-150)

40. Sgt. Strickland discovered later, on the day of the crash, there was an on-board camera, in the Amtrak train involved in the crash, that had taken video of the crash. He could not obtain a copy of the video, but was able to arrange to view the video. At hearing, Sgt. Strickland explained that the video corroborated his opinion regarding the crash, that the decedent intentionally stopped the car on the tracks in the path of the oncoming train. He noted that the "video shows the car sitting on the track, not moving" and:

   It doesn't appear there is any effort being made by the driver at all to get out of the car, to move the car, but just sitting there looking at the train.

(T p 179) Sgt. Strickland noted that the video showed that the car was parked on the track, in the left lane, and that the driver appeared to be sitting upright.

41. On the day of the crash, Mr. Daniels' body was transferred to the medical examiner's office. Dr. Theresa Kent was the Medical Examiner on call at the time. On the morning of June 10, 2009, Dr. Kent examined Mr. Daniels' body.

42. On June 10, 2009, Dr. Kent issued a death certificate listing the manner of death as "accident." (Resp. Exh. 3) In her June 12, 2009 medical examiner's report, Dr. Kent wrote that Mr. Daniels died "after his car was struck by a train while he was driving
around the gates across the tracks." (Resp Exh 2) Dr. Kent noted in her report that "Cause of death is consistent with multi-trauma secondary to MVC versus train." (Resp Exh 2) Dr. Kent listed the manner of death on her medical examiner's report of decedent's death as "accident." (Resp. Exh. 2). At that time, Dr. Kent did not have any information that the Raleigh Police Department considered the case a suicide, that the family contested that determination, or that there was any question that the case was anything other than an accident.

43. Within one week or so, Sgt. Strickland spoke with Petitioner. Petitioner informed Strickland that Mr. Daniels was a diabetic, and had not eaten at all the day of the crash.

44. Based on this conversation, Sgt. Strickland contacted Kevin Gerity in the Chief Medical Examiner's Office. Strickland informed Gerity that the RPD had ruled Mr. Daniels' death a suicide, and the family was disputing the determination. (T. p. 182; Resp. Exh 1-G) He asked whether tests could be done to determine whether Mr. Daniels may have suffered from some sort of diabetic episode before the collision. Mr. Gerity advised that while they did not perform an autopsy, they did take some blood from the victim, and they were already performing normal toxicology on that blood. Mr. Gerity advised that he would have to check with Dr. Butts, the Chief Medical Examiner at the time, and would get back to Sgt. Strickland. (Resp. Exh 1-G) Until this point, no one in the OCME was aware that there was any question regarding whether the death might be suicide rather than accident.

45. On June 23, 2009, Mr. Gerity called Sgt. Strickland, and indicated that urine was needed to perform any tests on Mr. Daniels' body for diabetes, and they were unable to get any urine from the victim. He would ask Dr. Butts if a diabetic reaction would/could cause a person to abruptly stop or if a person can feel it coming on. (T. p. 182) (Resp. Exh. 1-G)

46. Sgt. Strickland told Mr. Gerity about the Amtrak video of the collision and Mr. Gerity informed Dr. Butts of the video's existence. OCME arranged with Amtrak for Dr. Butts to be allowed to view the video.

47. On June 23, 2009, Mr. Harris made a statement by affidavit regarding the June 9, 2009 incident at issue. Harris described his eye contact with the driver of the car as follows:

As the train approached the subject vehicle, I saw the driver look up and we made eye contact with each other through the impact. At no time did the driver ever attempt to drive off the tracks or exit the vehicle prior to the impact.

(See Exh. R-2 to the Deposition Transcript)

48. On July 8, 2009, Sgt. Strickland, and Officers Sweden and Bradford returned to the scene to videotape the train coming through the intersection. The Amtrak train from
Charlotte comes through the subject site, Monday through Friday, at approximately 10:58 am. On that day, Sgt. Strickland parked his car beside the tracks with a perspective as similar as possible to that of the decedent's. They checked the timing between the onset of the gates and warning bells, and the train coming through the intersection. He observed his stopwatch stop again at 24.97 seconds, denoting 24.97 seconds passed from the time the gates and warning bells began to the time the train entered the intersection. (See Resp Exh 1-J) Radar also showed the train coming through the intersection at a speed of 80 mph. Sgt. Strickland explained that the approach of the train that close was indescribable. He stated that he knew that he was not going to be hit, but it was all he could do to stay there. (Tpp 173-174)

49. On or about July 9, 2009, Sgt Strickland attended a meeting with Raleigh Chief of Police Dolan, Petitioner, Petitioner's daughter, and Raleigh City Councilman Thomas Crowder. At the end of this meeting, Chief Dolan instructed Sgt. Strickland to conduct additional investigation into the June 9, 2009 incident involving Petitioner's husband.

50. On July 9, 2009, Sgt. Strickland returned to the scene to document the same information as they had on July 8, 2009. Using the radar, they determined that the train came through at 10:54 a.m. at a speed of 80 mph. Again, the stopwatch determined that the train entered the intersection 24.97 seconds after gates warning bells started. (Tpp 172-173)

51. Sgt. Strickland noted that there was room at the intersection for the car to move off the tracks even with the gates down. He stated "(a) car sitting there can move forward or backward with no problem." (T p 175) He also noted that even if a car were to hit the gate backing up, the gate would easily break and the car could get off the track. He further explained that the line of sight distance from the Royal Street crossing to the curve at Beryl Road was 1189 feet and six inches. Therefore, it took the train, travelling at 79 miles per hour, 10.5 seconds to travel that distance, without hitting the brakes.

52. Sgt. Strickland opined that this corroborated his findings at the scene indicating that the car was on the wrong side of the road, was stationary, and parked across the railroad tracks at the time of impact. He explained that the video corroborated his conclusion that this was a suicide, because it showed Mr. Daniels sitting in the driver's seat of the car as the train approaches. The video also showed that Mr. Daniels was not attempting to move the car or to get out of the car, and was looking directly at the oncoming train. Sgt. Strickland believes that such actions show an intent to deliberately place the car in the path of the train in order to commit suicide.

53. Based on his training and experience, Sgt. Strickland formed the opinion that Mr. Daniel's death was a suicide. His opinion was based on the evidence at the scene of the crash, the car on the wrong side of the track, the pattern of the debris field, the statement from the train engineer, information collected by the other officers at the crash scene, the video of the crash taken from the train, video and radar readings he and his fellow officers took of the same train passing through the same crossing at the same time of day, and the totality of the circumstances of the police department's investigation. (T pp
190-91) At hearing, he indicated that, I'll go to my grave thinking this was a suicide regardless." (T p 192)

54. On July 16, 2009, OCME’s Gerity advised Strickland by telephone that he and Dr. Butts had viewed the on-board video. Gerity informed Strickland that although he had previously told Strickland that OCME would not change their report, OCME would in fact change their official report to show Mr. Daniels’ case as a suicide. "Dr. Butts stated that the video was pretty conclusive to indicate the case was in fact a suicide." (Resp. Exh 1-L) Gerity told Strickland they would forward a new copy of their official report showing this case a suicide. (Resp. Exh. 1-L)

55. Dr. John Butts was the Chief Medical Examiner for North Carolina for 24 years, retiring in July of 2010. He has taught extensively in the areas of forensic pathology and medicolegal death investigation. He has personally performed approximately 7,000 autopsies, and overseen many thousands of medical examiner investigations. At the contested case hearing, the undersigned qualified Dr. Butts as an expert in the areas of forensic pathology and medicolegal examinations.

56. Once Dr. Butts learned that the Raleigh Police Department considered the decedent’s death a suicide, he went back to look at OCME’s file on the case. He reviewed Dr. Kent’s report, and saw that she classified the case as an accident. The police reports showed that the car was stopped in the crossing when it was struck. He received the information that there was an Amtrak video of the collision, and arranged with Amtrak to view the video.

57. After reviewing this case, Dr. Butts determined the manner of the decedent’s death was "suicide," and that the original medical examiner report and death certificate should be changed to reflect this.

58. On July 20, 2009, Dr. Butts changed the cause and manner of the decedent’s death to "suicide" on the OCME’s investigative report (Resp. Exh. 2). He added additional narrative to the summary of circumstances surrounding death to include the following:

The driver of the vehicle is visible upright behind the wheel as the train approaches. There is no attempt to exit the vehicle. This is consistent with an attempt on the part of the decedent to drive around the gates to get over the tracks and most consistent with his having deliberately placed himself in the car on the tracks in the path of the train. The manner of death will be amended to suicide.

(Resp. Exh. 4)

60. On April 26, 2011, Mr. Harris testified by deposition. Harris explained that on June 9, 2009, Petitioner's car was stopped on the tracks, in the left lane closest to the train, and was not moving. He blew his horn, hit the brakes, and attempted to stop the train. Harris could see the driver. When asked how well he could see the driver, Harris responded, "I could see him okay - pretty good." (Deposition, p 22) He explained that he saw the driver in the driver's seat, and that the driver was not slumped over, but sitting upright. He could see the driver's face and upper body, and the driver "was looking in my general direction and I was looking at him." (Deposition, p. 22, 40, 56) He did not see the driver try to open the door, or make any attempt to move the car or get out of the car. He also saw stated that the gate arms were down, and that the gates, and the warning lights, and bells, were functioning properly. (Deposition, p. 22, 40, 56)

61. Mr. Harris acknowledged that he had watched the video of the collision about two weeks before his deposition. He opined that the video accurately reflected the collision. However, Harris noted that you could not see Mr. Daniels with the same clarity in the video, that Harris was actually able to see from his vantage point at the time of the collision.

62. Mr. Harris acknowledged that he was being treated for pressure related to glaucoma before the June 2009 crash, and that he advised Amtrak that he was being treated for glaucoma before June 2009. Harris underwent tests to determine if he could safely drive a train, and his eyesight was found to be sufficient to be a locomotive engineer. During the deposition, Harris explained that the glaucoma did not interfere with his vision at the time of the subject crash, and that his vision was still 20/20 in June 2009. He was not having any problems with his eyesight when he looked at Mr. Daniels, and saw Mr. Daniels looking him in the eyes.

63. At the time of the collision, Mr. Harris was sitting in the train at a height of at least 13 feet. (Deposition, p. 42) As the train traveled the distance from the Beryl Road curve to the point of impact, Mr. Harris was also, according to his consistent statements, blowing the train horn. (Deposition, p. 21) During these same few seconds, he admitted that he was actively attempting to stop the collision by engaging not one but three separate sets of brakes. (Deposition, p. 43) Moreover, he was also, as was his training and custom, looking at the crossing guard arms to see if they were down or up. (Deposition, p. 17)

64. Significantly, Mr. Harris did not testify that he observed Mr. Daniels' expression or what he saw in his eyes. Mr. Harris never mentioned that Mr. Daniels was wearing glasses until asked about them on cross-examination. (Deposition, p. 44) In addition, engineer Harris' observations, that the crossing arm was down and Mr. Daniels' car was on the tracks after the train rounded the curve, does not address one very important question - whether the crossing arm was up when Mr. Daniels drove on to the tracks.

65. In comparing Mr. Harris' three statements, the preponderance of the evidence showed that Mr. Harris actually gave several different versions of the June 9, 2009 incident.
a. In his initial statement to the Raleigh Police Department, Harris said the man in the car "just kind of looked at me and that was it." (Resp. Exh. 1-E, Deposition Ex. R-1) In contrast, in his affidavit a year later, Mr. Harris expanded on this statement, saying, "I saw the driver look up and we made eye contact with each other through the impact." (Deposition, p. 29, Deposition Ex. R-2)

b. Another year later, during his deposition, Harris was less certain. He first stated that "he [Mr. Daniels] was looking in my general direction and I was looking at him." (Deposition, p. 29.) After reviewing his affidavit from a year after the collision, Harris confirmed that he made eye contact with Mr. Daniels. (Deposition, p. 29) However, when cross-examined, Harris lost that certainty, testifying that:

A: To my knowledge, I would say that he made general - he made eye contact with me.
Q: He looked you in the eye?
A: That's the way it appeared to me.

(Deposition, p. 40)

66. This comparison of Mr. Harris' different statements revealed small, but significant changes in Harris' account of the June 9, 2009 over time. He also admitted that he specifically looked at the crossing arm during the same time period when he was allegedly in direct eye contact with Mr. Daniels. Given this comparison, there was insufficient evidence to prove Harris kept eye contact with Mr. Daniels from the moment he first saw him until the moment of impact.

67. Having carefully and thoroughly reviewed the contemporaneous Amtrak video taken in the moments just before the train-car impact, I find that the video is blurry and indistinct. A viewer can, at best, see a blob at the approximate location at which one would assume or expect to see Mr. Daniels' face. Mr. Daniels' hands are not visible. Mr. Daniels' expression and demeanor is impossible to discern. I do not doubt assertions that the video is more blurry than what his human eyes saw.

68. A preponderance of the evidence established that the crossing arm at railroad track closest to Raleigh Wholesale had been malfunctioning. Mr. and Mrs. Daniels and others had observed those crossing arms malfunctioning on a frequent basis. (T p.20, 96) Sometimes the crossing arm would go up and down repeatedly without any sign of a train. (T p. 20, 99) The week before June 9, 2009, Mr. and Mrs. Daniels were present at this same railroad crossing, when Mrs. Daniels saw the crossing arms moving up and down, and no train was coming. (T p. 20-21) Mr. Marks had also observed the crossing arm at the subject intersection malfunctioning.

69. Respondent argued that Mr. Marks was not a credible witness, because Marks admitted he routinely drank beer with his friends behind Raleigh Wholesale, and was at that location on June 9, 2009 to drink beer. Respondent argued that Marks was a bias witness, because his nephew had been killed by a train at that same crossing. He thought his nephew's death had been improperly classified as a suicide. Respondent
argued that Marks was pre-inclined to believe that there was something wrong with equipment at crossing, and to interpret events in accordance with the preinclination.

70. At hearing, Mr. Marks appeared sincere and troubled by having witnessed the death of Mr. Daniels. He had no interest in the outcome of this case. Mr. Marks admitted that he was at the location near the collision to drink with his friends. Although he claimed that on the day in question, he had just opened a beer when the wreck happened. (T p. 98) He acknowledged that he had once been a heavy drinker. (T p. 111) Since this incident, Mr. Marks is employed, and no longer drinks. (T p. 111) He claimed that he saw the signals and gates working improperly at the time of the collision on June 9th, 2009.

71. As Sergeant in charge of the Reconstruction Unit, Sgt. Strickland oversaw the investigation into the June 9, 2009 crash. He wrote the final report, and determined on behalf of RPD, that Mr. Daniels' death was suicide. (Tp. 192; Resp Exh. 1A-1N)

72. Lieutenant Strickland said that he based his opinion that Mr. Daniels committed suicide on: the evidence on scene, the statement from the train driver, and that the video corroborated what he had determined. (T p. 192)

   a. He asserted that based on gouges on the road, Mr. Daniels' car had to have been on the wrong side of the road, and at an angle as if he had gone around the crossing arm. (T p. 147) Because the car was "square on" the tracks, "like it was positioned on the track for direct side impact." (T p. 151)

   b. Strickland opined that it take 10.5 seconds for a train at that speed to travel the 1189 feet from Beryl Road to the point of impact, and that "was plenty of time to move the car or get out." (T p. 160) "If the train conductor was hitting the brakes, it would take longer." (T p. 160) He noted that some railroad company workers determined the crossing arm equipment was working properly. (T p. 147)

   c. When Strickland viewed the video, he said "it confirmed my opinion," (T p. 178) and concluded that there was "intent on the part of the driver to be on the track." (T p. 159)

   d. At some point, Strickland informed Ms. Hand, Mr. Daniels' daughter, that the preliminary investigative finding was that Mr. Daniels had committed suicide. (T p. 166) One of the things he took into account in making his determination that the death was a suicide was that Mr. Daniels' daughter, Ms. Hand, made a statement to one of the officers which he said caused other questions to be asked. (T p. 166)

73. The preponderance of the evidence showed that Sgt. Strickland's opinion of death by suicide was formed early in the investigation, before all the evidence was in and without adequate knowledge. On the scene of the crash, one of Strickland's officers raised the issue of suicide. (T p. 150) However, neither Strickland nor any of his officers notified the medical examiner of the possibility of suicide at that time.
74. Although qualified as a general expert in crash reconstruction, Strickland had had taken only two (2) courses related to trains. Those two courses were taught by railroad companies, and did not focus primarily on train wrecks or reconstruction. (T p. 131) Despite his training and experience with train-car collisions, Strickland did not know that the train would have a video camera on board. (T p. 210) He did not know how high off the ground that camera was, or the angle of the camera, or that such matters could affect what the ultimate footage would show. (T p. 194) He also did not know that the Federal Railroad Administration requires a report on all fatalities, and thought such reports must not be public. (T p. 245) He neither asked for nor knew whether there was a federal report on Mr. Daniels’ death. (T p. 245)

75. On the one hand, Sgt. Strickland indicated that the weight of a vehicle involved in a crash affects what happens, including braking distance. Yet, on the other hand, on cross-examination, Strickland he did not know the weight of the train involved in the crash, or if the train was speeding or not. (T p. 195) There is no evidence that the Sgt. Strickland knew the reason why the speed of the train was changed on the police report or even why there are two different speed limits in that area. Further, he admitted that he “printed some stuff off” of the CSX website, but it was just hieroglyphics to him. (T p. 216)

76. Strickland explained, more than once on direct-examination, that Mr. Daniels had to have driven to the left, to go around the crossing arm, which he alleged was down at the time. (T p. 196) He opined that the car would have had to go off the road on a drop-off at that point. (T p. 196) However, on cross-examination, the Sergeant admitted that there was no physical evidence that had occurred. (T p. 197) In fact, medical examiner Butts contradicted Strickland’s statement when Butts noted that the video did not appear to show that the car had been trying to sneak across the tracks.

77. Lieutenant Strickland reluctantly admitted that Mr. Daniels’ state of mind was relevant to the determination whether Mr. Daniels’ death was a suicide. Yet, neither Sgt. Strickland nor his officers investigated issues determinative of Mr. Daniels’ state of mind by talking to Daniels’ family, or investigating Mr. Daniels’ health and finances. At the same time, Strickland relied upon a statement Kara Hand allegedly made to Officer Trueheart, to support his suicide determination, but without verifying the truth of such statement. Officer Trueheart had reported that Mr. Daniels’ daughter told him her parents had fought that morning, and had been having a lot of finances troubles with the family business. (Resp Exh 1-H) Similarly, Strickland concluded that Ms. Daniels was only looking for money (T p. 206) without providing any basis for such conclusion.

78. The preponderance of the evidence established that Petitioner and her husband were not having significant financial problems, and they had not argued on the morning of her husband’s death. The evidence demonstrated that while the economy had slowed their business, the Daniels were talking to a buyer for their store. The preponderance of the evidence also showed that Mr. Daniels exhibited no change in behavior or demeanor indicative of sadness, anger or depression before June 9, 2009. He made no statements to anyone indicative of emotional stress or problems. No suicide note was found after Mr. Daniels’ death, and there was no evidence that he had been giving away belongings or saying good-byes or other similar types of behavior. There was no
evidence produced at hearing that Mr. Daniels was familiar with or had researched the regular train schedule regarding when a train might be crossing those tracks.

79. Finally, having viewed and reviewed the train video, the undersigned disbelieves Strickland’s statement that the video showed that Mr. Daniels’ eyes were open, and staring at the train.

80. Sgt. Strickland is undoubtedly a professional, dedicated law enforcement officer who cares about his work and strives to do well at it. However, in this instance, the evidence shows that his determination of suicide is not believable.

81. Lieutenant Strickland implausibly denied that his findings had any impact on the determination made by the medical examiner, but Dr. Butts acknowledged that the police investigation was a factor in his decision to amend the cause of death. Butts admitted that he read the RPD’s report, and “took it face value of what was contained therein.” (T p 282) When he watched the video, he felt the video verified their [RPD’s] investigation, and conclusions. (T p 284) He noted that “[T]heir evaluation of the scene of death and the circumstances surrounding the death of physical actions that let up to Mr. Daniels’ demise.” (T p 293)

82. When Dr. Butts watched the video, he saw the decedent’s car parked across the railroad tracks, on the left side or the opposite side of where it should have been driving. He saw that the crossing gates were down, and the lights were flashing. He could clearly see that the car was stationary, and that there was a person sitting in the driver’s seat. Dr. Butts was particularly interested in whether you could see if the person was sitting upright or slumped over, because if the driver was slumped over, it could mean he was unconscious. Dr. Butts clearly remembered seeing that “he was sitting up in the driver’s seat in an upright position,” and “(t)here was no evidence of him having slumped forward.” (T p 260)

83. Dr. Butts could not convince himself that he could see the face. He could see the head, and:

[[I]t looked to me that he was either looking ahead or to the side, but I couldn’t make out that much detail. But I was satisfied that his head was upright.

(T p 260) The main thing that stood out was that the car was stationary, it was neither moving back or forth, and that there was an individual behind the wheel who was not moving or making an attempt to open the door. The on-board train video impacted Dr. Butt’s opinion on whether this was an accident or a suicide. (T pp 261-262)

84. Dr. Butts opined that Petitioner’s car being stopped on the tracks distinguished it from normal car-train collisions. Usually, someone doesn’t see a train coming, or is trying to beat the train when they pull out in front of it; they are usually in motion when struck. In this decedent’s death, however, the car was absolutely still on the track from the time the train first sees the car, it doesn’t move at all, and then collides with the car. (T pp 262-263)
85. In investigating cases of this nature, OCME may sometimes talk with a decedent’s family. Generally, contact with the family is made through law enforcement. In this case, Mr. Daniels’ family contacted OCME after Dr. Butts changed the manner of death from accident to suicide. One issue the family raised was whether Mr. Daniels’ diabetes could have affected him so Daniels was unable to move the car or get out of the car.

86. Dr. Butts had no evidence to suggest that the decedent’s diabetes was out of control to an extent that he may have had some diabetic episode. Dr. Butts opined that:

I can’t say that he didn’t have any medical problems or medical condition, but again, it would be a stretch, in my opinion, to say that that’s the explanation as to why he drove - either drove around the gate or, for some reason, before the gate came down, stopped his car on the tracks and just sat there.

(T p 265-66)

87. Dr. Butts further explained the determination that:

We decide or determine that a death is suicide when it’s the result of a deliberate, purposeful action voluntarily performed by an individual that ends up killing them when it’s an action that any reasonable individual watching them do it, or hearing what they’re going to do would also - would have concluded that that action would be likely to lead to death.

(T p 266) Applying that definition to this case, Butts expounded that, “parking a motor vehicle on the railroad tracks with a train coming is going to lead to someone’s death.” (T p 266) OCME uses the same definition of suicide in any suicide they approach. (T p 267)

88. Butts opined that evidence of suicidal thoughts or depression is not required to determine that a case is suicide. Such evidence causes OCME to examine a case more closely under such circumstances, but ultimately, it’s the circumstances of the fatal act itself that weighs most heavily in the decision that they make. (T p 268)

89. Dr. Butts acknowledged that the OCME did not perform an autopsy on Mr. Daniels’ body. He believed they did not perform an autopsy, because the circumstances presented to Dr. Kent were relatively straightforward. That is, Dr. Kent’s examination of Mr. Daniels and his injuries were consistent with his being in a car-train collision. OCME doesn’t routinely perform autopsies in that type of car fatality-related incident. (T pp- 273-274) The sole information the OCME knew, consisted of a man trying to get around a crossing in his car, and the car being struck as he was trying to cross the crossing. (T p 274) Dr. Butts later informed Dr. Kent that there was a question of whether the death was a suicide, and informed her of what he had seen in the video of the collision. Dr. Kent concurred with Dr. Butts’ decision that the manner of death would be amended to suicide.

90. Dr. Butts used an “operational definition” of suicide. (T pp. 267, 285) He admitted that there is no definition in the General Statutes, nor was he aware of any
definition of “suicide” in the Administrative Code. (T p. 293, 294) Dr. Butts noted that the definition of suicide which he uses is “generally accepted among medical examiners…” (T p. 294)

91. The undersigned takes official notice pursuant to G.S. §150B-30 that Title 10A, Chapter 44, Postmortem Medicolegal Examination, contains no definition of suicide.

92. Using the above-stated definition, Dr. Butts opined that Mr. Daniels’ death was a suicide, because Mr. Daniels put his own life in jeopardy knowing what was going to happen, but made no attempt to avoid being hit by the train. Specifically, Butts ruled Mr. Daniels’ death a suicide, because the crossing arm was down, the car was not moving and Mr. Daniels was upright in the car when viewed on the video. (T p. 274) At the same time, Butts admitted could not see Mr. Daniels’ hands, and so did not know if Mr. Daniels was trying to shift the car into gear, get out of his seat belt, or open the door so he could get out. Butts admitted that he did not know if the car was operational or not, and that some people freeze when in a situation in which they perceive themselves to be in danger. He did not know anything about whether Mr. Daniels was such a person, and had no evidence as to Mr. Daniels’ emotional state or state of mind on June 9, 2009.

93. Dr. Butts admitted that one must go by the “expectation” of the deceased at the time of death. (T p. 298) Yet, Dr. Butts indicated that it was uncommon for him to either contact families or have the investigators do so. (T p. 290) He basically indicated that evidence regarding Mr. Daniels’ state of mind was not relevant to him in this case. (T p. 290)

94. Dr. Butts explained that his decision was based on his evaluation of the circumstances of the actual fatal incident, “The action that actually led to his death and what was the most plausible explanation for how it could have occurred.” (T p 293) He opined that “the most probable event, that he drove the car onto the tracks and stopped and waited till the train hit him. … all I can say is the car got onto the tracks and it stopped there.” (T p 296)

95. Contrary to Dr. Butt’s opinion, the preponderance of the evidence showed there was insufficient evidence to prove that Mr. Daniels purposefully, deliberately, and voluntarily drove his car onto the railroad tracks at Royal Street on June 9, 2009 to commit suicide. In addition, there was no medical evidence presented at hearing to support Respondent’s classification of Mr. Daniels’ manner of death as suicide.

CONCLUSIONS OF LAW

1. The North Carolina Commission for Public Health has the authority to adopt, is required to adopt and has adopted rules necessary to implement the public health programs administered by the Department of Health and Human Services to carry out the provisions of Part I of Article 16 of Chapter 130A of the General Statutes, Postmortem Medicolegal Examinations and Services. G.S. §§ 130A-29, 130A-393.

2. Respondent is charged by N.C. Gen. Stat. § 130A-383 with investigating “the
death of any person resulting from violence, poisoning, accident, suicide or homicide; ...or occurring under suspicious, unusual or unnatural circumstances ...”.

3. Pursuant to N.C. Gen. Stat. § 130A-385, when a medical examiner takes charge of a body pursuant to G.S. 130A-383, the medical examiner is required to make findings regarding the cause and manner of death and report such findings to the Chief Medical Examiner.

4. N.C. Gen. Stat. § 130A-385 requires the medical examiner to complete a death certificate and, “(l)if the death was from external causes, the medical examiner shall state on the certificate of death the means of death, and whether, in the medical examiner’s opinion, the manner of death was accident, suicide, homicide, execution by the State, or undetermined.” N.C. Gen. Stat. § 130A-385(b).

5. Neither Chapter 130A nor any other chapter of the General Statutes contains a definition for the term “suicide”.

6. The Commission for Public Health has not adopted a rule defining the term “suicide” as used in G.S. § 130A-385.

7. In determining that the manner of Mr. Daniels’ death was suicide, Dr. Butts used what he termed an “operational definition” of suicide:

   “[T]he decedent die[s] as a consequence of a voluntary, deliberate/purposefully self initiated action that a reasonable person would view as certain to cause serious injury or death.”

   (Resp Exh 5)

8. The preponderance of the evidence demonstrated that the manner of Mr. Daniel’s death could not be determined. Given the circumstances surrounding the June 9, 2009 fatal incident, and the preponderance of evidence presented at hearing, there was insufficient evidence to prove that Mr. Daniels acted deliberately, acted purposefully, and voluntarily drove his car onto the railroad tracks at the Royal Street crossing to commit suicide.

9. At hearing, Dr. Butts acknowledged that his determination was based on, “all I can say is that car got onto the tracks and it stopped there.” (T p 296) However, merely seeing a car stopped on the railroad tracks was insufficient in and of itself to prove that Mr. Daniels' deliberately and voluntarily drove and stopped his car on the railroad tracks to commit suicide. In addition, there was no medical or other evidence presented at hearing to support the conclusion that Mr. Daniels' manner of death was suicide.

10. Based on the preponderance of evidence at hearing, there was insufficient evidence in the record to support Respondent’s classification of the decedent’s manner of death as a suicide. Instead, a preponderance of the evidence showed that the manner of the decedent’s death was “undetermined.”
DECISION

Based on the Findings Of Facts And Conclusions Of Law, the undersigned determines that Respondent's determination that the decedent's manner of death was suicide, should be REVERSED.

ORDER AND NOTICE

The North Carolina Department of Health and Human Services, Office of the State Health Director will make the Final Decision in this contested case. N.C. Gen. Stat. § 150B-36(b), (b1), (b2), and (b3) enumerate the standard of review and procedures the agency must follow in making its Final Decision, and adopting and/or not adopting the Findings of Fact and Decision of the Administrative Law Judge.

Pursuant to N.C. Gen. Stat. § 150B-36(a), before the agency makes a Final Decision in this case, it is required to give each party an opportunity to file exceptions to this decision, and to present written arguments to those in the agency who will make the Final Decision. N.C. Gen. Stat. 150B-36(b)(3) requires the agency to serve a copy of its Final Decision on each party, and furnish a copy of its Final Decision to each party's attorney of record and to the Office of Administrative Hearings, 6714 Mall Service Center, Raleigh, NC 27699-6714.

This the 22nd day of October, 2011.

MELISSA OWENS LASILIER
Administrative Law Judge
CERTIFICATE OF SERVICE

The undersigned hereby certifies that a copy of the foregoing DECISION was served upon the following persons by depositing same in the U.S. Mail, prepaid postage and addressed as follows:

Mr. Cody R. Hand
Attorney at Law
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Attorney for Petitioner

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Health and Public Assistance Section
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This the 7th day of October, 2011.

Vicki Marshall
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STATE OF NORTH CAROLINA  
WAKE COUNTY  

IN THE OFFICE OF  
ADMINISTRATIVE HEARINGS  
09 OSP 4492  

CHARLINE EMORY,  
Petitioner,  

V.  

N.C. DEPARTMENT OF HEALTH AND  
HUMAN SERVICE, O'BERRY  
NEURO-MEDICAL TREATMENT CENTER  
Respondent.  

DECISION  

This matter came before Administrative Law Judge Donald W. Overby on April 13, 14 and 15, and July 22, 25, 26, 27 and 28, 2011 in Raleigh, North Carolina.  

APPEARANCES  

For Petitioner:  
M. Jackson Nichols  
Catherine E. Lee  
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Raleigh, NC 27602  

For Respondent:  
Kathryn J. Thomas  
Assistant Attorney General  
N.C. Department of Justice  
9001 Mail Service Center  
Raleigh, NC 27699-9001  

WITNESSES  

Witnesses called by Petitioner  
1. Charline Emory, Petitioner  
2. Lanier Cansler  
3. James Silva  

Witnesses called by Respondent  
1. Charline Emory, Petitioner  
2. Eugenia Mewborn  
3. LaTonya Bass  
4. Robyn Peterkin
5. Gwendolyn Lee  
6. Cheroniqia Jones  
7. Kim Brantham  
8. Christine Carter  
9. Dennis Mays  
10. Janice Littleton  
11. Tammy Bridges  
12. Patricia Ann Preston  
13. Ines McFadden

EXHIBITS

Exhibits admitted on behalf of Petitioner ("Pet.'s Ex. __")

1. Emory resume and application for employment  
2. Position description form, cluster administrator  
3. Emory memorandum re Chain of Command, 3/11/09  
5. Respondent’s Responses to Petitioner’s First Request for Admissions, 9/10/10  
6. Unit Diagram  
7. Behavior Justification Summary, 2/13/08  
8. Person-Centered Plan for Client A, 4/29/08  
9. Supervision for Group Home 5-5 with in-service sheet attached  
10. Abuse, Neglect, Exploitation Investigation Report, Brantham and Mays, 3/17/09  
11. NOT OFFERED  
14. Employee statement, McFadden, 3/12/09  
15. Employee statement, Littleton, 3/12/09  
16. Employee statement, Mewborn, 3/12/09  
17. Employee statement, Bass, 3/12/09  
18. Employee statement, Bridges, 3/12/09  
19. Employee statement, Preston, 3/13/09  
20. Employee statement, Emory, 3/11/09  
21. Memorandum from Cansler re Zero Tolerance, 2/4/09  
22. Notice of Pre-Disciplinary Conference, 3/19/09  
23. Notice of Termination, 3/26/09  
24. Respondent’s Answers and Responses to Petitioner’s First Set of Interrogatories and Request for Production of Documents  
25. Resume of Dennis Mays  
26. Timeline developed by Preston, 3/11/09  
27. Letter, Farrell to Emory re Step 2 Grievance Decision, 4/14/09  
28. Autopsy Report, 3/12/09  
29. “Cherry Hospital Hit with New Citation,” The News & Observer, 5/7/10  
30. Letter, Cansler to Emory, 7/1/09
31. E-mails between Emory and Taylor re Training for GHMs and PCs in Cluster 5-5, 2/09
32. Copy of envelopes addressed to Emory postmarked 3/30/09 and 3/31/09
33. 42 C.F.R. 483.430
34. DHHS Statement of Deficiencies and Plan of Correction, 3/16/09
35. Spreadsheet of income
36. NOT OFFERED
37. Group Home 5-5 Program Schedule, 3/09
38. Staff Training record, Charline Emory, 9/23/08-4/30-09

Exhibits admitted on behalf of Respondent ("Res.'s Ex. __")

1. Respondent's notebook of documents, as redacted
2. NOT ADMITTED, OVER OBJECTION
3. E-Mails between Emory and Mays, 3/8/09-3/10/09

PRELIMINARY MATTERS

At the beginning of the hearing, the Respondent made a motion to seal the record to protect the confidentiality of the residents of O'Berry Neuro-Medical Treatment Center and certain personnel records of witnesses testifying at the hearing, or in the alternative, redaction of records introduced into evidence so that first initials are used. The undersigned ordered redaction of records introduced into evidence leaving first initials to be used to identify residents of O'Berry, and to protect certain personnel records.

At the beginning of the hearing, Petitioner moved to sequester all the witnesses, except for Petitioner and the Respondent's representative, which was allowed.

BASED UPON careful consideration of the sworn testimony of the witnesses presented at the hearing, the documents and exhibits received and admitted into evidence, and the entire record in this proceeding, the undersigned Administrative Law Judge ("ALJ") makes the following Findings of Fact. In making these Findings of Fact, the ALJ has weighed all the evidence and has assessed the credibility of the witnesses by taking into account the appropriate facts for judging credibility, including, but not limited to the demeanor of the witnesses, any interests, bias, or prejudice the witness may have, the opportunity of the witness to see, hear, know or remember the facts or occurrences about which the witness testified, whether the testimony of the witness is reasonable and whether the testimony is consistent with all other believable evidence in the case.

ISSUE

Did Respondent have just cause to dismiss Petitioner from employment for unacceptable personal conduct or grossly inefficient job performance, pursuant to N.C. Gen. Stat. § 126-35 and the applicable regulations?
FINDINGS OF FACT

I. Introduction

1. This matter is properly before the Office of Administrative Hearings ("OAH"), which has both personal and subject matter jurisdiction. The parties were properly noticed for hearing.

2. On July 30, 2009, through counsel, Petitioner Charline Emory ("Petitioner") filed a Petition for a Contested Case Hearing with OAH, claiming that she was discharged without just cause from her position as Cluster Administrator from O’Berry Neuro-Medical Treatment Center ("O’Berry") on March 26, 2009.

3. At all times relevant to this proceeding, Petitioner was a career state employee, as defined by N.C. Gen. Stat. § 126-1, and was subject to the provisions of the State Personnel Act. Tr. 1415-1416.

II. Respondent and Its Employees

A. Staffing at O’Berry

4. For all times relevant to this proceeding, O’Berry was a state-run intermediate care facility for the mentally retarded, which provides care and training to approximately 485 developmentally disabled individuals in a home environment. Tr. 1462; Res. Ex. 283.

5. At O’Berry, the clients reside in residential areas called "Clusters." O’Berry is comprised of approximately six (6) to eight (8) Clusters. Tr. 1462-1463.

6. Cluster 5 is comprised of four group homes, or units, and one acute care unit. Tr. 1018. In March of 2009, approximately fifty (50) to sixty (60) clients resided in Cluster 5. Tr. 1463. Approximately fourteen (14) clients resided in Cluster 5-5. Tr. 1463.

7. Employees in the position of Developmental Technicians ("DT") are responsible for providing direct care to O’Berry’s clients. DTs may be classified as DT I or DT II. Tr. 1464.

8. Each group home within a Cluster has two Group Home Managers ("GHM"), who supervise the DTs and the day-to-day operations of their respective group home. Tr. 1018; 1466.

9. Each group home within a Cluster has a Program Coordinator who supervises the GHM within his or her respective group homes. Tr. 1018. The Program Coordinator is sometimes referred to as Program Specialist.

10. Each Cluster has a Cluster Administrator, or Mental Retardation Unit Director, who supervises, among others, the DTs, the GHM and the Program Coordinator. The Cluster Administrator has overall responsibility for the management and supervision of his or her
respective Cluster. Tr. 1018; Res. Ex. 283-288. During her employment at O'Berry, Petitioner served as the Cluster Administrator over Cluster 5. Tr. 254.

11. The Cluster Administrator is supervised by the Deputy Director of Professional Services/Residential. For all times relevant to this proceeding, Mr. Dennis Mays held this position for Cluster 5. Tr. 1468.

12. The Deputy Director of Professional Services/Residential is supervised by the Director of Residential Services. For all times relevant to this proceeding, Dr. Frank Farrell held this position. Tr. 1468.

13. For all times relevant to this proceeding, Secretary Lanier Cansler has served as the Secretary of the North Carolina Department of Health and Human Services. O'Berry is one of the institutions over which Secretary Cansler has oversight responsibility. Tr. 233-234.

14. The DTs typically work either on Shift A, Shift B, or Shift C. In Cluster 5-5, at least five (5) DTs typically work during Shift A and Shift B. One GHM typically works on Shift A and one GHM typically works on Shift B. Tr. 1465-1466; Tr. 1018.

15. At the start of each shift, the DTs have a briefing with the GHM to discuss the activities in which the clients had been involved during the day. If the GHM is not available for the briefing, the Program Coordinator conducts the briefing with the DTs. Tr. 480-481.

16. When the GHM assigned to Cluster 5-5 is not working onsite, the DT II is in charge of ensuring that direct patient care is provided properly in Cluster 5-5. However, a GHM from another group home would have oversight responsibility of Cluster 5-5. Tr. 477; Pet. Ex. 3. When the GHM is absent, the Cluster Administrator does not assume the duties and responsibilities for the GHM. Tr. 479.

B. Relevant personnel

1). Program Coordinator for Cluster 5

17. The program coordinator (PC) is responsible for ensuring that staff receives all of the relevant information they need to provide appropriate care to individuals residing at O'Berry. (Tr. 700) One of the PC’s primary functions is to coordinate the annual person centered plan (PCP) meeting which involves an interdisciplinary team.

18. The personal care plan, as well as the behavior intervention plan and other sources of information about client needs and routines, can be found in group home planners, such as staff assignment schedules (R Ex pp 56-57); group home program schedules (R Ex pp 247-250); supervision assignment sheets (R Ex pp 64-65); in-service training documents (R pp 62-63).
19. For all times relevant to this proceeding, Ms. Eugenia Mewborn was employed by O'Berry as a Program Coordinator for Cluster 5. Tr. 343-346. At the time of Client A’s death, she had been employed by O'Berry for approximately seven (7) years and six (6) months. Ms. Mewborn did not have a direct supervisor between October 2008 and December 2008. Tr. 344-345. In January 2009, Petitioner became Ms. Mewborn’s supervisor. Tr. 1467.

20. Ms. Mewborn’s primary job responsibilities included ensuring that the team met to develop person-centered plans for each client. Tr. 345-346. She at times provided “in-service” training to direct care staff about client care. Ms. Mewborn typically worked from 8:30 a.m. until 5:30 p.m. Tr. 357-358.

21. Ms. Mewborn stated that it would have been appropriate for her to provide hands-on care to clients in Cluster 5, if needed. Tr. 360-361.

22. When she started work at O'Berry, Ms. Mewborn did not receive training on abuse, neglect, and residents’ rights because she was pulled from the course when a survey team came to survey in August 2008. She also did not receive training specifically for her role as a Program Coordinator. Tr. 358.

23. Ms. Mewborn was discharged from her employment at O'Berry in March 2009. Tr. 383.

2) Group Home Manager

24. Cathy Graham was the group home manager for 5-5. Group home managers supervised the work of the direct care staff, but also help with direct care coverage when they are short staffed. In addition, group home managers also have responsibility for office work. Group home managers were supervised by the cluster administrator. (Tr. 476-477; 479-480) Cathy Graham was on vacation the week that A. died.

3) DT IIs for Cluster 5

25. For all times relevant to this proceeding, Ms. Gwendolyn Lee was employed by O’Berry as a DT II/Cross Shift Trainer. At the time of Client A’s death, she had been employed by O’Berry for almost twenty-six (26) years. Tr. 470-472.

26. Ms. Lee has an associate’s degree from Wayne Community College in geriatrics. She worked at O’Berry in an internship in the summer of 1983, and she began working at O’Berry as a developmental technician (Tech I) in October 1983. She became a Tech II in 1994. Tech II’s sometimes assume supervisory duties including making staff assignments and completing census sheets. In addition, Tech IIs have meal prep duties, CAN duties and assigned housekeeping duties. Tech IIs are supervised by group home managers. The Tech IIs are in charge when the group home manager is absent. (Tr. 469-476)
27. Gwen Lee later became a "cross-trainer" and a "floater." When short staffed, she was
assigned to provide direct care to a group. The staff assignment sheet provides the information
about which staff member is assigned to a particular group, although assignments may be
changed during a shift. If Tech IIs are absent at the same time as the group home managers, the
cross shift trainer performs the supervisory duties. (Tr. 476-478)

28. Ms. Lee’s supervisor was GHM, Ms. Cathy Graham. As GHM, Ms. Graham was
responsible for monitoring the direct care being given to clients in Cluster 5-5. Tr. 475-477. Ms.
Mewborn was program coordinator on Cluster 5-5 and as such was Ms. Graham’s supervisor.
Tr. 1467.

29. Ms. Lee typically worked from 2:45 p.m. to 11:15 p.m. As cross shift trainer, she had
flex hours, which meant that she would at times work other shifts or hours. As a "floater" she
sometimes worked other shifts as well to help maintain adequate staffing levels. Tr. 480.

30. As a DT II, Ms. Lee had some leadership duties similar to those of a supervisor. In Ms.
Graham’s absence for vacation, Ms. Lee had additional supervisory duties. She also had
responsibilities for direct care of clients. Tr. 473-475. She had responsibility to make the staff
aware of which staff members would be assigned to each client. Tr. 483-484; Resp. Ex. 425-
433.

31. As the Cross Shift Trainer, Ms. Lee had extra responsibility for monitoring the groups of
clients and for making sure that the objectives for the clients were being met. Tr. 475; Resp. Ex.
425-433. At times Ms. Lee was responsible for making sure other staff members knew how to
monitor and give visual supervision to clients. Tr. 545-546.

32. Ms. Lee understood that clients could not be left alone in a training environment, such as
the yellow room. Tr. 552-553.

33. According to Ms. Lee, most of the younger direct care staff over whom she had
responsibility did not like supervising the clients in a group setting because they thought it was
boring. Ms. Lee testified that a lot of these staff members would inappropriately use their cell
phones while supervising the clients in a group and that she would send these staff members to
the dining room to keep them busy and out of trouble. Tr. 517-518. Petitioner also testified that
she had difficulty getting the staff to stop using their cell phones at work. Tr. 1474-1475.

34. Ms. Lee was discharged from her employment at O’Berry in March 2009. Tr. 607.

35. For all times relevant to this proceeding, Ms. Tammy Bridges was employed by O’Berry
as a DT II and typically worked from 2:45 p.m. until 11:15 p.m. in Cluster 5-5. Tr. 965; 977. At
the time of Client A’s death, she had been employed by O’Berry for approximately three (3)
years. Tr. 965.
36. On the evening of March 11, 2009, Ms. Bridges was not at the O'Berry facility between approximately 5:30 p.m. and 11:00 p.m. because she had taken several clients to the circus. Tr. 971; 976. Ms. Bridges still is employed by O'Berry. Tr. 965.

4) DT I's for Cluster 5

37. For all times relevant to this proceeding, Ms. Latonya Bass (Tonya) was employed by O'Berry as a DT I and typically worked from 2:45 p.m. until 11:15 p.m. in Cluster 5-5. Tr. 415. At the time of Client A's death, she had been employed by O'Berry for two (2) years. Her primary job responsibilities include providing direct care by, among other things, bathing, feeding, looking after the clients, and taking clients on trips. When she reported to work that day, she attended the briefing. Tonya was assigned to Client R. who requires one-on-one at all times. Ms. Bass still is employed by O'Berry. Tr. 414.

38. For all times relevant to this proceeding, Ms. Cheroniqkia ("C.J.") Jones was employed by O'Berry as a DT I and typically worked from 2:45 p.m. until 11:15 p.m. in a different cluster, Cluster 5-3. Tr. 643-644. At the time of Client A's death, she had been employed by O'Berry for approximately one (1) year and nine (9) months. Tr. 643.

39. On the evening of March 11, 2009, Ms. Jones worked in Cluster 5-5 rather than Cluster 5-3. Her job responsibilities include providing daily living direct care. Tr. 643-644. She stated that when she was helping out in another unit that was not her regular unit, she relied on the staff to tell her what needed to be done as well as the written information telling her about the clients' needs. C.J. stated that she has never taken over an assignment without knowing what responsibilities are associated with that assignment. Ms. Jones still is employed by O'Berry. Tr. 643-644.

40. For all times relevant to this proceeding, Ms. Ines McFadden was employed by O'Berry as a DT I and typically worked from 2:45 p.m. until 11:15 p.m. in Cluster 5-5. Tr. 1296-1297. At the time of Client A's death, she had been employed by O'Berry for approximately eight (8) years and six (6) months. Tr. 1294. Ms. McFadden no longer works for O'Berry, but not for reasons associated with Client A's death. Tr. 1293.

41. For all times relevant to this proceeding, Ms. Janice Littleton was employed by O'Berry as a DT I and typically worked from 2:45 p.m. until 11:15 p.m. in Cluster 5-5. She received a certified nursing assistant certification from Wayne Community College. Her job responsibilities included direct care of the clients such as bathing, feeding and training on a day-to-day basis. At the time of Client A's death, she had been employed by O'Berry for approximately seven (7) months. Ms. Littleton still is employed by O'Berry. Tr. 929.

42. For all times relevant to this proceeding, Ms. Christine Carter was employed by O'Berry as a DT I and typically worked from 2:45 p.m. until 11:15 p.m. in Cluster 5-5. Her job responsibilities included following the program content and making sure all the clients were
accounted for and okay. Tr. 846. At the time of Client A’s death, she had been employed by O’Berry for approximately five (5) years. Ms. Carter still is employed by O’Berry. Tr. 845.

43. On the evening of March 11, 2009, Ms. Carter was not at the O’Berry facility between approximately 5:30 p.m. and 11:00 p.m. because she had taken several clients to the circus. Tr. 849.

5). Cluster 5 Nurse

44. For all times relevant to this proceeding, Ms. Robyn Peterkin was employed by O’Berry as a licensed practical nurse and typically worked in Cluster 5-3 and 5-5. Tr. 440-442. At the time of Client A’s death, she had been employed by O’Berry for approximately thirteen (13) years six (6) months. Her shift is 3:45 p.m. to 12:15 a.m. Her direct supervisor is the nurse supervisor Terri Deaver. She is not supervised by other staff in Cluster 5. Ms. Peterkin still is employed by O’Berry. Tr. 441.

6). Advocates

45. For all times relevant to this proceeding, Ms. Kim Brantham was employed as the Chief Advocate. Tr. 655. At the time of Client A’s death, she had been employed by O’Berry, or its affiliate, for more than twenty-five (25) years. Tr. 656. Ms. Brantham still is employed as the Chief Advocate.

46. For all times relevant to this proceeding, Ms. Pat Preston was employed as an Advocate I. At the time of Client A’s death, she had worked at O’Berry since December 2006. Prior to her employment with O’Berry, she was employed with several ICF facilities. Ms. Preston still works at O’Berry. Tr. 1001-1002.

47. All Advocates, including Ms. Brantham, are supervised by Wendi McDaniel who works for Customer and Advocacy Services in Raleigh. Advocates are not directly supervised by anyone in the facility where they work other than Ms. Brantham. Tr. 658. Advocates must have a four year degree and are expected to have a background in working with the population at the facility. Tr. 662.

48. As Chief Advocate, Ms. Brantham supervises the advocacy department, which is comprised of three (3) Advocate I positions. Among other duties, Ms. Brantham supervises the work performed by employees holding the position of Advocate I in connection with investigations regarding abuse, neglect, and exploitations, rights infringements, and death reviews. She performs these types of investigations as well, and she contends that she personally has handled hundreds of investigations of abuse, neglect and exploitation. Tr. 675-676.

49. Ms. Brantham has a working relationship with the facility director at O’Berry but is not supervised by anyone at O’Berry. Tr. 657-658.
50. Pat Preston described her job as client advocate at O'Berry as involving advocating for the individuals in her caseload in terms of rights issues such as restrictive interventions in behavior plans including medications. She attends person centered plan meetings. The advocacy department, including Ms. Preston, is responsible for responding to allegations of abuse, neglect or exploitation and conducting those investigations. In conducting investigations, the advocates usually pair up with the Cluster Administrator of the unit in which the client resides. Tr. 665.

51. According to Ms. Brantham, investigations are conducted in a very timely manner, and investigations take precedence over meetings and other staff events. Tr. 671. Investigations may be conducted during the dinner hours when there are adequate staff levels. Tr. 666-667.

7). Deputy Director of Program Services

52. For all times relevant to this proceeding, Mr. Dennis Mays was employed as the Deputy Director of Program Services. As Deputy Director, he is responsible for quality assurance, speech and language pathology, psychology, recreation therapy, education, vocational services, and the barber and beauty services. Tr. 878-879. He has bachelor’s and master’s degrees in clinical psychology. At the time of Client A’s death, Mr. Mays had been employed by O'Berry for over nineteen (19) years. Tr. 879. Mr. Mays still is employed by O’Berry.

53. Mr. Mays initially came to O’Berry as a unit director or cluster administrator for Cluster 1, and served as a cluster administrator for nearly ten years. For the majority of his time at O'Berry, his responsibilities have been closely connected with the residential services. Tr. 898. Mr. Mays is very familiar with the position of cluster administrator.

III. Petitioner

A. Work History

54. At the time of her discharge from employment, Petitioner had twelve (12) years of total service with the state of North Carolina. At the time of her discharge from employment, she was a career state employee within the definition of N.C. Gen. Stat. § 126-1. Tr. 1415-1416.

55. At the time of her discharge from employment, Petitioner had received an undergraduate degree in sociology from East Carolina University and had completed approximately forty (40) hours of coursework toward a graduate degree in health care administration from Cappella University. Tr. 1417.

56. From June 1991 through February 1992, Petitioner worked in a direct care position for Pitt County Group Homes. Tr. 1418. She had previously worked while in college as a summer intern at Murdock Center as direct care staff.
57. At Pitt County Group Homes, she was responsible for providing direct care to six individuals with moderate, severe and profound mental retardation. Her job responsibilities included implementing behavior plans and individual program plans which included taking the individuals on trips, encouraging socialization, communication and anything that would help the individuals be more independent in their lives. Prior to working with these individuals she took a training course which lasted several weeks and included first aid, CPR, advocacy, HIPAA and PIC training. Prior to working independently with the individuals she was required to go over every individual's individual program plan, and prior to having the individualized training she was required to be shadowed by an experienced staff person. Tr. 27-28.

58. From March 1992 until March 1997, Petitioner worked as an advocate at Murdoch Center in North Carolina. Tr. 1418. Like O’Berry, Murdoch Center operated under ICF/MR federal regulations and State regulations. Tr. 30-42, 50, 256; R Ex p 262. As an Advocate, she was not expected to provide direct, hands-on care.

59. At Murdoch, Petitioner received a two week training course and received shadow training from her colleagues for over a month. Although she was not directly responsible for clients, Petitioner received some of the same training as hands-on, direct care staff.

60. As part of her duties as an Advocate, Petitioner investigated allegations of abuse, neglect and exploitation. She would prepare reports from those investigations which were reviewed by the advocacy team. She performed from five to 25 investigations a month. The investigatory reports included conclusions about whether abuse, neglect or exploitation had occurred, and made recommendations for corrective measures, including disciplinary action and retraining. Petitioner was also responsible for training staff on laws, policies, rules and regulations governing the care and treatment of developmentally disabled individuals, including Murdoch Center abuse, neglect and exploitation policy.

61. From March 1997 until September 1998, Petitioner worked as a qualified developmental disability professional (QMRP) with Person County Group Homes, Inc. in Roxboro, NC. Tr. 1418-1419. Person County Group Homes also was operated under ICF/MR federal regulations. She supervised about 30 staff in two group homes and a day program. There were 12 clients per group home. Clients had profound, moderate and severe mental retardation, and three or four were wheelchair bound. It took 6 to 7 months before she knew the clients’ programs in detail.

62. She directly supervised the supervisors of the group homes and the day program, and thereby indirectly supervised the direct care staff. She also supervised the work performed by the professional staff including physical therapists, occupational therapists and psychologists, although personnel issues were handled by the personnel manager. She provided training to the staff including abuse, neglect and exploitation.

63. After she had been at the facility for some time and was familiar with the individual program plans, she provided assistance with such things as kitchen duties. While at Person...
County Group Homes, she directly supervised clients 9 or 10 times with a long term staff member in the area. Tr. 43-54; R Ex p 262.

64. From September 1998 until April 2000, Petitioner worked as a behavior support specialist/care coordinator for Frontier Health/Opportunities Unlimited in Tennessee. Tr. 1419.

65. At Frontier Health, she had a week long training course, and after a year of working under the supervision of a psychiatric doctor, she became a certified behavior support specialist in the State of Tennessee. As a care coordinator she was responsible for work similar to the QMRP including evaluating the progress of programs and making recommendations for changes. Providing in-service training for staff on behavior support plans was part of Petitioner’s responsibilities. After approximately 6 or 7 months she became quite familiar with the individuals for whom she was responsible.

66. Petitioner worked for the State of Tennessee, Department of Mental Health as a Mental Retardation Specialist II for 20 months in 2000 to 2002. Mental Retardation Specialist II is similar to a surveyor position in that she surveyed private owned homes and institutions under ICF/MR regulations and State law. The homes were licensed to provide services for up to 4 people and are like small community-based group homes. Her training consisted of shadowing her supervisor for 6 months, but she did not attend any classes. After 6 months she surveyed independently. During her employment, Petitioner attended additional training courses.

67. In surveying a small facility, she would do the survey by herself, but in larger institutions the survey was conducted by a team. She was responsible for surveying on her own approximately 20 small facilities.

68. Her job responsibilities included going into each facility and monitoring. If she had questions or found discrepancies, she looked at files, policies and procedures, and questioned staff. She used checklists but also followed up on specific things that did not appear to be correct. She monitored staff, clients and their interactions. She looked for safety hazards and reviewed staff training records. She monitored supervision requirements. She monitored nurses and reviewed the medical files. She also investigated abuse, neglect and exploitation issues based on complaints. Tr. 64-75; R Ex p 261.

69. From January 2002 until January 2009, Petitioner was employed by the North Carolina Division of Facility Services (now known as the Division Health Service Regulation (DHSR)) as a Facility Survey Consultant I by the North Carolina Division of Health Services. Tr. 77-78. Petitioner attended basic training for intermediate care for the mentally retarded which lasted three to four days, after which she was allowed to work independently, although her initial training also consisted of shadowing another staff person for six months. She later received CLEAR training which took about two days. The purpose of this training was to provide instruction on how to investigate and how to better ask questions. Tr. 75-99, 107; R Ex pp 261, 355.
70. In her employment with DHSR, she individually surveyed group homes which had up to
6 clients. Along with a survey team she would survey State institutions including O’Berry,
Caswell and Murdoch Center. Each North Carolina facility was surveyed annually under
ICF/MR guidelines. Her work in North Carolina differed from her work in Tennessee in that
only a few of the facilities she surveyed in Tennessee were covered by ICF/MR guidelines, and
all of the facilities she surveyed in North Carolina were governed by ICF/MR guidelines.
Annual surveys of the groups homes usually took more than one day, and the State facilities
would take 3-4 days. She surveyed O’Berry, Murdoch and Caswell at least six times for annual
surveys and found violations of ICF/MR regulations including violations based on allegations
involving abuse, neglect and exploitation. Unit directors were the primary contact for surveyors.

71. During her time at DHSR as a surveyor, she evaluated facilities for their compliance with
ICF/MR using “tags” as cross reference to the federal regulations. Surveyors are not required to
take the same training as facility staff because a surveyor has no responsibility for the clients or
the staff in the facility. Tr. 87-91; R Ex p 261.

72. Mr. Jay Silva served as Petitioner’s supervisor while she was employed in that position.
Tr. 1371. In working with Petitioner, Mr. Silva found Petitioner to be a bluntly honest and very
truthful person. Mr. Silva also thought Petitioner was very persistent. Mr. Silva also found her
to be extremely conscientious and really serious about doing a good job in every single aspect of
it. Tr. 1382-1384.

B. Hiring Process for Petitioner

73. The unit director for Cluster 5 retired in September 2008. Mr. Mays was responsible for
hiring the new cluster administrator. The PC had also retired and Eugenia Mewborn was hired.
Mr. Mays was worried about Ms. Mewborn because she was soft-spoken. He was particularly
concerned because he knew that some staff on 5-5 could be very challenging.

74. Mr. Mays submitted a request for posting in September 2008 and posted the position with
a description of the work to be performed, as well as knowledge and skills and training &
education requirements. The duties included being responsible for the 24 hour operation of a unit
for 50-60 individuals to ensure providing the best possible care, the most effective habilitation,
and active treatment. Responsibilities including hiring the direct care staff through group home
managers and PCs, as well as budget. Training and experience requirements included at least a
bachelor’s degree in one several specific majors that were listed and/or a combination of
education and work experience. Tr. 909-911; R Ex pp 255-259. The position was advertised:
Tr. 908.

75. Petitioner submitted an application. Tr. 908. Mr. Mays was familiar with Petitioner
because she had been a surveyor at O’Berry for several years, but he had not had a lot of direct
interaction with her. He had seen her audit of the facility and had a favorable impression of her.
Tr. 911-912.
76. Mr. Mays formed a team to assist him in hiring the new unit director, which included Deborah Exum, assistant to the director, Carol Davis, director of vocational education, and Kim Allen, a nurse. Deborah Exum and Carol Davis had both been unit directors in their past professional experience. The team reviewed her application. Mr. Mays thought Petitioner had a very solid application, and they were extremely interested in interviewing her. Much of Mr. Mays' favorable perception of Petitioner application was based upon his perception of how her experience would translate into the position.

77. Because Petitioner was going on vacation they were not able to interview her in person. Petitioner was interviewed by Mr. Mays and the team on the telephone on October 30, 2008. Petitioner was in Florida on vacation when she was called about setting up an interview. She was asked at that time if she had a copy of the job description, and she said that she did not. A copy of the job description was emailed to her, and she was called back within 10-15 minutes for the interview.

78. She had a chance to look over the job description and was asked if she had any questions about it. Her response was "not at this time." The job description does not state anything about whether the position would be responsible for direct care for individuals.

79. The interview went very well, and the team felt that her responses to the questions were very good. Petitioner also thought the interview went well. The consensus of the interview team was that she would be a good fit. Tr. 909, 916-919; R Ex pp 282-290.

80. At the end of the interview when asked if she had any questions, Petitioner stated she did not have much experience with budgeting. Tr. 1082. Petitioner stated that she voiced her concerns that she did not have budgetary experience, or fiscal experience, or management experience for a facility this large. Tr. 180-181, 184; R Ex pp 284-290.

81. Mr. Mays submits his questionnaires for the applicant interviews to HR for review. He did not ask Petitioner about any weaknesses she may have because the HR staff suggested they remove that question from the questionnaire. He never discussed with Petitioner any expectation that she would provide direct care to clients. Tr. 1206-1207.

82. Mr. Mays called her supervisor, Jay Silva, who gave her a very good reference. Petitioner did not tell Mr. Mays that she had an active prior written warning. Mr. Silva did not tell Mr. Mays about Petitioner’s prior written warning. Tr. 1146-1147.

83. After the team made its decision, they sent the hiring package through the system, and Mr. Mays was able to call Petitioner to make an offer. Initially she was concerned about the salary, but she did accept the position. Tr. 920-921.

C. Petitioner’s Employment with O’Berry
84. On January 5, 2009, Petitioner was employed by O’Berry as the Cluster Administrator for Cluster 5 and remained so employed until she was terminated effective March 26, 2009. Tr. 254.

85. Petitioner was initially in orientation, but Mr. Mays made the decision, with the director’s approval, that since she had such extensive experience in the field, to put her on the unit so that she could begin to learn the job. They intended to continue her training, but just not at the beginning of her employment. Tr. 1082-1085; R Ex pp 299, 386-389.

86. Mr. Mays thought Petitioner needed to get on the unit to learn the personality of the people working there as well as the needs of the individuals on the unit. He told her that he was concerned because Eugenia Mewborn was new and was soft-spoken. There were also some other supervisors who were relatively new. He told her to pay particular attention to unit 5-5 and he thought having a staff meeting with the staff was a good place to start. He stated that he did not expect her to know everything right away. Tr. 1085-1087.

87. Petitioner stated that when she started working at O’Berry, she was “told that the unit was a mess and it needed to be cleaned up,” and she “was being pulled out of training” so that she “could go into that unit and start getting things in order.”

88. Mr. Mays told Petitioner that she could use Lucy Boykin, another cluster administrator, as a mentor and resource. In his opinion he tried to be responsive to her questions and concerns. Tr. 1088-1089.

89. As a Cluster Administrator, Petitioner repeatedly experienced problems with Program Coordinators failing to follow her instructions to implement changes that were necessary to bring O’Berry into compliance with federal regulations. Tr. 205-206.

90. Specifically, Petitioner experienced numerous instances in which the Program Coordinators would not write individual habilitation plans in accordance with ICF regulations. In particular, a number of individual habilitation plans would not include information on the client’s supervision requirements. Tr. 168-169. Petitioner described the plans as “horrid” and sent some of them back several times before she was satisfied.

91. A number of DTs in Cluster 5-5 resented the operational changes that Petitioner was attempting to implement at O’Berry. Tr. 932-933; 999-1001; Tr. 1474-1476. At times, the DTs were insubordinate to Petitioner, and a number of DTs tried to avoid talking to her. Tr. 864; 1211-1212.

92. According to Ms. Mewborn, Petitioner was very knowledgeable about the needs of the clients due to her experience working as a state surveyor. Tr. 379. According to Ms. Mewborn, Petitioner tried to make some changes at O’Berry, but due to the culture of the center, it was difficult for her to do so. Tr. 384.
93. As a Cluster Administrator, Petitioner oversaw four (4) to five (5) abuse, neglect or exploitation investigations in Cluster 5-5 within a 42-day period. Tr. 194. These investigations took more than forty (40) percent of Petitioner’s work time. Tr. 218-219. According to Ms. Brantham and Ms. Preston, the number of investigations conducted in Cluster 5-5 during this time was higher than average. Tr. 757-758; 1053.

94. Mr. Mays thought Petitioner was dealing with supervision issues appropriately. He thought she was frustrated sometimes because some situations could not be changed very quickly. In his opinion, she had experience dealing with difficult people similar to others in management. Tr. 1089-1090.

95. Mr. Mays noticed weaknesses with regard to Ms. Mewborn’s performance as a Program Coordinator for Cluster 5. According to Mr. Mays, during Petitioner’s employment, Cluster 5-5 began to be a point of concern, and he began to recognize the supervision problems with Cluster 5-5. Tr. 1094.

96. Mr. Mays concedes that once he began to see the supervision issues coming up in unit 5-5 he may have said something to the effect of “this is a bigger mess than I thought.” Tr. 1095.

97. Mr. Mays testified that he thought Petitioner was doing a “really good job” during her employment at O’Berry as Cluster Administrator. Tr. 1099.

D. O’Berry’s Training Policies

98. On February 4, 2009, Secretary Cansler issued a memorandum to the institutions over which he has oversight responsibility that set forth a zero-tolerance policy for the abuse, neglect, and exploitation of clients. Tr. 236-238; Pet. Ex. 21.

99. On May 6, 2010, Secretary Cansler testified before the Legislative Oversight Committee on issues related to funding for staff training in North Carolina’s health care facilities. Tr. 239. Secretary Cansler testified before the Legislative Oversight Committee that, “If we want to improve our facilities, we’ve got to have adequate training for staff.” Tr. 240.

100. Further, Secretary Cansler testified before the Legislative Oversight Committee that:

We can’t expect our employees to do everything the way they ought to do it if we do not provide them with the training to do it right . . . . I do not feel that it’s fair for me to hold our employees responsible for doing something improperly if we have not given them the training that they need, and I don’t mean one time for two hours. I mean constant training. . . . To be fair to our employees, we’ve got to make sure they have training and know what needs to be done, know what they can do, know what they can’t do, and then if they violate the protocols, we’ll hold them accountable. . . . Tr. 239-240.
101. According to the applicable federal regulations, staff members are required to have training for the position for which they were hired. Tr. 255; 1366-1369; Pet.’s Ex. 33. Cluster Administrators are supposed to be given management training courses and are supposed to go through the first several weeks of basic training. Tr. 256.

102. Federal Regulations require staff to have initial basic training prior to working independently with clients. Petitioner was not specifically hired to work directly with clients. The subject had not been discussed one way or the other. Tr. 87; 1368; Pet.’s Ex. 33.

103. During her interview for the position of Cluster Administrator, Petitioner contends that she asked what type of training she would receive if she were hired for the position. Petitioner was told that she would get the “usual” training. Tr. 252:5-6. Petitioner did not inquire of Mr. Mays after her initial interview to ask about training. There is no evidence that she would have known or had any idea what training she would receive or what was the appropriate training for her to receive. She was aware that orientation was the first day and a two week course was to follow. She admitted that she had considerable training in her prior work experience. Tr. 259-260.

104. Generally, Cluster Administrators receive a specific training curriculum, including a new employee orientation, when they start employment at O’Berry. Cluster Administrators also are provided with on-the-job training by either a mentor or a supervisor within the O’Berry facility. Tr. 752.

105. When Petitioner started her position as Cluster Administrator, Petitioner immediately was placed in a mandatory training course, which was supposed to last for two (2) weeks. However, after Petitioner only had received approximately three (3) hours of training, Mr. Mays removed Petitioner from the training class so that Petitioner could start her work on the unit. Tr. 258-259; 1082-1083; 1563-1564.

106. Mr. Mays told Petitioner that she could use Lucy Boykin, another cluster administrator, as a mentor and resource.

107. Although Petitioner had received training related to hands-on, direct care services in the early 1990’s, that training was outdated and did not address the specific, unique needs of the clients at O’Berry. Tr. 256-257. That training would not have supplanted any training requirements by O’Berry.

108. As a surveyor for the State of North Carolina, Petitioner did not receive CPR training, NCI training, or basic hands-on training for a person who is in an ICF/MR facility while employed. Tr. 91.

109. Even though Petitioner testified that she had to learn everything from the ground up, it was Mr. Mays’ opinion that, based on her experience, she was not any different than other new
staff at O'Berry in terms of understanding her job. In his opinion, an individual with experience like Petitioner had usually made the transition fairly easily, especially with a mentor. Tr. 1098.

110. As a Cluster Administrator, Petitioner made efforts to ensure that clients were receiving services in the most optimum setting, including by requesting additional training for the staff. Tr. 166:3-12; Res. Ex. 283. Despite Mr. Mays' concerns regarding Cluster 5-5, Petitioner's requests for additional training for the staff, including herself, were denied. Tr. 166-167; 211.

111. Mr. Mays only remembers that Petitioner asked for training for the unit on effective communication for group home managers. Because that was not available right away, they had to wait until the series came up on the schedule. He told her to work on that directly on the unit, and try to work on getting the staff to work collaboratively. Tr. 1090.

112. After starting her employment, Petitioner asked Mr. Mays several times for copies of O'Berry's policy and procedure manuals, but she was not provided with them. Petitioner attempted to locate the policies and procedures online, but was able to obtain only part of the documents. Mr. Mays attempted to get them to her through Lucy Boykin; however, Petitioner never received them. Although Petitioner told Mr. Mays that she could not locate the other policies and procedures online, Mr. Mays still did not provide them to Petitioner. Tr. 261-262; 1442-1447.

113. According to Ms. Mewborn, no policy exists at O'Berry on how to visually supervise clients. Tr. 394-395.

114. In or around late February/early March 2009, Ms. Mewborn conducted an in-service training session for the DTs with regard to supervision requirements of clients in Cluster 5-5. Petitioner did not attend the in-service training but reviewed the printed materials that were prepared by Ms. Mewborn in advance. Some, but not all, DTs were present for the in-service training session. The DTs who were not present were instructed to read over the document and to sign the acknowledgment sheet. Tr. 385-386; Res. Ex. 16-17.

115. Ms. Mewborn conducted the in-service training session in late February/early March 2009 to instruct the DTs that clients should not be left unsupervised in the training environment, such as the yellow room. Tr. 386-387; Res. Ex. 16. Previously, DTs had left clients in the training rooms unattended; however, this practice was discontinued in late February/early March 2009, prior to Client A's death. Tr. 386-387; 395.

116. The in-service training provided by Ms. Mewborn specifically provided that Client A should be monitored from a visual distance at least every fifteen (15) minutes and listed a number of places in which Client A could be placed away from the group; Client A's bedroom was not listed as a place in which Client A may be located. Tr. 1078; Pet. Ex. 9:
IV. Cluster 5-5

A. Layout of Cluster 5-5

117. Cluster 5-5 has a number of “activity” rooms for its clients. One activity room is called the “yellow” room. Another activity room is called the “retreat” or “rec” room. The activity rooms are considered training areas. Tr. 15-18. Pet. Ex. 6.

118. The yellow room is across the hall from the activity room that is attached to the kitchen and dining rooms. Pet. Ex. 6.

119. There is no place in which staff members can stand in the yellow room that would allow them to see the entire kitchen and all of the dining room at the same time. Tr. 568.

120. Client A’s bedroom was located on the same side of Cluster 5-5 as the “yellow room.” Tr. 1488.

121. Some witnesses testified that staff members could not see into Client A’s bedroom while standing in the yellow room and that staff members would have to leave the yellow room and enter the bedroom hall to see Client A’s bedroom. Tr. 592-593; 940.

122. Other witnesses testified that staff members could see a portion of Client A’s bedroom if they stood in a particular spot in the doorway of the yellow room. At best, staff members could only see both Client L—who required constant visual supervision—in the yellow room and Client A in her bedroom at the same time if Client L’s recliner was positioned in a particular way. Tr. 868-869. Petitioner testified that Client L’s recliner was not pulled out while she was supervising the room; rather, Client L’s recliner was pushed up against a wall in the yellow room, which would have been a position where staff members would not have been able to see both Client L and Client A if she were in her bedroom. Tr. 1488.

B. Clients in Cluster 5-5, Including Client A

123. Client A was a client in Cluster 5-5 at the time of her death on March 11, 2009. Tr. 1463-1464. Client A had resided at O’Berry for 33 years. She was profoundly mentally retarded with a mental age of 7 months. She was non-ambulatory and non-verbal. She was dependent on the staff at O’Berry for her activities of daily living. When she was in her wheelchair, she liked to tuck her legs under her. She had some functional use of her arms and hands, and could reach, grasp, hold and manipulate objects briefly. Tr. 99-100; R Ex 123.

124. Client A enjoyed being alone either watching TV or resting. Tr. 100. Client A liked to watch people but did not like being in the middle of a crowd. Tr. 1078-1079.

125. Client A had a tendency to scoot down in her chair, and part of her person centered plan indicated that staff should help reposition her in her chair if she scooted down. She had a seat
belt that was used for proper positioning/alignment. Tr. 697; R Ex 139-140. She would scream or yell if she was in her chair for too long to signal that she wanted to get out of her chair or to lie down. Tr. 932, 100.

126. Ms. McFadden had a special relationship with Client A and said that she felt like Client A was a “daughter” to her. Ms. McFadden gave special attention and supervision to Client A during her shifts. Tr. 566. The DT staff knew that Ms. McFadden had a special relationship with Client A and that she spent most of her time with Client A. Tr. 1296; 1315-1316. For instance, when Client A would scream, Ms. McFadden would take her into the kitchen or walk her around the facility. Tr. 1296.

127. Clients across the O’Berry Center have different supervision requirements. Some clients require checks every fifteen (15) minutes. Some clients require checks every thirty (30) minutes. Some clients can go without checks for two (2) hours. Tr. 306.

128. Petitioner understood that two (2) clients in Cluster 5-5 had special supervision requirements. One client—Client L—required constant visual supervision, meaning that a staff member had to observe Client L at all times but could do so while observing other clients as well. These supervision requirements were in place because Client L would sometimes try to get up suddenly and fall. Tr. 1056-1057. Another client—Client R—required one-on-one supervision, meaning that a staff member had to observe Client R at all times and could not observe any other client at the same time. Tr. 165; 279.

129. Petitioner had experienced problems with the staff members adhering to Client L’s supervision requirements. Specifically, on the afternoon of March 11, 2009, Petitioner observed Ms. Lee failing to maintain visual contact with Client L for a period of time during which she was supposed to be supervising Client L. Tr. 562-563.

130. Petitioner received inconsistent information from the direct care staff as to whether the Cluster 5-5 clients, other than Client L and Client R, had to be checked every 15 minutes or whether they had to be checked every 30 minutes. Tr. 165.

131. Petitioner reviewed Client A’s behavior plan; however, she did not go on the unit to see Client A or try to put the behavior plan in some kind of context. Petitioner only reviewed Client A’s behavior plan for form but not content. As a result, she knew nothing substantive about Client A, including the nature of Client A’s disabilities. Tr. 276-279; R Ex 243-240.

132. Most, but not all, of the staff understood that Client A required 15 minute checks when she was alone. The direct care staff had recently reviewed her supervision requirements. Tr. 699; R Ex 62-63.

133. According to Ms. Lee, staff members would have complied with Client A’s supervision requirements by checking on her every thirty (30) minutes. Tr. 584; 633.
134. Nowhere in the person-centered plan in place for Client A at the time of her death does it provide that Client A must be checked every fifteen (15) minutes when she is by herself. Tr. 398-399; Pet. Ex. 8. Such information about her supervision requirements should have been in her person-centered plan. Tr. 766; 830; 1246.

135. According to Ms. Mewborn, anyone who knew that Client A was in her bedroom on the evening of March 11, 2009, was responsible for making the required checks. Tr. 382.

136. When Petitioner spent time in Cluster 5-5, Client A usually was under a blanket, and Petitioner could not see her face and could not see her physical disabilities. Tr. 278-279.

137. According to Mr. Mays, it was not against any O’Berry policy for Petitioner to give direct client care. Tr. 311; 1226; 1454-1455. Mr. Mays had stated that he had only given direct care once during an emergency.

V. Day of Client A’s Death, March 11, 2009

A. Approximately 3:00 p.m. and 5:20 p.m., March 11, 2009

138. During the afternoon and evening of March 11, 2009, Ms. Graham was not scheduled to work, and Ms. Lee was in charge of Cluster 5-5, as the DT II and Cross Shift Trainer on site. Tr. 485. As the Cross Shift Trainer, Ms. Lee was responsible for keeping the staff informed about all matters involving the clients. Tr. 295-296; 456-457.

139. On that shift for March 11, 2009, Ms. Lee was the person whom staff expected to answer questions about the clients’ activities and supervision requirements in Cluster 5-5. Tr. 863.

140. Petitioner and Mr. Mays walked around Cluster 5-5 around 3:15 p.m. to 3:30 p.m. on March 11, 2009. During that time, Petitioner and Mr. Mays observed Ms. Lee, failing to give Client L visual supervision in accordance with her supervision requirements. Mr. Mays indicated to Petitioner that she would need to open an investigation into the matter. Tr. 283; 1113-1115; 1226.

141. Petitioner and Mr. Mays ended their walk-through of Cluster 5-5, and Petitioner then received a report of potential neglect, involving a staff member’s alleged failure to change a patient’s urine bag. Petitioner attempted to page Ms. Preston, but Ms. Preston was delayed in responding to Petitioner’s page because she had left her pager in her car, which is against O’Berry’s procedures. Tr. 286. Ms. Preston eventually returned Petitioner’s page. Petitioner would have had the pager numbers for all advocates.

142. Approximately 4:15 p.m., Petitioner and Ms. Preston started an investigation into the alleged failure to change a client’s urine bag. The shift for the nurse allegedly involved in that incident ended at 5:00 p.m., so they decided to conduct that investigation first. Tr. 285. The
investigation ended at approximately 5:00 p.m., when Petitioner and Ms. Preston concluded that the patient at issue had not been neglected. Tr. 288-289; 1032-1036; 1477-1478.

143. Between approximately 5:00 and 5:20 p.m., Petitioner and Ms. Preston initiated the investigation into Ms. Lee’s failure to supervise Client L in accordance with Client L’s constant visual supervision requirements. Tr. 289; 1478.

B. Dinner Schedule

144. In Cluster 5-5, dinner usually is started for the clients between 5:30 and 5:40 p.m. Tr. 514; 1334. All of the clients in Cluster 5-5 do not eat dinner together at the same time. Tr. 515. On March 11, 2009, dinner was served around 5:30 p.m. Tr. 430.

145. There is a schedule established for the order in which the clients are to be fed. According to Ms. Lee and Ms. McFadden, Client A typically ate dinner before Client S and Client C. Tr. 591; 1327.

146. According to Ms. Lee, the kitchen staff was responsible for taking Client A to the dining room when it was time to feed her. Tr. 586.

147. According to O’Berry policies, a minimum of five (5) staff members must be working on each shift in Cluster 5-5 during clients’ waking hours. Tr. 594; 1465.

148. Cluster 5-5 was not short-staffed during dinner time on March 11, 2009. Tr. 805. During this time, Cluster 5-5 had five (5) direct care staff working: Ms. Bass, Ms. Chase, Ms. McFadden, Ms. Lee, and Ms. Littleton. Tr. 814-815.

149. Additionally, Ms. Mewborn assisted briefly with supervising clients in Cluster 5-5 during dinner time on March 11, 2009. Tr. 369. According to Ms. Lee, it was unusual for a program specialist to assist on the floor.

150. Additionally, Ms. C.J. Jones began assisting with direct client care in Cluster 5-5 around 6:15 p.m. on March 11, 2009. Tr. 651. Ms. Jones arrived while the staff was feeding their clients dinner. Tr. 647.

151. Furthermore, two (2) clients from Cluster 5-5 had gone on a community outing to the circus with Ms. Bridges and Ms. Carter, so Cluster 5-5 had fewer clients on-site than usual. Tr. 971.

152. According to Ms. Jones, dinnertime is mostly slow because the clients are together in a group. Tr. 647-648.

153. According to the March 2009 Group Home 5-5 Program Schedule, certain clients in Cluster 5-5, including Client A, typically spent time in the bonus room between 5:00 p.m. and 5:30 p.m., prior to eating dinner. Pet. Ex. 37; Tr. 390-392.
154. According to the March 2009 Group Home 5-5 Program Schedule, Client A’s typical location between 5:45 p.m. and 7:15 p.m., while she was not eating dinner, was the rec room. Pet. Ex. 37; Tr. 391.

155. On the evening of March 11, 2009, the normal routine of the residents in Cluster 5-5 was altered, at Ms. Lee’s direction. Normally, the residents would remain in the bonus room on the kitchen/dining area side of the home before and during dinnertime. After dinner, the residents would be moved to the yellow room. However, on March 11, 2009, the residents were transferred to the yellow room prior to dinnertime. Tr. 745-746. Ms. McFadden testified that it was rare for the clients to be in the yellow room before dinner. Tr. 1318.

156. Ms. Lee contends that Petitioner directed that the clients be moved to the yellow room, but in light of the other events of the day and the supervisory structure of the unit, this is not otherwise corroborated and is found to not be credible.

157. A number of witnesses testified that it was not routine for Client A to be in her bedroom right before dinner. Ms. Mewborn testified that she had seen Client A in the rec room, along with other clients, before dinner. Tr. 376-377; 394. Ms. Bass also testified that Client A sometimes would lie down in the retreat room before dinner. Tr. 428. Ms. Lee testified that, before dinner, Client A sometimes would lay down in a cot in the activity room. Tr. 518. Ms. Lee testified that Client A would not always go to her bedroom while she was waiting for dinner. Tr. 521.

158. It was unusual for Client A to be left in her wheelchair in her bedroom around dinnertime. According to Ms. Bass, the only time she could recall seeing Client A in her wheelchair before a meal was on the night of her death. Tr. 439; 633.

C. Between Approximately 5:20 p.m. and 6:00 p.m. on March 11, 2009

159. While Ms. Preston and Petitioner were initiating the investigation into Ms. Lee’s failure to properly supervise Client L, the DTs began transferring clients in Cluster 5-5 to the retreat room. Tr. 1299.

160. A little bit after 5:30 p.m., Ms. McFadden moved Client A from the activity room to her bedroom. Tr. 1299. In so moving Client A, Ms. McFadden wheeled Client A in her wheelchair through the yellow room. Ms. McFadden testified that no one was in the yellow room at the time she wheeled Client A through the room. Tr. 1302.

161. Ms. Lee saw Ms. McFadden take Client A out of the activity room and wheel Client A across the hall in her wheelchair. However, Ms. Lee did not see Ms. McFadden take Client A to her bedroom. Tr. 523. Ms. McFadden did not tell Ms. Lee that she had taken Client A to her bedroom and left her in her wheelchair. Tr. 570.
162. Meanwhile, Petitioner and Ms. Preston decided that they should interview Ms. Lee regarding her supervision of Client L earlier during the day. Ms. Mewborn was asked to bring Ms. Lee to Petitioner's office. Ms. Mewborn left Petitioner's office and then returned shortly thereafter without Ms. Lee. Ms. Mewborn told Petitioner and Ms. Preston that Cluster 5-5 was short-staffed. Tr. 290.

163. According to Petitioner, Ms. Mewborn suggested that Petitioner take Ms. Lee's place in Cluster 5-5, so that Ms. Lee could participate in the interview. Petitioner agreed to do so, as it would have been a conflict of interest for her to participate in Ms. Lee's interview because she had witnessed Ms. Lee's apparent failure to supervise Client L earlier during the day. Tr. 290.

164. According to Petitioner, when Ms. Mewborn reported that Cluster 5-5 was short-staffed, Ms. Preston said to Petitioner, "We don't have to, but I'd like to go ahead and get it done." Tr. 292. Obviously, they were all aware that the clients were being fed. Petitioner made the decision to proceed with the investigation.

165. Petitioner then left her office and went down to the yellow room in which Ms. Lee was supervising four (4) clients. Tr. 1478; 1582-1583. At the time that Petitioner left, Ms. Preston and Petitioner expected Ms. Lee's interview to take only five (5) to ten (10) minutes and, therefore, expected Petitioner to take over Ms. Lee's responsibilities only for that short period of time. Tr. 1061-1062.

166. When she entered the yellow room, Petitioner observed Ms. Lee with four (4) clients. Petitioner told Ms. Lee that she was needed in the office and that she would be relieving her. In an attempt to determine who Ms. Lee was supervising, Petitioner asked Ms. Lee something to the effect of, "Are these your ladies?" Tr. 292-294; 1481.

167. Ms. Lee responded to Petitioner with a non-verbal answer, by looking at each of the four individuals in the room, one at a time, and by nodding toward Petitioner. Petitioner then asked Ms. Lee something to the effect of, "What are these ladies doing?" Ms. Lee said something to the effect of, "They are watching TV," or "They are relaxing." Tr. 292-294; 1481-1483

168. Ms. Lee testified that Petitioner did not ask her any questions or that she did not respond in any manner including a non-verbal response. This testimony is found to not be credible.

169. According to Ms. Bridges, if a staff member were relieving someone in an activity room and asked that person, "Is this your group," and the person responded affirmatively, the staff member could assume that the group consists only of those assembled in the activity room. Tr. 998.

170. When Ms. Lee left the yellow room to go to Petitioner's office, she informed the DTs in the dining room that she was leaving. Tr. 580-581.
171. According to Ms. Lee, the kitchen staff should have known that Client A was in her bedroom. Tr. 636-637.

172. Petitioner did not know that Client A was in her bedroom when she took over the yellow room. According to Ms. Lee, the only way Petitioner could have known that Client A was in her bedroom was if the staff had told her. Although Petitioner had brief interaction with other staff members, no one had told her that Client A was in her bedroom. Tr. 591-592. Mr. Mays testified that Petitioner had not been employed by O’Berry long enough to know that Client A might have been in her bedroom and that he did not hold her responsible for that. Tr. 1122.

173. Petitioner remained in the yellow room while Ms. Preston and Ms. Mewborn interviewed Ms. Lee. While Petitioner remained in the yellow room, she was responsible for monitoring the four (4) clients in the yellow room. Tr. 294.

174. One (1) of the four (4) clients in the yellow room was Client L, who requires visual supervision at all times. Tr. 295. There is some discrepancy between the witnesses, but the more credible evidence is that staff would only be able to visually check on Client A in Client A’s bedroom and maintain visual supervision of Client L if Client L was in a particular position in the yellow room.

175. The credible evidence is that Client L was not in the position to be under constant visual supervision should staff be in a position to check on Client A in her bedroom. To check on Client A while she was supervising the yellow room, Petitioner would have had to leave the yellow room or at the very least stand in the doorway. Had she known Client A was in her bedroom, in order to check on Client A, Petitioner (or any staff for that matter) would have been out of visual contact with Client L, in violation of Client L’s supervision requirements. Tr. 533-534.

176. Petitioner was aware of Client L’s supervision requirements. Tr. 295. In fact, the investigation for which she had relieved Ms. Lee was to investigate Ms. Lee’s failure to maintain constant visual contact with Client L. Tr. 283; 1113-115; 1226.

177. The four (4) clients who were in the yellow room at the time Petitioner took over supervision were part of Group B. Client A was part of Group A. At that time Petitioner was not aware of specifically which clients were assigned to the particular groups. Tr. 317.

178. While Petitioner was supervising the yellow room, other staff members came in and out of the room. Tr. 294. Petitioner testified that Ms. McFadden walked through the yellow room, from the back bedroom area to the kitchen area, at approximately 5:40 p.m. Ms. McFadden did not say anything to Petitioner when she walked through the yellow room at this time. Tr. 1583.

179. Between 5:40 p.m. and 5:45 p.m., Ms. McFadden walked across the yellow room to Client J’s room, so that she could bring Client J to the kitchen for dinner. Ms. McFadden
testified that Petitioner was supervising the yellow room between 5:40 p.m. and 5:45 p.m. Tr. 1329-1330.

180. While Petitioner was supervising the yellow room, she observed that the clients were not watching the movie, so she turned on music for the clients. The clients began playing tambourines and appeared to be enjoying themselves. Tr. 295. One staff member commented to Petitioner, “I’ve never seen [the clients] that happy.” Tr. 309. According to Ms. Lee, the clients seemed to be enjoying the music. Tr. 603-604. Ms. McFadden testified that she observed the clients listening to music and having a good time. Tr. 1330.

181. According to the program schedule, the clients in Cluster 5-5 sometimes would be encouraged to participate in “musical movement activities” between 5:00 p.m. and 5:30 p.m. before dinner. Tr. 604-605; Pet.’s Ex. 37.

182. The music that Petitioner turned on for the clients was not excessively loud. Although Ms. Lee thought that the music was “loud enough” and louder than usual, Ms. Preston testified that the music was not excessively loud. Tr. 531, 1068. Ms. Lee did not turn the music down when she took over responsibility for the yellow room from Petitioner. Tr. 602. The music would not have prevented Petitioner from hearing Client A if she had cried out. Tr. 1488. Mr. Mays testified that, through the course of his investigation into Client A’s death, he did not conclude that the music was too loud. Tr. 1267.

183. Ms. Mewborn walked by the yellow room while Petitioner was supervising the clients. At hearing, she could not remember if she heard the radio playing when she walked by the room. Tr. 370-371.

184. During her investigatory interview of Ms. Lee regarding her supervision of Client L, Ms. Preston became frustrated with both Ms. Lee and Ms. Mewborn because they were not able to explain the nature of Client L’s supervision requirements or what staff members had been told about Client L’s supervision requirements. As a result, Ms. Preston, Ms. Lee, and Ms. Mewborn walked to the bonus room so that Ms. Lee could show them where she was standing at the time she was supervising Client L. Ms. Preston concluded that Ms. Lee could not see Client L from where she was standing, despite Ms. Lee’s assertions to the contrary. Tr. 1038-1039.

D. Between Approximately 5:50 p.m. and 6:50 p.m. on March 11, 2009

185. Between approximately 5:50 p.m. and 5:55 p.m. Ms. Lee finished her investigatory interview with Ms. Preston and Ms. Mewborn, and she returned to the yellow room to relieve Petitioner. Tr. 1483-1484.

186. When Ms. Lee returned to the yellow room, some of the clients that were in the yellow room were different than the clients that had been there when she left. Tr. 585. Ms. Lee assumed that the staff had taken certain clients to the kitchen to feed them while she was gone.
However, Ms. Lee did not know whether any of the kitchen staff had checked on Client A while she was gone. Tr. 586. There is no evidence that Ms. Lee made any inquiry concerning who she should be supervising.

187. When Ms. Lee returned to relieve Petitioner from her supervision of the yellow room, Petitioner left the yellow room and attempted to put a mop bucket into the appropriate closet, but she could not figure out where the mop bucket should be stored. Petitioner spent more or less fifteen (15) minutes trying to put the mop bucket away. There is some disagreement as to how much time it took. Tr. 1483-1484.

188. Ms. Preston tried to help Petitioner, as she attempted to put the mop bucket away. Tr. 1040:20-24. Because Petitioner could not find the closet, Ms. Preston asked Ms. Lee to help Petitioner put the mop bucket away. Tr. 1041. Ms. Lee left the yellow room and showed Petitioner where the mop bucket should be stored. Tr. 300-301.

189. As Ms. Lee was leaving the yellow room to help Petitioner with the mop bucket, she stopped herself and pointed to Client L and Client C, who were in the room. While doing so, Ms. Lee asked Ms. Preston, “Can you watch the ladies for me?” Ms. Preston responded, “Sure.” Tr. 1041-1042.

190. Ms. Preston did not ask Ms. Lee who she was supposed to be watching when Ms. Lee turned over the room to her. Ms. Preston did not ask Ms. Lee who had eaten or who was in the kitchen. Ms. Lee did not convey any information at all to Ms. Preston. There was no mention at all of Client A. Tr. 585.

191. Ms. Preston remained in the yellow room for approximately one (1) minute while Ms. Lee helped Petitioner put away the mop bucket. Tr. 1042.

192. At the time Ms. Preston took over responsibility for the yellow room, no one had ever explained to her the type of questions that needed to be asked prior to taking over supervision of clients. No one had explained to Ms. Preston the type of information that she needed to have prior to taking over supervision of clients. Tr. 1052.

193. At the time Ms. Preston took over responsibility for the yellow room, she could not recognize all of the clients in Cluster 5-5 by face. In fact, she could not have recognized Client A by face on March 11, 2009 because Client A was similar in appearance and size to several other ladies in the unit. Tr. 1052-1053.

194. At approximately 6:00 p.m., Petitioner went back to her office. At that time, Ms. Preston and Petitioner decided to interview Ms. Bass in connection with the investigation into Ms. Lee’s supervision of Client L. Ms. Mewborn went to the yellow room to retrieve her at about 6:15 p.m. Tr. 1478. Petitioner and Ms. Preston waited for approximately twenty (20) to twenty-five (25) minutes for Ms. Bass to come to Petitioner’s office. Tr. 301-302; 1478.
195. When Ms. Mewborn went to the yellow room to retrieve Ms. Bass, Ms. Mewborn took responsibility for supervising the clients in the yellow room from Ms. Lee. Ms. Mewborn directed Ms. Lee to take Ms. Bass’ position in the kitchen, so that Ms. Bass could participate in the interview. Tr. 369. Ms. Mewborn took responsibility for the yellow room between approximately 6:30 and 6:40 p.m. Tr. 378-379.

196. At the time Ms. Mewborn took responsibility for the yellow room, Ms. Lee did not tell Ms. Mewborn who she was supposed to be watching. Ms. Lee testified that Ms. Mewborn did not ask any questions. There was no mention of Client A in any regard. Ms. Lee did not tell Ms. Mewborn who had been fed and who still needed to be fed. Tr. 587.

197. At the time that Ms. Mewborn assumed supervision over the clients in the yellow room, the clients consisted of individuals from Group A and Group B. According to Ms. Mewborn, it was not routine for clients from Group A and Group B to be mixed together in one setting. Tr. 393. It appeared to Ms. Mewborn that all of the clients from Group A and Group B were either in the dining room or in the yellow room. Tr. 369-370.

198. When Ms. Lee went into the kitchen to relieve Ms. Bass, Ms. Lee felt that Client A should have already eaten dinner. It appeared to Ms. Lee that the kitchen staff had forgotten to get Client A and to bring her back to the kitchen to eat dinner. Tr. 591. At this time, Ms. Lee still did not attempt to check on Client A.

199. There is no evidence of before or after her interview that Ms. Lee made any attempt to check on Client A. Ms. Lee knew that Client A was in her bedroom. Tr. 571. Ms. Lee also acknowledges that she would have been responsible for Client A since she was on that side of the hall. Tr. 573

200. Client L, who required visual supervision at all times, was in the yellow room when Ms. Mewborn took it over. Tr. 371. According to Ms. Mewborn, a staff member had to be near Client L at all times because she would attempt to stand and hurt herself. Tr. 372. According to Ms. Mewborn, all of the DTs should have known that Client L needed to have a staff member near her in case she tried to stand up. Ms. Mewborn discussed Client L’s supervision requirement with the DTs during Client L’s person-centered plan meeting in February 2009. Tr. 399.

201. Petitioner and Ms. Preston interviewed Ms. Bass for less than ten (10) minutes. Tr. 302; 1478-1479. According to Ms. Mewborn, she supervised the yellow room for approximately ten (10) to fifteen (15) minutes during this time. Tr. 373-374.

E. Between Approximately 6:50 p.m. on March 11, 2009 and Early Morning on March 12, 2009
202. After Petitioner and Ms. Preston had finished interviewing her, Ms. Bass left Petitioner’s office. Ms. Bass returned to the kitchen and asked the kitchen staff whether any clients still needed to eat. Ms. Bass was directed by kitchen staff that Client A still needed to eat dinner. Ms. Bass then left the kitchen, walked through the yellow room, and proceeded to Client A’s bedroom. Tr. 374.

203. After Ms. Bass walked through the yellow room, Ms. Mewborn heard Ms. Bass call out, “It’s A. Come here. It’s A.” However, Ms. Mewborn could not leave the yellow room because she was required to maintain visual supervision of Client L. Tr. 379. Ms. Mewborn did not know that Client A had been in her bedroom until she heard Ms. Bass yell for assistance. Tr. 374.

204. Ms. McFadden testified that she gave her charge of Client R to Ms. Jones and went to Client A’s bedroom for a brief time and checked on Client A. When nurses arrived she returned to care of her Client, but was very upset.

205. While she was feeding a client in the dining room, Ms. Jones heard Ms. Mewborn yell for help. Tr. 651. Ms. Jones ran to Client A’s bedroom and attempted to determine what had happened to Client A. She asked the staff members nearby what had happened and why they were not giving Client A CPR, but she received no response. Ms. Jones began to initiate CPR, and then Nurse Peterkin took over the CPR when she re-entered the room. Tr. 652.

206. Nurse Peterkin ran to Client A’s room when Ms. Mewborn told her that help was needed. When Nurse Peterkin arrived in Client A’s bedroom, she found Ms. Bass standing in the room in a shocked state. Nurse Peterkin then ran out of the room and called a “code blue.” Tr. 451.

207. Nurse Peterkin observed that Client A was breathing and still had a pulse when she arrived at her bedroom. Tr. 464; 451. Nurse Peterkin did not begin to administer CPR to Client A until after she called the “code blue” because she did not know, and no one could tell her, what had happened to Client A. As a result, Nurse Peterkin was delayed approximately thirty (30) seconds before starting to administer CPR to Client A. Tr. 460.

208. Ms. Peterkin received disciplinary action, a written warning, for leaving Client A’s bedroom when she arrived at the scene. Ms. Peterkin was told that she should have remained at the scene and someone else should have called the “code blue.” Tr. 461-462.

209. About five (5) minutes after Ms. Bass left Petitioner’s office, Petitioner and Ms. Preston heard a “code blue 5-5” announcement over the intercom. Tr. 306-307; 1043. Petitioner went to the bedroom area of Cluster 5-5 and attempted to direct the staff to their appropriate areas. Tr. 307.

210. Ms. Preston had been frustrated during the investigation and was distraught over what was happening to Client A. She and Petitioner had begun the investigation into the situation with
Client A. At some point, she called her supervisor, Kim Brantham, who was on call at that point. Ms. Brantham arrived at O’Berry at approximately 7:30 p.m. and found a chaotic scene and a very emotional staff. At that point Petitioner and Ms. Brantham conducted the investigation. Tr. 319-320, 679, 719, 774.

211. Upon learning of Client A’s condition, Petitioner immediately attempted to contact Mr. Mays, but was unable to reach him until about midnight. Tr. 1116; 1227; 1492; 1496.

212. When Petitioner eventually made contact with Mr. Mays around midnight, Petitioner mentioned to him that she had been on the floor during the evening. Tr. 1496-1497. At some point during her discussion with Mr. Mays about Client A, Mr. Mays told Petitioner that responsibility for the incident involving Client A belonged to the direct care staff in the unit and that he “wouldn’t expect [Petitioner] to go in there and to know everything” and that he “would want staff to tell [him]” what he needed to know. Tr. 325-326.

213. Petitioner spoke with Dr. Farrell about the incident soon after Client A was found unresponsive. Dr. Farrell told Petitioner, “I don’t care how long it takes. I want you to stay here and investigate this issue.” Tr. 319. Dr. Farrell then left the area without assisting Petitioner. Tr. 1494-1495.

214. Petitioner remained at the O’Berry Center until about 3:00 - 3:30 a.m. on the morning of March 12, 2009, conducting the investigation in accordance with Dr. Farrell’s instructions. Petitioner returned to the O’Berry Center around 6:30 a.m. She felt a responsibility to inform the first shift staff about Client A’s death because no other management staff member was onsite at the time. Tr. 321; 1497.

VI. March 12, 2009

215. On March 12, 2009, Mr. Mays told Petitioner something to the effect that it had been the DTs’ responsibility to assure that Petitioner knew adequate information when taking over a group, since Petitioner could not have known what the staff and/or clients are doing at any given time, especially considering that she’d been employed by O’Berry for less than two and a half months. Tr. 1151-1152; Res. Ex. 171-175.

216. Sometime between 8:30 a.m. and 9:00 a.m. on March 12, 2009, Dr. Farrell, Mr. Mays, and Ms. Brantham came to Petitioner’s office. Petitioner was told that Client A’s guardian had been given the wrong information regarding her death and that a volunteer was needed to contact the guardian. Because no one else volunteered, Petitioner said that she would make the call if it needed to be done, but that she didn’t want to do so. The other individuals in the meeting indicated that Petitioner should make the call. Tr. 321; 1500-1501.

217. After calling Client A’s guardian, Mr. Mays directed Petitioner to go back to Cluster 5. Tr. 1501.
218. After lunch, Mr. Mays came to Petitioner’s office and told her that she was being placed on investigatory status, but that she should not be overly concerned since this was routine. Tr. 1501. Around this same time, Petitioner was asked to sign O’Berry’s zero tolerance policy. Tr. 1501-1502.

VII. Investigation

A. O’Berry’s Policies Regarding Abuse, Neglect or Exploitation Investigations

219. According to O’Berry’s policy, O’Berry must notify the Health Care Personnel Registry within twenty-four (24) hours of a suspected incident of abuse, neglect, or exploitation. Res. Ex. 589; Tr. 769.

220. According to O’Berry’s policy, an investigation report with regard to an investigation into a suspected incident of abuse, neglect, or exploitation must be completed and faxed to the registry within five (5) working days of the suspected incident, unless an extension of time is provided. The majority of investigations are completed within the five (5) day time period. Res. Ex. 589; Tr. 770.

221. According to O’Berry’s policy, the Cluster Administrator is responsible for completing the reports in a timely fashion. Tr. 770-771.

222. According to O’Berry’s policy, steps must be taken during the course of abuse, neglect, or exploitation investigation to interview all staff members who may have knowledge about the incident. Res. Ex. 589; Tr. 773-774.

B. O’Berry’s Investigation into Client A’s Death

223. Although Client A was pronounced dead at the hospital, O’Berry considered it a death at the facility and initiated a death review. A death review is separate and apart from an abuse-neglect investigation.

224. On the evening of March 11, 2009, Ms. Brantham was the on-call advocate. Tr. 677. After being informed of the incident involving Client A, Ms. Brantham reported to O’Berry at around 7:30 p.m. She and Petitioner initiated the death review into Client A’s death. Tr. 678; 720; Tr. 774.

225. At some point, Ms. Brantham spoke to the Cherry Hospital Police to let them know that there had been a death at O’Berry. She spoke to various hospital administrators as well. Tr. 682. During this time, the staff continued to provide care to the clients on the unit. Tr. 721.

226. Petitioner and Ms. Brantham conducted interviews with staff late into the night on March 11, 2009. It was a difficult time because the staff was still very emotional. The investigation lasted for several days according to Ms. Brantham. Along with the personal interviews, staff was
asked to provide a written statement; some provided more than one. Petitioner provided a written statement, although not on the usual form.

227. Petitioner had provided a written statement for the earlier investigation as well, which stated that she “instructed staff to enter the room where L. was and to provide visual supervision at all times as individuals in the other room only need at least 15 minute checks.” Tr. 744; R Ex 228. There is no evidence about whom she was speaking that would need fifteen (15) minute checks, nor that Client A was among either group.

228. It is not disputed that Client A’s PCP in effect at the time of her death did not have a requirement for fifteen (15) minute checks, although some of the staff was aware of that requirement.

229. During the course of the death review on the evening of March 11, 2009, Ms. Brantham concluded that Client A had not been given visual checks every fifteen (15) minutes during the evening of March 11, 2009 and that this failure constituted neglect. Ms. Brantham concluded that Petitioner was one of the individuals who had shared responsibility for supervising Client A. Tr. 684.


231. Because Ms. Brantham concluded that Petitioner had shared supervision responsibility over Client A on the night of her death, Mr. Mays took over the investigation from Petitioner. Ms. Brantham and Mr. Mays completed an investigation report into the circumstances surrounding Client A’s death. Tr. 683-684; 753.

232. Following the investigation into Client A’s death, Ms. Brantham and Mr. Mays concluded that:

a. The staff were required to check on Client A every fifteen (15) minutes while she is out of the group;

b. Client A was away from the group from between approximately 5:45 p.m. and 6:50 p.m. on March 11, 2009;

c. Client A was not provided with checks every fifteen (15) minutes during that timeframe;

d. Ms. Lee, Petitioner, and Ms. Mewborn were responsible for Client A’s supervision during that timeframe;

e. Ms. Lee, Petitioner, and Ms. Mewborn had neglected Client A by failing to carry out the level of supervision required to keep her safe; and
f. Ms. McFadden had failed to communicate adequately to Ms. Lee about where Client A had been placed but that the failure did not impact Ms. Lee's actions.  

Tr. 743-744.

233. Following the investigation into Client A’s death, Ms. Brantham and Mr. Mays did not conclude that Client A had been abused. Tr. 771.

234. Following the investigation into Client A’s death, Mr. Mays determined that whether music playing in the yellow room was too loud on the evening of March 11, 2009, was not an issue with which to be concerned. Tr. 1107.

235. Following the investigation into Client A’s death, Ms. Brantham and Mr. Mays concluded that Cluster 5-5 was adequately staffed on the evening of March 11, 2009. Tr. 804-805.

236. In drawing her conclusions, Ms. Brantham assumed that Client A could be observed in her bedroom from the yellow room. Tr. 746. However, neither Ms. Brantham nor Mr. Mays had first-hand knowledge about where Client A was placed in her bedroom because they were not at O’Berry’s facility during this time. There is no indication that Ms. Brantham’s conclusion took into account the necessity to have visual supervision with Client L and still observe Client A.

237. In drawing her conclusions, Ms. Brantham incorrectly assumed that Petitioner had received her new employee orientation. Tr. 754.

238. In drawing her conclusions, Ms. Brantham incorrectly assumed that Petitioner had received the on-the-job training typically provided to new employees. Tr. 756.

239. In drawing his conclusions, Mr. Mays did not know that a number of the DT staff felt resentment toward Petitioner and did not know that they had tried to avoid talking to her. Tr. 1208.

240. In drawing her conclusions, Ms. Brantham incorrectly assumed that Petitioner knew that Client A required fifteen (15) minute checks because Petitioner had participated in previous investigations that had addressed the supervision level of other clients in Cluster 5-5. Tr. 838. However, Ms. Brantham did not know the identity of the other clients involved with the previous investigations with which Petitioner assisted. Ms. Brantham also assumed that Petitioner knew that Client A required fifteen (15) minute checks because Ms. Preston had told Ms. Brantham that she saw in Charlaine’s office a copy of the late February/early March 2009 in-service that Ms. Mewborn had prepared regarding supervision requirements. Tr. 843-845.

241. In drawing their conclusions, neither Ms. Brantham nor Mr. Mays investigated the cause of Client A’s death. Tr. 801. Ms. Brantham and Mr. Mays reached no conclusions as to whether
the staff’s failure to provide fifteen (15) minute checks on Client A contributed to Client A’s death. Tr. 802-803.

242. Mr. Mays stated that Petitioner would not have been terminated but for the fact that someone died. Mr. Mays stated that Petitioner’s discipline would have been drastically different without the death, possibly even just a written warning. He felt strongly that he had no flexibility in his decision to terminate once there was a death; therefore, the cause of death could have been very important. Tr. 1122, 1232, 1268.

243. Ms. Brantham did not review Client A’s autopsy report before concluding that Petitioner had neglected Client A. Ms. Brantham reviewed Client A’s autopsy report after completing her investigation report but did not make any changes to the investigation report after such review. Tr. 773.

244. Ms. Brantham and Mr. Mays concluded that Petitioner had supervision responsibility for Client A between approximately 6:00 p.m. and 6:30 p.m. Tr. 779-780. However, Petitioner contends that she had taken over supervision responsibility for the yellow room between approximately 5:24 p.m. and 5:50 p.m. There is conflicting testimony about the specific times Petitioner was responsible for the yellow room; however, the exact time is not determinative of the issues at hand. It is clear that Petitioner did not check Client A during the time she was responsible for the yellow room and that time exceeded fifteen (15) minutes.

245. Ms. Brantham and Mr. Mays concluded that there was no communication between Petitioner and Ms. Lee at the time she took over responsibility for supervising clients from Ms. Lee. Tr. 790. However, Ms. Brantham testified that she did not know whether Petitioner asked Ms. Lee any questions about who she should be supervising. Tr. 790-791. Furthermore, Mr. Mays contradicted this conclusion, when he testified that he knew Petitioner had asked Ms. Lee follow-up questions regarding the activities of the clients for whom she was assuming responsibility. Tr. 1264.

246. Mr. Mays stated that Petitioner would not have known that some clients might have been in other rooms, but he goes on to say that he would not have held her responsible for that. Tr. 1122. Her not having that knowledge is essentially an issue of supervision, which is why she was ultimately terminated.

247. Respondent contends that Petitioner should have asked more probing questions of Ms. Lee, especially in light of the fact that clients would have been going out or coming into the yellow room. There is no evidence that she did not ask relevant questions as each client either left the room or was being brought into the room. Supervision of those clients is not the issue. The issue is the communication concerning Client A.

248. Mr. Mays stated that he would have expected Petitioner to have asked for more specific information because of her previous experience; that is, he is making a decision which ultimately
leads to Petitioner’s dismissal based on an assumption of what she may or may not have known from a prior work history.

249. Mr. Mays concluded that lack of supervision was the issue, not the cause of death. Tr. 1122. He felt that Petitioner had a responsibility to ask questions, to probe more, but that she did not. Tr. 1133, 1267

250. Generally, when conducting investigations, advocates will interview all of the individuals with knowledge about the incident. Tr. 1053.

251. During the investigation into Client A’s death, Ms. Brantham formally interviewed all of the staff members with knowledge about facts related to the circumstances surrounding Client A’s death, with the exception of Petitioner. Tr. 1259. In fact, Ms. Brantham and Mr. Mays talked to Petitioner about her knowledge about the facts only after they had concluded that she had neglected Client A. Tr. 818-820; 1258. Petitioner testified that the only time she was asked about the circumstances surrounding Client A’s death was during her predismissal conference. Tr. 1491.

252. Generally, when conducting investigations, advocates will ask the individuals who are interviewed to write a statement before the interview is concluded. The advocates would then review the statements in the presence of the person being interviewed, so that the advocates could ask questions they might have about the statements. Tr. 1054-1055. During the investigation into Client A’s death, neither Ms. Brantham nor Mr. Mays asked Petitioner to prepare a statement. Petitioner was asked for a statement only after they had decided to place her on administrative leave. Tr. 1259.

253. Despite a number of discrepancies regarding the facts related to Client A’s death that came to light during the course of their investigation, Mr. Mays and Ms. Brantham did not attempt to follow up with Petitioner to ask questions about her statement until her predismissal conference. Tr. 1268-1269.

VIII. Termination of Petitioner’s Employment

254. On March 24, 2009, Petitioner met with Mr. Mays and Ms. Carolyn Davis, the deputy director of residential education services, for her pre-dismissal conference. During that meeting, Mr. Mays was considering whether to dismiss Petitioner from employment because it appeared to him that she had not gotten the right amount of information that she needed to adequately supervise the group. Tr. 1142; 1144.

255. Petitioner’s pre-dismissal conference lasted approximately thirteen (13) minutes. During that predismissal conference, Petitioner provided the panel with a written statement of events that transpired on March 11, 2009. Resp. Ex.171-175. Petitioner was not asked any questions about her written statement. Tr. 1502-1503.
256. While Mr. Mays agonized over terminating Petitioner because she was doing an overall good job, at some point he concluded that he had no flexibility and that his only option was to terminate her because there had been a death. Had Client A not died, Petitioner’s discipline would have been drastically less severe. Tr. 1122, 1232.

257. Petitioner received a letter from Mr. Mays on March 30, 2009, telling her that her employment with O’Berry was terminated effective March 26, 2009. Petitioner did not receive a copy of her grievance procedures with her letter of termination; instead she received her grievance rights by separate letter on March 31, 2009. Tr. 1416.

258. The March 26, 2009 termination letter (Pet.’s Ex. 23) that Mr. Mays sent to Petitioner, which sets forth the grounds for Petitioner’s dismissal, provides that:

   a. “At approximately 6:00, at your request, you assumed supervision of Group A ladies, to include Client A, who was in her bedroom.” Whether Petitioner either knew or should have known if she was assuming supervision of Client A is the crucial issue to be determined. Petitioner relieved Gwen Lee in the yellow room, but to say that she requested responsibility of the yellow room on March 11, 2009 is not exactly accurate. The four (4) clients in the yellow room at the time Petitioner took over supervision were in Group B, not Group A. Tr. 317; 1507-1508; Pet.’s Ex. 23.

   b. “You failed to effectively communicate with Ms. Lee to gain needed information to assist you in providing the appropriate care and supervision of Group A.” Petitioner asked questions of Ms. Lee and attempted to communicate with Ms. Lee, but Ms. Lee willfully refused to effectively communicate with Petitioner. Tr. 1508; Pet.’s Ex. 23. Aside from the general acrimony from staff towards Petitioner, Ms. Lee in particular was being investigated for failure to supervise, an investigation initiated by Petitioner.

   c. “Client A’s habilitation plan clearly specifies that she must receive 15 minute checks during her personal time alone.” Client A’s habilitation plan did not contain this information. Petitioner had been told by other staff that clients in Cluster 5-5 could be checked on every fifteen (15) to thirty (30) minutes. Tr. 165; 1239-1240; 1508; Pet.’s Ex. 23.

   d. “At approximately 6:30 p.m., you returned supervision of Group A back to Gwen Lee.” Since there had been turn-over among the clients in the yellow room for feeding, the group was more blended and not just Group A. Petitioner did return supervision of the clients in the yellow room to Ms. Lee. Tr. 1508-1509.

   e. “Your failure to provide active treatment as set forth in Client A’s habilitation plan combined with your failure to effectively communicate with Ms.
Lee resulted in Client A not receiving the required supervision for 30 minutes while she was in your care, as a result [sic], the patient died.” Both Mr. Mays and Ms. Brantham testified that, during the course of the investigation, they reached no conclusion that Client A’s death resulted from Petitioner’s alleged actions. Tr. 802-803; 1235-1236.

259. As a result of the events that transpired on the evening of March 11, 2009 with regard to Client A, Ms. Lee and Ms. Mewborn were also terminated from their employment and Ms. McFadden was given a written warning. Tr. 1156. Mr. Mays concluded that Ms. Lee was the most culpable person involved with the events concerning Client A’s death.

260. Ms. Preston had supervised the group in the yellow room for a very brief period of time on March 11, 2009, and she was not disciplined for her involvement. Tr. 1157.

261. Mr. Mays terminated Petitioner’s employment because he concluded that Petitioner had engaged in grossly inefficient job performance and unacceptable personal conduct, as defined in Section 7, pages 4-8 of the State Personnel Manual. Tr. 1146.

262. Mr. Mays testified that the level of discipline taken against Petitioner was heightened because Client A died. If Client A had not died, the level of disciplinary action would have been different. Tr. 1232. However, no conclusions were reached as to whether the staff’s failure to provide fifteen (15) minute checks to Client A contributed to Client A’s death. Tr. 802-803; 1235-1236.

263. Petitioner had received a written warning on November 9, 2007, while employed by the DHHS, Division of Health Service Regulation, for an incident that did not constitute neglect, abuse, or exploitation. Mr. Mays did not rely on this prior written warning when he decided to terminate Petitioner’s employment. Tr. 1146.

264. Petitioner timely appealed the termination of her employment and went through Steps 1, 2, and 3 of the O’Berry grievance procedure. Tr. 1179-1180; 1509-1513.

265. Mr. Silva, Petitioner’s former supervisor, spoke very favorably about her job performance while working with him and that, if her termination of employment were overturned and his department had a vacancy, he would be willing to rehire Petitioner as a surveyor. Tr. 1383.

CONCLUSIONS OF LAW

1. The Office of Administrative Hearings (“OAH”) has jurisdiction over the parties and the subject matter pursuant to Chapters 126 and 150B of the North Carolina General Statutes. The parties have given proper notice of the hearing and all parties are properly before this Administrative Law Judge.
2. There has not been an issue raised as to procedural defects nor to whether the Petitioner was properly and sufficiently apprised with particularity of the acts which lead to her dismissal.

3. To the extent that the Findings of Fact contain Conclusions of Law, or that the Conclusions of Law are Findings of Fact, they should be so considered without regard to the given labels.

4. Petitioner was a career state employee at the time of her dismissal and therefore entitled to the protections of the North Carolina State Personnel Act, including the provision that prohibits the termination of her employment except for just cause. N.C. Gen. Stat. §§ 126-1 et seq., 126-35, 126-37(a); 25 NCAC 01J. 0604(a).

5. N.C. Gen. Stat. § 126-35(a) provides that “No career State employee subject to the State Personnel Act shall be discharged, suspended, or demoted for disciplinary reasons, except for just cause.”

6. Because Petitioner has alleged that Respondent lacked just cause for her termination, the Office of Administrative Hearings has jurisdiction to hear her appeal and issue a recommendation to the State Personnel Commission, which will make the final decision in this matter.

7. Pursuant to N.C.G.S. § 126-35(d) and N.C.G.S. § 150B-29(a), Respondent has the burden of proof by a preponderance of the evidence on the issue of whether it had just cause to discipline, in this instant matter whether to dismiss Petitioner for grossly inefficient job performance and unacceptable personal conduct.

8. 25 N.C. Admin. Code 11 .2301(c) enumerates two grounds for disciplinary action, including dismissal, based upon just cause: (1) unsatisfactory job performance, including grossly inefficient job performance; and (2) unacceptable personal conduct.

9. 25 NCAC 1J .0604(c) provides that an employer may discipline or dismiss an employee for just cause based upon grossly inefficient job performance as defined in 25 NCAC 1J.0614. Grossly inefficient job performance may result in dismissal without any prior disciplinary action as provided in 25 NCAC 1J.0606.

10. “Grossly Inefficient Job Performance” is defined as “a type of unsatisfactory job performance that occurs in instances in which the employee fails to satisfactorily perform job requirements as specified in the job description, work plan, or as directed by the management of the work unit or agency and that failure results in . . . the creation of the potential for death or serious bodily injury to . . . a person(s) over whom the employee has responsibility.” 25 N.C. Admin. Code 1J .0614(5).

11. Pursuant to 25 NCAC 1J .0608(a), an employer may dismiss an employee without warning or prior disciplinary action for a current incident of unacceptable personal conduct.

12. “Unacceptable personal conduct” is defined as “conduct for which no reasonable person should expect to receive prior warning; the abuse of a . . . person(s) over whom the employee has
charge or to whom the employee has a responsibility; . . . [or] willful violation of known or written work rules.” 25 N.C. Admin. Code 18.0614(8).

13. O’Berry’s Procedure Manual on Report of Abuse, Neglect and Exploitation of Clients defines neglect as “not providing goods or services necessary to maintain the mental or physical health of a client,” which includes “failing to provide for necessary . . . personal care or habilitative needs (may result in injury) . . . failing to carry out orders for treatment placing the individual at risk . . . [and] leaving a client who requires assistance unsupervised, placing them at risk.” Res. Ex. 587.

14. The fundamental question in a case brought under N.C. Gen. Stat. § 126-35 is whether the disciplinary action taken was “just.” Although the statute does not define “just cause,” the words are to be accorded their ordinary meaning. Amanini v. Dep’t of Human Resources, 114 N.C. App. 668 (1994) (defining “just cause” as, among other things, good or adequate reason).

15. While just cause is not susceptible of precise definition, our courts have held that it is “a flexible concept, embodying notions of equity and fairness that can only be determined upon an examination of facts and circumstances of each individual case.” An inquiry into whether the disciplinary action was taken for just cause “requires an irreducible act of judgment that cannot always be satisfied by the mechanical application of rules and regulations.” N.C. Dep’t of Env’t & Natural Res. v. Carroll, 358 N.C. 649, 669 (2004).

16. Determining whether Respondent had just cause to discipline Petitioner requires two separate inquiries: 1) whether Petitioner engaged in the conduct O’Berry alleges; and 2) whether that conduct constitutes just cause for the disciplinary action taken. See Carroll, 358 N.C. at 669.

17. The evidence does not show that Petitioner engaged in the conduct O’Berry alleges that is grossly inefficient job performance:

a. The evidence does not establish that Petitioner failed to satisfactorily perform her job requirements as specified in her job description, work plan, or as directed by O’Berry management. The evidence show that Petitioner was performing her work as Cluster Administrator exceptionally well, as attested to by Dennis Mays. Petitioner had been hired to assume responsibility for a cluster with a history of problems, especially problems with supervision. She had been working very diligently at improving the cluster, including having initiated a higher than usual number of disciplinary investigations, which created resentment toward her from her subordinates.

b. An essential question to be answered: was it wrong or improper for her to accept control of a group at all? Based on substantial and credible evidence, the answer would be “no”—it was not improper for her to assume control of a group under the circumstances that existed at that time.
c. While there has been some testimony that some of the staff had not seen other CA’s assume responsibility for direct care, there was no evidence to prohibit it. There is no evidence as to whether or not Petitioner had ever seen another CA assume responsibility for direct care. Mr. Mays stated that CA’s should only give direct care in limited circumstances—obviously not a prohibition. Whether or not others had given direct care is of little or no consequence.

d. Petitioner was assuming responsibility for a group which was located across the hall from numerous experienced and qualified staff should something go wrong or need immediate attention. The direct care would be of very short duration.

e. Nothing prohibited her from assuming responsibility for the group. There might have been a question of whether or not she was capable of caring for this group. There is no question that she did not receive proper training at O'Berry for direct care. Early in her career she provided direct care. Her experience and training prior to coming to O'Berry would indicate that she would be capable of supervising the women in the yellow room, especially considering the activities in which they were engaged, and that they were in the process of being fed and that trained staff were across the hall.

f. There has not been an issue about the care she provided to the clients who were in the yellow room; therefore, the question becomes who constitutes the group over which she assumed responsibility. Stated more succinctly, the essential question at issue is whether or not Petitioner assumed responsibility for Client A by assuming responsibility for the clients in the yellow room, and if so, should she be held responsible for failing to supervise Client A which lead to her death because she did not check on her within 15 minutes. Based on substantial and credible evidence, Petitioner did not assume responsibility for Client A under the facts and circumstances that existed at that time and therefore she should not be held responsible in any regard for failing to properly supervise Client A.

g. On March 11, 2009, Petitioner attempted to gain the necessary information needed to supervise the clients from Ms. Lee when she took over responsibility for the yellow room, to facilitate a neglect investigation which involved Ms. Lee. It was expected that she would only supervise for a short period of time. Ms. Lee was the person who was responsible for conveying all information necessary for Petitioner to assume responsibility. To the extent that necessary information was not conveyed to Petitioner, that fault rests almost entirely with Ms. Lee, who willfully refused to communicate information about Client A.

h. Ms. McFadden is more culpable to a degree not heretofore acknowledged by Respondent. Whenever she would move Client A from place to place, she was assuming responsibility for Client A. She assumed responsibility for Client A whenever she moved her to her bedroom. She had a duty to tell Ms. Lee who was at that time in charge of the yellow room. Although Ms. Lee says she assumed
Client A was in her bedroom, Ms. McFadden did not communicate that to her. Also, McFadden was working the kitchen on that evening and the evidence is that the kitchen staff would go and get the clients to serve the meals in the order assigned, and Ms. McFadden would have been the only kitchen staff member who would have known where Client A was located. Apparently, no one else on the kitchen staff so much as inquired where Client A was either.

i. Respondent contends that Petitioner should have asked more probing questions of Ms. Lee, especially in light of the fact that clients would have been going out or coming into the yellow room. There is no evidence that she did not ask relevant questions as each client either left the room or was being brought into the room. Supervision of those clients is not the issue.

j. The issue is the communication concerning Client A. She asked appropriate questions of Ms. Lee to determine over whom she was responsible. The group was not of a single group—either Group A or Group B—of the clients. She had not been at O'Berry long enough to have known the clients individually or who was in which group. She was assuming responsibility for a group of people that she could actually see. What she did and what she asked were reasonable under the circumstances.

k. Even if Petitioner had asked Ms. Lee more specifically about Client A and her supervision requirements, Ms. Lee believed that Client A could be checked on every fifteen (15) to thirty (30) minutes and likely would have conveyed this information to Petitioner. Because Petitioner supervised the yellow room for less than thirty (30) minutes, she would not have checked on Client A during this time, even if Ms. Lee had chosen to effectively communicate with her.

l. Client A’s PCP did not contain the requirement for fifteen (15) minute checks. Some staff knew of the requirements, but not all staff knew. The fact that Petitioner had mentioned fifteen (15) minute checks in another investigation is of no consequence since she was referring specifically to a client about whom she was familiar, and there is no evidence of the other clients in the room at the time, and more specifically that Client A was among them.

m. Even if Petitioner was familiar with the in-service training concerning fifteen (15) minute checks given by Ms. Mewborn, that in-service specifically listed a number of places where Client A could be placed away from the group, and Client A’s bedroom was not listed as such a place where Client A could be placed. Therefore, even if she were familiar with this in-service, there would have been nothing to put her on notice that Client A might be in her bedroom.

n. Mr. Mays stated that he would have expected Petitioner to have asked for more specific information because of her previous experience; that is, he is making a decision which ultimately leads to Petitioner’s dismissal based on an assumption of what she may or may not have known from a prior work history.
Nothing about her prior work history nor prior training would have given her any insight that another staff member had moved a client into a bedroom which was out of her sight, much less that she should inquire about clients not in the room. If so—where would the list end? To require her to make such inquiry about clients not physically present within the room is not reasonable under the circumstances and in light of the fact that she had been at the center for less than two months.

o. Although there was some testimony to the effect of how extensive some would question when assuming responsibility for clients being “handed off” to them, there is not consistency and does not seem that all staff were trained in the process of handing off.

p. Petitioner was not properly trained by O’Berry Center. She was removed from training within a matter of hours without having finished orientation or any of the mandatory training. She was immediately placed in the cluster so that she could become familiar with it. That decision was based upon her extensive background, but as such is based almost entirely on an assumption of her capabilities because of that work history, even though she had never served as a cluster administrator, a role significantly different from her prior experience.

q. Petitioner was not given copies of the policies and procedures for O’Berry and the Respondent, despite the fact that she requested them numerous times. She had only received a portion of the policies and procedures.

r. Assuming arguendo that Petitioner failed to satisfactorily perform her job responsibilities, there is no evidence that Petitioner’s actions on March 11, 2009, contributed to Client A’s death in anyway. Mr. Mays and Ms. Brantham stated that they reached no conclusions as to whether the lack of fifteen (15) minutes checks contributed to Client A’s death. While the cause of death was stated as asphyxiation, seizure was not ruled out as the cause of death.

s. It was not neglect for her to assume that the clients physically present in the yellow room at the time she assumed responsibility were the only ones for whom she was responsible.

18. The evidence does not show that Petitioner engaged in unacceptable personal conduct.

a. The evidence does not establish that Petitioner engaged in any willful conduct for which no reasonable person should expect to receive prior warning or willful violation of a work rule.

b. To the contrary, Petitioner performed her job responsibilities to the best of her abilities on the evening of March 11, 2009; Respondent has presented no evidence showing Petitioner engaged in a willful act or omission that contributed to Client A’s death.
c. "Willfulness" implies knowledge and awareness. That knowledge is not imputed or implied; nor is it constructive knowledge.

19. Secretary Lanier Cansler made a number of public pronouncements to the effect that the Respondent had a duty to provide proper training of the employees, that one cannot be expected to properly perform his or her duties without the proper training, and that it would be wrong to discipline or dismiss them when they had not been properly trained. Such an observation is in keeping with the spirit of Carroll, that a discipline must be "just" and that it must embody "notions of equity and fairness." See Carroll, at 669.

20. Petitioner was not provided by O'Berry with training for the position for which she was hired as required by federal regulations. Respondent assumed that Petitioner was capable of performing all functions of that position without adequate training and assumed that it was permissible to provide the training at a later date.

21. Assuming arguendo that Petitioner should be held accountable as contended by Respondent, the essential question then becomes whether or not she was appropriately disciplined. Mr. Mays incorrectly stated that he had no flexibility in the decision and that his only option was to terminate Petitioner. It is clear that State Personnel Policy in effect at the time of these events did not mandate termination, and, in fact, a written warning was a permissible discipline for grossly inefficient job performance or unacceptable personal conduct even if serious injury or death were the result of the conduct. The Respondent's Zero Tolerance Policy in effect at the time was for abuse only and there is no issue of abuse in this contested case.

22. Secretary Cansler's directive dated February 4, 2009 states that "[d]ismissal is expected in cases where the abuse or neglect results in physical harm." While close, it is not a mandate that in every case, the employee shall be dismissed. Further, Secretary Cansler's directive points to the State Personnel Manuel as the guide for disciplining anyone who violates the abuse, neglect, and exploitation policy. Mr. Mays stated that the O'Berry Center policy was in the process of being revised in accord with the Secretary's instructions at the time of this incident, but at the time of the incident, the policy did not mandate dismissal.

23. Mr. Mays struggled with what discipline would be appropriate, in large part because Petitioner was performing very well in the position. He even stated that, but for the death, he would probably have given her a written warning. His decision to terminate was because he felt it was his only option. His conclusion that he had no other options was in error and he could have and should have considered other options for discipline.

24. In light of the evidence presented, Respondent has not met the burden of proving that "just cause" existed for the dismissal of Petitioner from employment.

DECISION

As Respondent did not meet its burden of proof and did not have just cause to dismiss Petitioner based on the evidence presented, its decision to dismiss Petitioner for just cause is REVERSED, and it is recommended that the State Personnel Commission:
1. Direct that Respondent reinstate Petitioner in a comparable position at the Department of Health and Human Services, with the same pay grade and rate of compensation that she had on March 26, 2009;

2. Direct that Respondent shall pay to Petitioner back pay and benefits accruing from the date of Petitioner’s dismissal (March 26, 2009) through her date of reinstatement;

3. Direct that Respondent remove from Petitioner’s personnel file the following documents:
   a. The March 19, 2009 notice of pre-disciplinary conference;
   b. The March 26, 2009 letter of termination;
   c. The November 9, 2007 written warning; and
   d. Any and all other documents indicating that Petitioner was terminated from employment by Respondent in March 2009.

4. Direct that Respondent shall reimburse Petitioner for costs of this action, including reasonable attorney’s fees.

**NOTICE**

The Decision of the Administrative Law Judge in this Contested Case will be reviewed by the agency making the final decision according to standards found in N.C. G.S. §150B-36(b)(b1) and (b2). The agency making the Final Decision in this contested case is required to give each party an opportunity to file exceptions to this Decision and to present written arguments to those in the agency who will make the final decision, in accordance with N.C.G.S.§ 150B-36(a).

The agency that will make the final decision in this contested case is the North Carolina State Personnel Commission.

The State Personnel Commission is required by N.C. Gen. Stat. § 150B-36(b) to serve a copy of the final decision on all parties and to furnish a copy to the parties’ attorney of record and to the Office of Administrative Hearings.

This the [2] day of [April], 2011.

[Signature]
Donald W. Overby
Administrative Law Judge
A copy of the foregoing was mailed to:

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This the 18th day of November, 2011.

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