STATE OF NORTH CAROLINA

COUNTY OF WAKE

IN THE OFFICE OF
ADMINISTRATIVE HEARINGS
14 OSP 02904

KEVIN GERITY,

Petitioner,

vs.

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES,

Respondent.

FINAL DECISION

BACKGROUND

Petitioner initiated this contested case by filing a petition on April 23, 2014, alleging that Respondent constructively discharged him because he made reports that qualified as protected activity under the Whistleblower Act. On August 27, 2014, the presiding administrative law judge directed that the case not proceed until Petitioner had pursued the internal grievance process and received a Final Agency Decision. Respondent's Final Agency Decision, which had been approved by OSHR, was issued on November 6, 2014. The case was heard in Raleigh on January 7-9, 2015, by Senior Administrative Law Judge Fred Gilbert Morrison Jr.

APPEARANCES

For Petitioner: Michael C. Byrne, Esq.
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For Respondent: Joseph E. Elder
Assistant Attorney General
North Carolina Department of Justice
P.O. Box 629
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ISSUE

Whether Respondent constructively discharged Petitioner because he made reports that were protected activity under the Whistleblower Act.

EXHIBITS ADMITTED INTO EVIDENCE

For Petitioner: 1A-C, 2, 3, 6-11, 13-16

For Respondent: 2-4, 6, 7, 9, 10, 12, 13, 14

WITNESSES

For Petitioner:
Lou F. Turner, PhD
Deborah Radisch, M.D.
Samuel Simmons, M.D.
Thomas Clark, M.D.
Maryanne Gafney-Craft, M.D.
William Holloman
Kevin Gerity
Deann Rudd

For Respondent:
Daniel Staley
Deborah Radisch, M.D.
Tracy Yorkdale

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 Senior Administrative Law Judge (SALJ) makes the following Findings of Fact. In making these Findings of Fact, the SALJ has weighed all the evidence and has assessed the credibility of the witnesses by taking into account the appropriate factors 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. Facts material to a determination of the contested issue are as follows:

FINDINGS OF FACT

1. Petitioner was continuously employed with the North Carolina Department of Health and Human Services (DHHS), Division of Public Health (DPH), Office of the Chief Medical Examiner (OCME), from 1993 to December 31, 2013. In November 2003, Petitioner became the autopsy facility manager with the OCME. Petitioner's employment with the State ended when his retirement became effective on January 1, 2014.

2. Throughout the term of his employment, Petitioner generally received high ratings on his performance evaluations.

3. The OCME is comprised of pathologists who serve as medical examiners. These pathologists conduct autopsies as the need arises. Autopsy technicians assist the pathologists during autopsies. An autopsy includes both an external examination of a body and an internal examination in appropriate cases. Conducting autopsies is the primary duty of the OCME.

4. Dr. Simmons started a forensic pathology fellowship at the OCME in June 2008. In the summer of 2009, he became an associate medical examiner there.

5. Dr. Radisch became the Chief Medical Examiner in July 2010. Prior to becoming the Chief Medical Examiner, Dr. Radisch worked as a staff pathologist at the OCME from 1986 to 1994 and from 2001 to 2010.

6. The OCME was not fully staffed for the first few years of Dr. Radisch's tenure as Chief Medical Examiner. During this time, Dr. Radisch's caseload prevented her from devoting as much time to her administrative duties as she would have liked.

7. Dr. Radisch's administrative duties included developing written policies and procedures for OCME employees regarding the collection of evidence during autopsies. Due in part to the understaffing at the OCME, Dr. Radisch did not develop any written policies or procedures in 2010 or 2011.

8. Despite the lack of written rules or procedures, the OCME developed various policies, protocols or practices through years of performing autopsies. Some of these policies, protocols or practices varied depending on the preferences of individual pathologists. Other policies, protocols or practices appeared to be essentially universal at the OCME.

9. Generally, the autopsy technician would assist the pathologist by removing organs from the body at the pathologist's direction. The autopsy technician would also at times, at the pathologist's direction, assist with the retrieval of evidence from the body.

10. Generally, the pathologist would clean and dry any evidence recovered and place it in an evidence bag. The pathologist would then label the bag with the autopsy number, the decedent's name, and a description of the evidence and where it was recovered. The pathologist would sign and seal the bag with evidence tape and initial the tape. Autopsy techs generally would not sign the bag or evidence tape because the pathologist has the responsibility of certifying that the evidence was recovered by him or her, or at his or her direction.

11. Each pathologist had his or her own evidence locker for keeping items of evidence recovered during autopsies until they could be turned over to law enforcement. This prevented evidence from being lost or tampered with.

12. One of the OCME's unwritten policies or practices requires autopsies to be conducted in the pathologist's presence. If an item of evidence is discovered when the pathologist is not in the room, the OCME practice requires the autopsy technician to leave the evidence in its original condition and summon the pathologist back to the autopsy room. Unlike many of the OCME's other unwritten policies, these protocols did not vary from pathologist to pathologist.

13. These unwritten protocols stemmed from the fact that the pathologist is ultimately responsible for the results of the autopsy, the autopsy report, and any evidence recovered. The pathologist needs firsthand knowledge of any evidence recovered during an autopsy so that he or she can testify to the evidence's collection at trial.

14. Although they were not written, autopsy technicians learned about these policies, protocols and practices through experience and on-the-job training.

15. Petitioner participated in more than 10,000 autopsies during the term of his employment with Respondent. As a result, Petitioner knew or should have known of the OCME's unwritten policies, protocols and practices, including those relating to the handling of evidence discovered out of the pathologist's presence.

16. In 2010, Dr. Radisch hired Dr. Nichols for the position of Deputy Chief Medical Examiner. Dr. Nichols took over for the outgoing Deputy Chief Medical Examiner, Dr. Clark, who had held the position since 2002. As the Deputy Chief Medical Examiner, Dr. Nichols served as Petitioner's supervisor. Dr. Nichols and other pathologists were over-burdened/over-worked.

17. Petitioner had a good working relationship with his outgoing supervisor, Dr. Clark. In contrast, Petitioner had a less than satisfactory relationship with Dr. Nichols. Petitioner expressed distrust for Nichols and repeatedly questioned the quality of Dr. Nichols' work when speaking with coworkers and superiors. Dr. Nichols distrusted and was not always satisfied with Petitioner's behavior and interactions with fellow pathologists and staff.

18. On May 10, 2011, the OCME performed two autopsies on the victims of an apparent double homicide. Dr. Simmons served as the pathologist for one of the autopsies. Dr. Nichols served as the pathologist for the other autopsy, which involved a victim named Terrell Boykin. Petitioner assisted Nichols on the Boykin autopsy. Mr. Holloman served as the photographer for the Boykin autopsy.

19. Boykin presented with an apparent gunshot wound to the head. An initial x-ray was said to indicate what appeared to be the presence of an item in the brain. The x-ray was not produced, offered or admitted into evidence.

20. Petitioner was responsible for removing the organs from the body during the Boykin autopsy. Among other things, Petitioner removed Boykin's brain. He testified that he did not find a bullet in the head when he was removing the brain. Dr. Nichols did not find or recover a bullet during his examination of the brain or skull cavity. Petitioner asked Dr. Nichols if he should perform a second x-ray, but Dr. Nichols instructed Petitioner that none was necessary.

21. After the conclusion of the autopsy, Dr. Nichols instructed Petitioner to release the body to the custody of law enforcement. Dr. Nichols then left the autopsy room. William Holloman had also departed after taking his photographs. Petitioner remained to clean up the room.

22. After Dr. Nichols left the autopsy room, Petitioner disobeyed Dr. Nichols' instruction and performed a second x-ray of the body. This x-ray did not indicate the presence of any object in the skull cavity. Petitioner released the body to the custody of law enforcement and began cleaning the autopsy room.

23. Shortly thereafter, Petitioner called Mr. Holloman back into the autopsy room.

24. Petitioner showed Mr. Holloman an unmarked, unlabeled evidence bag that contained a small object. Petitioner told Mr. Holloman that he found the object while cleaning the area around Dr. Nichols' cutting board. Petitioner told Mr. Holloman that he had washed coagulated blood off the object and placed it in the bag. Petitioner asked Mr. Holloman to take a picture of the bagged item, but Mr. Holloman refused. Petitioner then took a picture of the bagged object with his personal cell phone, and Mr. Holloman left the autopsy room.

25. Petitioner did not contact Dr. Nichols to ask him to return to the autopsy room. Petitioner later admitted to DHHS investigators that he called Mr. Holloman instead of Dr. Nichols because he wanted to show Mr. Holloman that Dr. Nichols' work was "sloppy."

26. At the hearing, Petitioner testified that he called Mr. Holloman back into the autopsy room instead of Dr. Nichols because he did not trust Dr. Nichols. Petitioner also stated that he would have handled the situation differently had he been working with any other pathologist. Thus, Petitioner knew that the normal practice for such occasions was to recall the pathologist who had conducted and directed the autopsy.

27. After Holloman left the room, Petitioner took the bagged object to Dr. Nichols' office. Petitioner presented the bagged object to Dr. Nichols and told him that he found the object near Dr. Nichols' cutting board. Dr. Nichols took the bagged object from Petitioner and placed it in his desk drawer. Dr. Nichols did not report this object on his official autopsy report, no doubt because he did not trust Gerity and he had not recovered/discovered it and could not certify where it came from. Nichols kept the object in his desk drawer and had it readily available upon request.

28. Neither party has produced the object Petitioner claims to have recovered or any photographs thereof. At the hearing, Petitioner testified that he found a "round bullet," or "a whole bullet." Dr. Radisch testified as follows:

Q: With respect to the item that was recovered, have you ever seen that item?
A: Yes.
Q: And have you been able to determine what that item is?
A: Yes.
Q: And what is it?
A: It's a piece of copper projectile jacket.

29. Dr. Nichols' autopsy report contained the following relevant information::

CERTIFICATION

Cause of Death
Gunshot wound to the head

The facts stated herein are correct to the best of my knowledge and belief.
Digitally signed by
Clay Nichols MD 17 August 2011 11:23

DIAGNOSES

Perforating gunshot wound to left head with:
Cerebral laceration
Associated epidural, subdural and subarachnoid hemorrhage
Associated skull fractures
Bullet exists and is not recovered
Status post organ harvesting

INJURIES

A distant, perforating gunshot wound is identified to the left side of the head at a distance of 1.5" from the top of the head and 2.4" to the left of midline. The wound is rather atypical with lacerated edges measuring 1 x 1" in greatest diameter. A faint abrasion border is present at the 7 o'clock position measuring up to 0.2" in greatest diameter. No soot or powder stippling is identified. The bullet is found to enter the skull at this point taking a tangential track and exiting a short distance from the entrance wound at a distance of 3" from the top of the head and 2.5" to the left of midline. The exit wound is gaping measuring 1 x 1.2". In addition, a satellite injury caused by a fragment exits the left side of the head above the left ear at a distance of 3.2" from the top of the head and 2.2" to the left of midline. This measures up to 0.2" in greatest diameter. Along its course, the bullet causes cerebral laceration as well as associated skull fractures and epidural and subdural hemorrhage. No bullet is recovered.

Neurologic
Brain Weight 1560 grams
The scalp is reflected and hemorrhage is found beneath the previously described gunshot wound. Appropriate inward bevelling and outward bevelling around the entrance and exit wounds through the skull. Epidural, subdural and subarachnoid hemorrhage are identified around the previously described gunshot wound. Some degree of cerebral edema is present. No other significant abnormality is identified on the cerebral or cerebellar hemispheres. The basilar artery and circle of Willis are free of significant atherosclerotic occlusion. On section, the ventricles are filled with blood tinged cerebrospinal fluid. No additional abnormality is noted.

SUMMARY AND INTERPRETATION

A complete autopsy was performed on the decedent identified as Terrell Boykin on May 10, 2011. Reportedly, the deceased was in a car when shot. Another individual may have also been killed in this shooting.

At autopsy, the significant findings include the presence of a perforating gunshot wound to the left side of the head with subsequent cerebral laceration. The major organs were harvested prior to autopsy.

Microscopic examination of the brain confirms the presence of hemorrhage without a significant inflammatory infiltrate.

No ethanol was identified in admissions blood.

After review of the autopsy findings contained herein, it is my opinion that Terrell Boykin died as the result of a gunshot wound to his head.

30. In June 2011, Petitioner examined the preliminary Boykin autopsy report. At the time, Dr. Radisch was out of the country on vacation. As a result, Petitioner contacted Pat Barnes, an administrator at the OCME, and asked that the Boykin autopsy report not be published until Dr. Radisch returned from her vacation.

31. On July 28, 2011, Dr. Radisch returned from her vacation. Petitioner contacted Dr. Radisch that day to express his concerns about the Boykin autopsy report. Petitioner told Dr. Radisch that he personally found a whole bullet after Dr. Nichols left the autopsy room; that he washed, cleaned, and bagged the bullet; and that he took the bag to Dr. Nichols' office. Petitioner complained that the autopsy report inaccurately stated "the bullet exists and is not recovered."

32. Dr. Radisch told Petitioner that she would look into the matter, but she did not contact Dr. Nichols or take any other meaningful action at that time. Dr. Radisch had prior concerns with Petitioner and she had never known an attending pathologist not being called back when items had been discovered in similar circumstances.

33. On September 9, 2011, Dr. Nichols sent Petitioner an email concerning certain shortcomings in his secondary employment and improper interactions with co-workers. The body of this email is reproduced below:

Mr. Gerity,

I see that you are still using your cell phone to conduct outside business on OCME time. You have told been told several times by both Dr. Radisch and myself that this is not allowable under your secondary employment agreement. You have been told personally by me not to bring your Nextel to work. You ignored that. Now that you have a different brand of cell phone, you have decided on your own, that since that your cell phone is not technically a Nextel, you can do with it what you want. This passive aggressive attitude adversely affects your position as an employee, compromises your ability to effectively supervise and only exposes and magnifies your true personality. You obviously need more help in doing what is right and what is expected of you. To that end, I will help you comply with your agreement:

1. You will immediately cease any use of any cell phone to conduct any business.

2. You will immediately call the appropriate personnel at WC-7, Wake County Sheriff's Office, Raleigh PD, CCBI, Durham law enforcement agencies and anyone else of importance that I have left off of the list and inform them that you are no longer able to accept calls from them on your cell phone. Please give them the appropriate office phone number and fax number. I will follow up with my own letters to the heads of the various agencies to clarify and reinforce the proper procedures for contacting the OCME with specific instructions not to contact you. I will give you adequate time to do this on your own.

3. If there is even a suspicion that you are conducting other than authorized OCME business, your secondary employment agreement will be immediately revoked. You may then choose for whom to work. One or the other, but not both.

In addition, your contempt for Dr. Radisch is palpable. This includes a long history of belligerence, snide remarks and on at least one occasion, openly confrontational. After this particular episode, you boasted to you coworkers essentially ,"I guess I told her" or words to that effect. Once again, this adversely reflects on your value as an employee and effectiveness as a supervisor; you have set a poor example for others to follow.

Since I have specifically asked you in the past not to do this and once again you have failed, especially even after you asked for a clean slate, I will help you with this problem:

1. You will immediately subordinate yourself to the Chief Medical Examiner for the State of North Carolina, Dr. Radisch. To put it more clearly, she is the boss, you are a low level manager.

2. You will immediately adjust your attitude to be helpful and maintain a harmonious work environment. Passive aggressiveness is not an option.

3. I have compiled a list of supervisor level classes that <u>you</u> <u>will</u> <u>attend</u>. Failure to do so may adversely affect your position at the OCME. The list is at the bottom.

You have the opportunity to make something good out of this or something bad. I sincerely hope that we can use your years of experience in a constructive manner for a long time to come.

will be available at the beginning of the week for further discussions on this matter. A more formal letter will given to you at that time. You will be asked to sign one copy.

List of classes to attend:
<u>Results-Based Interactions</u>. "This leadership development program teaches participants how to be effective leaders with the ability to coach and mobilize others to achieve desired results." It is a 3-day course. Upcoming sessions are October 25-27, 2011 and December 13-15, 2011 at the Dix Campus in Raleigh.

The <u>Equal Employment Opportunity Institute</u> (EEOI) Level I course focuses on equal employment opportunity (EEO) laws, including American Disability Act (ADA), workplace harassment, and issues concerning the value and management of diversity. Next session is November 1-2, 2011 at the Division of Child Development in Raleigh. Registration deadline is September 24.

<u>Leadership: Facilitating Change.</u> "This four-hour training session introduces the four phases of change and the roles of leaders." One of the goals of this training is to "establish greater role clarity for themselves and develop others." Next session is December 1, 2011 on the Dix Campus.

34. Shortly after receiving this email, in a "tit for tat," Petitioner emailed Dr. Radisch to complain that no action had been taken regarding the concerns he had relayed about the Boykin autopsy report. Petitioner copied Pat Barnes and Dr. Lou Turner, the Section Chief of the DPH, on this email. The body of this email is reproduced below:

Dr Radisch 09/09/2011

I am formally requesting a follow up meeting to the conversation we had on July 28, 2011, in regards to the case I worked with Dr Nichols. During our meeting, I informed you of an incident where, on x-ray, I saw a piece of metal in the head of a homicide victim and when I informed Dr Nichols, he told me not to worry about it, he did not find any part of the bullet when he cut the brain. This case was part of a double homicide from Cumberland County B11-2005.

While cleaning up after he left the room I found the whole bullet lying next to his cutting board. I compared the bullet to the x-ray and found it appeared to be the same piece of metal. Another x-ray of the head confirmed that the metal from the first x-ray was no longer there. Another employee was in the room with me when I compared it to the x-ray. I placed the bullet in to a plastic evidence bag and took it right down to Dr Nichols office and told him I found it lying next to his cutting board.

I waited for you to return from vacation to report this incident out of respect for you and this office; and you told me you would follow-up and take appropriate action.

During another homicide case, also from Cumberland County, in which I worked with Dr. Nichols he said he did not need to recover the piece of metal found on x-ray in the victim's back. This concerned me and led me to review the previous case to ensure the autopsy report had been revised to include that the bullet was recovered.

The autopsy report released to the public states "no bullet was recovered". This disturbs me because I personally recovered the bullet in this case and personally handed it to Dr. Nichols, yet this is not reflected in the final report.

I feel our office has an obligation to be as thorough as possible in performing autopsies, as well as being as accurate as possible in the reports we release. My name appears these autopsy reports, as the autopsy technician, and I feel that releasing a report that we know is inaccurate, not only puts me in a precarious position personally, but also puts this entire office in jeopardy

As representatives of the State Medical Examiner's office, I feel strongly we have an obligation to rectify this error by providing accurate information to law enforcement and/or anyone who might be affected by the inaccuracy of this report.

I would like to sit down and discuss this matter with you at your earliest convenience, as I feel it is imperative that corrective action take place as soon as possible.

35. Neither Pat Barnes nor Dr. Turner took any immediate action as a result of Petitioner's email to Dr. Radisch. Dr. Radisch also took no action other than forwarding Petitioner's email to Dr. Nichols.

36. Despite his reporting concerns about the Boykin autopsy to Dr. Radisch, Petitioner received a "successful" rating on his June 2012 and June 2013 annual performance evaluations. Petitioner's 2012 evaluation did mention frequent confrontations with pathologists that needed to be addressed, and his 2013 evaluation noted improvement in this area. No specific mention was made of the Boykin autopsy on these annual evaluations

37. In June 2012, Dr. Radisch issued a written warning to Petitioner. This written warning was not related to the Boykin autopsy, but rather arose out of a verbal altercation between Petitioner and Dr. Privette, another pathologist at the OCME. The written warning included notice of appeal rights, and Petitioner grieved the warning internally. The warning was upheld.

38. In September 2013, DHHS leadership was made aware of a State Bureau of Investigation (SBI) investigation into the Boykin autopsy. SBI investigators interviewed Petitioner as part of this investigation.

39. Around the same time, several local media outlets began reporting stories about understaffing and other problems at the OCME, including during the Boykin autopsy.

40. Some OCME employees, including Dr. Radisch and Dr. Turner, suspected that Petitioner had leaked information about the Boykin autopsy to third parties, and that this conduct prompted the SBI investigation and media reports. Dr. Turner asked Petitioner if he had leaked information about the OCME, including internal OCME documents, to any third parties. Petitioner denied having leaked information about the OCME or the Boykin autopsy to any third parties.

41. In October 2013, Mark Payne, Chief of Staff for DHHS, ordered an internal personnel investigation into the Boykin autopsy. Lillie Peebles and Deann Rudd conducted the investigation, which initially focused on Dr. Nichols' conduct during and following the Boykin autopsy. Ms. Peebles and Ms. Rudd interviewed several OCME employees as part of the DHHS internal investigation, including Petitioner, Dr. Radisch, Dr. Simmons, Mr. Holloman, and Dr. Nichols. Their report was included as Exhibit 1 (Under Seal) with Respondent's Motion to Dismiss and For Summary Judgment filed on August 18, 2014. According to Ms. Peebles and Ms. Rudd, Petitioner provided detailed information about the OCME's unwritten policies, protocols and practices for evidence collection. They reported that Petitioner acknowledged that an autopsy technician should call the pathologist back into the room upon finding evidence outside the body. Dr. Simmons and Dr. Radisch both expressed a lack of trust in Petitioner and confirmed that they had never experienced a situation in which an autopsy technician removed evidentiary items from the autopsy room. Dr. Simmons confirmed that, under such circumstances, it would be difficult to verify where the item came from and how it was preserved.

42. On November 5, 2013, DHHS terminated, without giving a reason, Dr. Nichols' employment after his position had been classified as exempt from the Human Resources Act. No criminal charges were filed against him following the SBI report to the district attorney, nor was any evidence introduced noting any sanction by the North Carolina Medical Board.

43. On November 8, 2013, Dr. Simmons sent a letter to Mr. Payne and Dr. Aldona Wos, Secretary of DHHS. The body of this letter is reproduced below:

> Earlier this week on Wednesday, Dr. Turner officially broke the news to OCME about the termination of Dr. Nichols. I appreciate the potential severity of the situation, and I understand your decision regarding Dr. Nichols. However, as one of the individuals who were interviewed by DHHS representatives regarding this situation, I have some residual concerns.
>
> I was interviewed by Lillie Peebles and Deann Rudd on October 18, 2013. During the first portion of the interview, Ms. Peebles put forth information and scenarios that seemed to be related to the incident involving Dr. Nichols and an autopsy tech who still works for our office. The scenarios described frankly bizarre behavior by the autopsy tech in his handling of evidence (cell phone photos and packaging evidence) that I have not ever seen or experienced when working with any autopsy tech in our office over the last six years. Based on those descriptions from Ms. Peebles, the chain of custody for that evidence was jeopardized long before it ever reached Dr. Nichols, and those behaviors sounded quite purposeful. I would hope this individual is not being given "whistleblower" status, as is seems his actions potentially created, or at least worsened the evidentiary situation related to this incident.
>
> I am concerned that this autopsy tech is not only still working at OCME, but he is also still participating in autopsies and evidence recovery on a regular basis. If he is going to continue to be employed at OCME with that type of access, and without some sort of reprimand for his seemingly contributory behavior in the incident with Dr. Nichols, I (along with all the other current and soon-to-be-starting physicians) need some input from you. Given that the main theme from Dr. Turner's message Wednesday was "maintaining integrity" at OCME, I would like to know how you plan to protect us from being exposed to similar behaviors from this individual. I like to think that I am very methodical in my autopsy exams and evidence collection. However, it is difficult to protect oneself from an individual who sounds, quite frankly, like they were out to sabotage a physician. If we cannot protect ourselves, how do you propose to protect us from such behaviors in the future?

44. As a result of its investigation and Dr. Simmons' letter, DHHS management decided to pursue termination of Petitioner's employment. Dr. Turner and Dr. Radisch agreed with the decision of DHHS management and provided information about Petitioner's conduct and the OCME's procedures, protocols and practices to Danny Staley, who was acting as DPH's Chief Operating Officer.

45. On Friday, December 6, 2013, Petitioner attended a meeting with Dr. Turner and Antonio Gomez, his human resources contact. At this meeting, Petitioner received an investigatory placement with pay notice and a pre-disciplinary conference letter. Both documents were signed by Mr. Staley. No one at this meeting mentioned, suggested or discussed the possibility of Petitioner resigning or retiring.

46. The pre-disciplinary conference letter (Petitioner's Exhibit 8) consisted of seven pages setting out the allegations being made against Petitioner based on the internal investigation conducted by DHHS into the Boykin autopsy. The body of this letter is reproduced below:

Dear Kevin Gerity:

This letter is to notify you that a pre-disciplinary conference has been scheduled for December 9, 2013, at 11:00am in the Director's Board Room, 5605 Six Forks Road, Building 3, Raleigh, NC. Danny Staley and Lou Turner will be conducting this conference. The purpose of this conference is to ensure that the decision to be made is not based on misinformation and to give you an opportunity to respond. In accordance with State Human Resources Policy, attorneys are not to be present during the pre-disciplinary conference.

Dismissal from your current position as Autopsy Facility Manager, Office of the Chief Medical Examiner (OCME) of the Division of Public Health (DPH), has been recommended based on unacceptable personal conduct and unsatisfactory job performance as defined in Section 7, pages 3 and 4 of the State Human Resources Manual. Your actions represent 1) conduct for which no reasonable person should expect to receive prior warning; 2) conduct unbecoming a state employee that is detrimental to state service; and 3) the willful violation of known or written work rules (i.e., handling of evidence/chain of custody during an autopsy). Unsatisfactory job performance is work related performance that fails to satisfactorily meet job requirements as specified in the job description, work plan, or as directed by management. This recommendation is based on your actions as described below.

Recently, the SBI conducted an investigation and interviewed numerous employees at OCME. The Department of Health and Human Services (DHHS) executive management became aware of the investigation and requested a Department investigation into the autopsy incident on October 16, 2013. The investigation was conducted by Deann Rudd, Employee Relations Specialist and Lillie Peebles, Agency Legal Specialist.

I. Unacceptable personal conduct

The investigation revealed the established, known protocols/work rules for the handling of autopsies and evidence retrieved during the autopsies. Pathologists are responsible for the internal and external examinations of the body during an autopsy, bagging evidence recovered during the autopsy, chain of custody forms, and the autopsy report. The autopsy technician is responsible for helping the pathologist at the pathologist's direction. It is a known protocol/work rule that autopsy technicians assist the pathologists in retrieving evidence such as bullets or bullet fragments during the autopsy. It is a known protocol/work rule that the technician hands over projectiles to the pathologist and the pathologist rinses, bags, and labels the evidence.

It is a known protocol/work rule that in the rare circumstances where evidence is discovered on the autopsy table, bench, or cutting board, the technician is to notify the pathologist so that the pathologist can observe for him/herself the location of the projectile. At that point, the pathologist will rinse, bag, and label the evidence. If the pathologist is out of the autopsy room when a technician finds a fragment or projectile, the technician is to leave the evidence as is and contact the pathologist. It is a known protocol/work rule that at no point does a technician bag evidence, remove evidence, or transfer evidence outside of the autopsy room.

As a part of the investigation, you were interviewed on October 17, 2013. You indicated you had assisted pathologists in thousands of autopsies throughout your many years with OCME. You were also able to explain, in detail, the protocols/work rules for the handling of autopsies and evidence retrieved during the autopsies as detailed above. For example, you stated that the pathologist is responsible for bagging evidence and if a technician sees something out of the ordinary, the technician is supposed to stop and contact the pathologist.

You stated you were the autopsy technician who assisted Dr. Clay Nichols, former Deputy Chief Medical Examiner, during the Boykin autopsy. You stated the X-ray of the decedent's head indicated that there was a projectile present. Per you, Dr. Nichols also viewed the X-ray. You stated that when you removed the brain, you told Dr. Nichols the bullet was not in the skull. After completing his dissection, Dr. Nichols told you that he did not find the bullet in the brain. You stated you took a second X-ray of the head and noted that the bullet was no longer visible. You stated you told Dr. Nichols the projectile was no longer visible, and Dr. Nichols replied the bullet was not in the brain and exited the room.

You stated that you then began to clean up the autopsy table and bench. You indicated that you discovered a bullet in "coagulated blood" on the bench, on the right side, near/underneath the cutting board.

You admitted during your investigation interview that you removed the bullet from its location, rinsed it off, and put it in an unlabeled plastic bag. You admitted that instead of contacting Dr. Nichols as required in the known work rules of OCME, you phoned Mr. William "Bill" Holloman, OCME Photographer, and told him that you wanted to show him something. You stated you wanted to show Mr. Hollomon how "sloppy Dr. Nichols was".

You admitted during your interview that when Mr. Holloman arrived you took a picture of the evidence with your personal cell phone. You also admitted you transported the bullet, in the plastic bag, to Dr. Nichols' office which was on a different floor than the autopsy room.

When the investigators asked you why you transported the evidence to Dr. Nichols instead of following known protocol/work rule, you stated you personally walked the bag down to Dr. Nichols' office because Dr. Nichols had leg problems and would be unable to take the stairs to return to the autopsy room quickly. However, you indicated that there was a working elevator in the building. You also stated you took the bullet to Dr. Nichols' office in case the detective on the Boykin case was still on his way to the parking lot. The investigators did not consider these responses truthful.

When asked why you contacted Mr. Holloman instead of Dr. Nichols, you first replied you were not sure why you did not contact Dr. Nichols. You then relayed that you did not trust Dr. Nichols. You then admitted that you would not have handled the evidence in the manner that you did (in violation of known work rules) if it had been Dr. Radisch or Dr. Simmons performing the Boykin autopsy.

During his October 16, 2013 interview, Mr. Holloman confirmed you took a photo of the bullet with your cell phone. Mr. Holloman stated that the bullet was in a small evidence bag and you told him you were taking it to Dr. Nichols. The bag was not labeled.

Mr. Holloman stated that it is not unusual to find something left after an autopsy. Mr. Holloman stated he has known you to call pathologists back upstairs to the autopsy room when you have found a projectile (bullet). Mr. Holloman stated whenever something is found after an autopsy, the technicians call the pathologists to return back to the autopsy room and the pathologists take possession of the evidence and enter the item into evidence.

During her October 17, 2013 interview, Deborah Radisch, Chief Medical Examiner, stated if a technician finds a fragment or projectile, the technician should stop and call the pathologist. The technician should leave it as is. If the pathologist is still in the autopsy room when the projectile is found, the technician should show the pathologist where the projectile was found. Dr. Radisch stated it would be a problem if a technician bags evidence and brings it to the pathologist. Dr. Radisch stated that is known through training that a technician does not remove the evidence or the chain of custody will be broken. Dr. Radisch stated that she has never been put in that situation (technician removing evidence) in all her years as a pathologist.

During his October 18, 2013 interview, Dr. Sam Simmons, Associate Medical Examiner, stated at some point you informed him about a bullet he found in one of Dr. Nichols' cases. Dr. Simmons did not remember the specifics, but he remembered that you seemed very intent on making sure it was a "big deal" for Dr. Nichols. Dr. Simmons thought it was odd that you would document evidence before bringing it to the attention of Dr. Nichols. Dr. Simmons stated that it did not seem like an innocent thing with you; it seemed "insidious".

Dr. Simmons stated that on the rare occasions a technician finds a piece of evidence and he is not in the autopsy room, the technician notifies him and shows him the evidence. If the item is moved, he is unable to verify where the evidence was found, and the chain of custody is broken. Dr. Simmons stated that you presenting the bullet to Dr. Nichols in the manner in which you did, seems suspicious; you were targeting Dr. Nichols.

During his October 18, 2013 interview, Dr. Nichols stated he returned to his office on the 10th floor after completing the examination portion of the autopsy. You later came to his office after the Boykin autopsy and provided him with an unlabeled plastic bag that contained a bullet jacket stating "here; I won't tell anyone." Dr. Nichols stated "everyone knows that you don't do transfers like that." Dr. Nichols stated if a technician finds something after the autopsy, the technician is supposed to call the pathologist and indicate that s/he needs to return to the autopsy room.

Dr. Nichols stated that your actions were deliberate. Dr. Nichols stated had you called him to return to the autopsy room when the projectile was found, he would have gone back to check his findings and may have been able to certify the evidence. Per Dr. Nichols, the chain of custody for the projectile was broken due to you cleaning, bagging, and removing it from the autopsy room.

A. Willful violation of known or written work rules

The investigation substantiated that you willfully violated known or written work rules when you:

1. Upon discovering the bullet jacket after the Boykin autopsy, purposefully failed to contact Dr. Nichols to inform him of the bullet jacket;
2. Willfully removed the bullet jacket from the bench/cutting board;
3. Willfully rinsed off the bullet jacket after removing it from it the bench/cutting board;
4. Willfully placed the rinsed off bullet jacket in an unlabeled plastic bag after removing it from it the bench/cutting board;
5. Willfully contacted Mr. Hollomon to have him view the bullet jacket;
6. Willfully took a photograph of the bullet jacket with your personal cell phone;
7. Willfully removed the bullet jacket from the autopsy room;
8. Willfully transported the rinsed off, bagged, and unlabeled bullet jacket up a flight of stairs to Dr. Nichols's office; and
9. Willfully broke the chain of custody for evidence during the Boykin autopsy.

During the investigation, you clearly admitted you did not follow established and known protocol/work rules and procedures for handling of evidence during the Boykin autopsy. You also clearly indicated that you purposefully handled the evidence in this manner because Dr. Nichols was the pathologist for the case.

You, Dr. Radisch, Dr. Simmons, and Dr. Nichols all agreed that it is a known protocol/work rule that the technician hands over projectiles to the pathologist and the pathologist rinses, bags, and labels the evidence. It is a known protocol/work rule that in the rare circumstances where projectile is discovered on the autopsy table, bench, or cutting board, the technician is to notify the pathologist so that the pathologist can observe for him/herself the location of the projectile. At that point, the pathologist will rinse, bag, and label the evidence.

If the pathologist is out of the autopsy room when a technician finds a fragment or projectile, the technician is to leave the evidence as is and contact the pathologist. It is a known protocol/work rule that at no point does a technician bag evidence, remove evidence, or transfer evidence outside of the autopsy room.

Drs. Radisch, Simmons, and Nichols all agreed that the chain of custody was broken in this situation by the way the evidence was retrieved by you. Drs. Radisch and Simmons also stated they have never been faced with a technician bagging evidence and transporting it out of the autopsy room in the past.

Therefore, based on the information obtained in this investigation, it was substantiated that you willfully violated known work rules when you purposefully removed, bagged, and transported evidence outside of the autopsy room without Dr. Nichols' knowledge or observation. Further, taking a photograph of autopsy evidence for your own personal use is shocking, unacceptable, and not in accordance with known procedure. You knew the work rules and chose to willfully violate them.

B. Conduct unbecoming a state employee that is detrimental to state service and conduct for which no reasonable person should expect to receive prior warning

During the investigation, you clearly admitted you did not follow established and known protocol/work rules and procedures for handling of evidence during the Boykin autopsy. You also clearly indicated that you purposefully handled the evidence in this manner because Dr. Nichols was the pathologist for the case.

Further, after the conclusion of the investigation, Dr. Simmons forwarded a letter to Dr. Aldona Wos, Secretary DHHS, and Mark Payne, Chief of Staff DHHS, expressing his concerns that you were still participating in autopsies and evidence recovery at OCME. Dr. Simmons shared that the way you handled the bullet jacket in the Boykin autopsy was "frankly bizarre behavior by the autopsy tech in his handling of evidence..." Dr. Simmons indicated that the handling of evidence was something he "...has never seen or experienced when working with any autopsy tech in [OCME] over the last six years." Dr. Simmons stated that the chain of custody for the evidence was jeopardized long before it reached Dr. Nichols.

Dr. Simmons also stated in his letter that although he considers himself "methodical" in his autopsy exams and evidence collection, it is concerning to have an employee "...who sounds, quite frankly, like they were out to sabotage a physician" working at OCME.

Therefore, based on the information obtained in this investigation, it was substantiated that your actions constituted conduct unbecoming a state employee that is detrimental to state service and conduct for which no reasonable person should expect to receive prior warning.

You purposefully violating known work rules for your own personal vendetta is unconscionable. Taking a photograph of autopsy evidence for your own personal use is shocking and unacceptable. You determinedly broke the chain of custody and damaged the perception of the OCME. Your actions also jeopardized a homicide investigation that could negatively affect the Boykin family and the criminal justice system.

II. Unsatisfactory Job Performance

Per your job description, you have the responsibility to "[a]ssist the pathologist in the proper packaging and labeling of material to preserve the chain of custody of evidence." "Errors… made…such as loss of evidence chain of custody…will result in invalidating tests or samples."

You failed to preserve the chain of custody of the bullet jacket by removing, bagging, and transporting evidence outside of the autopsy room without Dr. Nichols' knowledge or observation. You should have followed known protocol/work rules when you discovered the bullet jacket while cleaning the autopsy area. Therefore, the investigation substantiated that you did not satisfactorily perform your job responsibilities.

Finally, it was substantiated that you failed to maintain a harmonious working environment with your co-workers. During the investigation, all the pathologists interviewed (Radisch, Simmons, Nichols) expressed their concern regarding your trustworthiness and reliability during the performance of the autopsies. It should be noted that in your June 11, 2012 written warning for unacceptable personal conduct and unsatisfactory job performance, Dr. Jonathan Privette, former OCME pathologist, also expressed concerns regarding your ability to "undermine and sabotage his work".

Dr. Radisch stated during her interview you were a "bully" and you take out your frustrations on your employees. You have insulted her in front of others and have also had altercations with other pathologists in the office. Dr. Radisch stated that the autopsy room runs smoother when you are not there.

During her October 16, 2013 interview, Dr. Lou Turner, Deputy Section Chief, Epidemiology Section, stated you were a "bully". You intimidate your staff by spreading lies and causing problems, and that you do all of this "covertly". Dr. Turner thinks you create a hostile working environment. Dr. Turner stated in her October 16, 2013 written statement that you have been hard to deal with in terms of maintaining staff. "Many leave (ex. Molly, Tracy). [Your] behavior is listed as one reason why [at] least 3 forensic pathologists also left (Gaffney-Kraft, Gardner, Privette)."

Further, during your investigation interview, you referred to your staff as the "help". You specifically stated that you, Dr. Radisch, and Dr. Nichols should not socialize (i.e., buying lunch, riding together in the same vehicle, etc.) with the autopsy technicians, "your help". As a supervisor, you should not refer to, nor relate to, your staff in a derogatory manner, such as the "help".

Your interactions with staffs have been mean-spirited, improper, unprofessional, and certainly not in keeping with maintaining harmony in the workplace.

You currently have one active action in your personnel file. You were issued a written warning on June 11, 2012, for unacceptable personal conduct and unsatisfactory job performance. You were aggressive, insulting, and physically confrontational with Dr. Privette.

You also received a documented counseling from Dr. Nichols via email on September 9, 2011 for violation of the secondary employment policy and failure to maintain a harmonious working environment.

You will have the right to respond to this proposal in the conference and offer information. Your response will be reviewed and considered before a final decision is made.

If you do not attend the conference and have not discussed rescheduling, a decision will be made based on the information available.

If you have questions, please feel free to contact me at 919-707-5024. If you wish to discuss this situation with anyone other than management, you may contact Deann Rudd, Assistant HR Director and Employee Relations Specialist, at (919) 707-5450.

47. Over the weekend, Petitioner contacted Mr. Gomez and requested that the pre-disciplinary conference be delayed so that he could seek the advice of legal counsel. Mr. Gomez denied this request.

48. The pre-disciplinary conference occurred as scheduled on December 9, 2013. Petitioner, Mr. Staley, and Dr. Turner attended the conference, as did Greg Chavez, DHHS' new Human Resources Manager.

49. Immediately after the conference began, Petitioner interrupted Mr. Staley and stated that he would save everybody some time. Petitioner then presented a pre-written resignation letter which he had prepared and brought to the conference. The body of this letter is reproduced below:

Dear Mr. Staley,

Please accept this letter of resignation effective today, December 9, 2013. I would like to have my last day worked with OCME; Division of Public Health will be today, December 9, 2013. It is my intention to retire effective January 1, 2014. In order to continue my benefits I would like to exhaust leave from December 10, 2013 – December 31, 2013, according to my Beacon quota overview I have Overtime Comp Time of 21.00 and 8.00 of Holiday Comp Time along with the 2013-2014 Special leave that I would like to exhaust through the end of December, along with some annual leave. Also if I am in payroll status through December my health insurance will be active through January, since the retirement system will not cover me or my dependent until February 1st. Please consider this request as it would be most beneficial for my family in a most stressful situation.

Thank you

Kevin J. Hasty

50. At no time during the abbreviated conference did anyone suggest that a final determination to dismiss Petitioner had been made or that Petitioner should resign or retire. Petitioner freely decided for his own reasons that it was best to resign and retire. Petitioner did not question or offer any remarks concerning the allegations in the pre-disciplinary conference letter, nor did he contend that he was being constructively discharged or threatened with discharge in violation of the Whistleblower Act.

51. Mr. Staley accepted Petitioner's resignation at the conference. Later that day, Mr. Staley issued a letter to Petitioner, the body of which is reproduced below:

Dear Mr. Gerity:

This is to officially confirm acceptance of your resignation from your employment, effective immediately, as Autopsy Facilities Manager, Epidemiology Section, Office of the Chief Medical Examiner, Division of Public Health. This action is based on your letter of resignation received today, December 9, 2013. Based on your request, documented in your letter of resignation that was effective today, I will administratively approve for you to exhaust leave from December 10, 2013 – December 31, 2013, so that you may retire January 1, 2014, without a break in service.

If you have any state properties in your possession, please contact Greg Chavez, DPH Human Resources Manager at 919-707-5457. The property must be returned to DPH no later than Friday, December 20, 2013. If you have any questions about your benefits, please contact Deann Rudd at 919-707-5454.

If you have questions, please feel free to call me at 919-707-5424.

Sincerely,

Danny Staley

52. Petitioner went on active retirement January 1, 2014. Sixty-three (63) days later, on February 10, 2014, he submitted a Step 1 grievance form to Respondent, alleging for the first time that he had been constructively discharged without just cause and threatened with discharge in violation of the Whistleblower Act. Ms. Rudd acknowledged receipt of the grievance form and indicated on the form that it was not submitted timely. On February 12, 2014, Chavez sent a letter to Petitioner informing him that his grievance was untimely and that the matter was administratively closed.

53. On April 23, 2014, Petitioner filed a Petition for Contested Case Hearing. On November 6, 2014, Respondent issued its Final Agency Decision, which had been approved by OSHR, finding that there was no retaliation under the Whistleblower Act; that Petitioner's internal grievance was not timely filed; and advising him of his appeal rights. The 180 day time period for issuing a decision in this case began to run upon receipt of the FAD on November 6, 2014.

BASED UPON the foregoing Findings of Fact, the undersigned makes the following:

CONCLUSIONS OF LAW

1. All parties are properly before the Office of Administrative Hearings (OAH) and jurisdiction and venue are proper. 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.

2. A court need not make findings as to every fact that arises from the evidence and need only find those facts which are material to the settlement of the dispute. *Flanders v. Gabriel*, 110 N.C. App. 438, 440, 429 S.E.2d 611,612, *aff'd* 335 N.C. 234, 436 S.E.2d 588 (1993).

3. North Carolina's policy is to encourage State employees to report fraud, substantial and specific dangers to public health and safety, and other similar matters to appropriate authorities. N.C. Gen. Stat. § 126-84(a) (2014). As a result, under the Whistleblower Act, a State agency may not "discharge, threaten, or otherwise discriminate against a State employee" for accurately reporting fraud or a substantial and specific danger to public health and safety. *Id.* § 126-85(a).

4. In order to establish a claim under the Whistleblower Act, an employee must demonstrate: "(1) that the plaintiff engaged in a protected activity, (2) that the defendant took adverse action against the plaintiff in his or her employment, and (3) that there is a causal connection between the protected activity and the adverse action taken against the plaintiff." *Newberne v. Dep't of Crime Control and Safety*, 359 N.C. 782, 788, 618 S.E.2d 201, 206 (2005).

5. Relatively few published opinions exist discussing the evidence necessary to establish the elements of a Whistleblower claim in North Carolina. Because Whistleblower actions often closely parallel Title VII and Section 1983 cases, however, courts may follow the reasoning suggested in those cases. *See Kennedy v. Guilford Tech. Cmty. Coll.*, 115 N.C. App. 581, 584, 448 S.E.2d 280, 282 (1994).

I. Whether Petitioner Engaged in Protected Activity

6. In order to qualify for protection under the Whistleblower Act, an employee must first demonstrate that he engaged in protected activity. *Newberne*, 359 N.C. at 788, 618 S.E.2d at 206. An employee engages in protected activity when he reports, *inter alia*, fraud or a substantial and specific danger to public health, unless the employee knows or has reason to believe the report is false. N.C. Gen. Stat. § 126-85(a).

7. Petitioner claims that he engaged in protected activity when he reported his concerns about the Boykin autopsy report to his supervisors. Petitioner claims that Dr. Nichols' autopsy report was fraudulent because it stated that "the bullet exists and is not recovered."

8. After considering all of the evidence, it is found that Petitioner failed to show by a preponderance of the evidence that he found a whole bullet during the Boykin autopsy. Neither party produced the x-ray, the bagged object, or any photographs thereof, and the parties offered conflicting evidence on whether the bagged item consisted of a whole bullet, a bullet jacket, a bullet fragment, or something else. It is concluded that Dr. Radisch's description of the object as a "piece of copper projectile jacket" is more credible than Petitioner's description of a "whole bullet," particularly in light of the autopsy report which clearly describes a "gaping" exit wound.

9. Even if the object Petitioner said he found was a whole bullet, it is not clear that Dr. Nichols' autopsy report was fraudulent or even inaccurate. Dr. Nichols prepared a thorough autopsy report that identified Mr. Boykin's cause of death and described in considerable detail the entry and exit wounds made by a bullet. Petitioner claims to have discovered a bullet and contends that the report was fraudulent because Dr. Nichols stated that a "bullet exists and is not recovered." But although Dr. Nichols' statement could be read as an assertion that no one at the OCME found a bullet, it could also be interpreted as a truthful assertion that Dr. Nichols did not personally find and recover a bullet and thus he could not verify or vouch for one's recovery. This interpretation is supported by the fact that the OCME had no rules for how pathologists should respond to items presented to them outside the autopsy room, likely because this situation had never arisen before.

10. After considering all of the evidence, it is concluded that Petitioner's complaints about the Boykin autopsy primarily concerned his dissatisfaction with Dr. Nichols' job performance rather than fraud or a substantial and specific threat to public safety. Petitioner admitted that he did not trust Dr. Nichols and that he called Mr. Holloman to show him that Dr. Nichols' work was "sloppy." Dr. Nichols, in turn, obviously distrusted and was not always satisfied with Petitioner. The timing of Petitioner's complaints about the Boykin autopsy also suggest a kind of "tit for tat," with Petitioner complaining about Dr. Nichols' work in retaliation for Dr. Nichols' warnings about Petitioner's secondary employment and interactions with others.

11. Another potential form of protected activity also bears mentioning. At the hearing, Petitioner testified that Dr. Turner, Dr. Simmons, and other members of OCME management suspected him of leaking information about the Boykin autopsy to the media and SBI. Petitioner never testified to leaking this information, however, and OCME management did not testify that they believed he had. Regardless, Petitioner does not contend that he actually prompted the media reports or SBI investigation. As a result, there is no need to determine whether such behavior would qualify as protected activity under the Whistleblower Act.

12. In sum, the greater weight of the evidence does not support a conclusion that Petitioner engaged in protected activity when he reported his concerns about the Boykin autopsy to his superiors at the OCME, or that Petitioner leaked information about the Boykin autopsy to third parties outside of DHHS, including the media and the SBI. Accordingly, Petitioner has not shown that he engaged in protected activity, a necessary element of a Whistleblower claim.

II. Whether Petitioner Suffered an Adverse Employment Action

13. Even if Petitioner had engaged in protected activity, his Whistleblower claim would fail because he did not suffer an adverse employment action. An employee who voluntarily resigned from his position may not bring a claim for wrongful discharge. *See Gravitte v. Mitsubishi Semiconductor America, Inc.*, 109 N.C. App. 466, 472, 428 S.E.2d 254, 258 (1993). "Employee resignations are presumed to be voluntary. This presumption will prevail unless [the] plaintiff comes forward with sufficient evidence to establish that the resignation was involuntarily extracted." *Christie v. United States*, 518 F.2d 584, 587 (Ct. Cl. 1984).

14. An employee's seemingly voluntary resignation may be considered involuntary, however, if the employer extracted the resignation through misrepresentation or coercion. *See Stone v. Univ. of Md. Med. Sys. Corp.*, 855 F.2d 167, 174 (4th Cir. 1988).

15. Under the misrepresentation theory, a resignation is involuntary if it was "induced by an employee's reasonable reliance upon an employer's misrepresentation of a material fact concerning the resignation." *Id.* Here, Petitioner does not allege that Respondent made any material misrepresentations of fact regarding his ability to contest the recommendation of dismissal or the consequences of his retirement. Accordingly, Petitioner must proceed under the coercion theory.

16. Courts look to the totality of the circumstances when determining whether a resignation was extracted through coercion. *Id.* Among the factors relevant to this consideration are (1) whether the employee was given an alternative to resignation, (2) whether the employee understood the nature of his choices, (3) whether the employee was given a reasonable period of time to decide, and (4) whether the employee was allowed to select his own retirement date. *Id.* Ultimately, "[coercion] is not measured by the employee's subjective evaluation of a situation. Rather, the test is an objective one." *Christie*, 518 F.2d at 587.

17. With regard to the first factor, almost any reasonable alternative to immediate resignation appears to suffice. *Compare Salter v. E&J Healthcare, Inc.*, 155 N.C. App. 685, 689–90, 575 S.E.2d 46, 49 (2003) (employee lacked a meaningful alternative when employer presented her with a resignation letter and instructed to sign it immediately or be fired on the spot) *with Stone*, 855 F.2d at 174 (administrative appeals process provided adequate alternative to resignation). "[T]he mere fact that the [employee's] choice is between comparably unpleasant alternatives—e.g., resignation or facing disciplinary charges—does not of itself establish that a resignation was induced by duress or coercion, hence was involuntary." *Stone*, 855 F.2d at 174; *see also Covington v. Dep't of Health and Human Servs.*, 750 F.2d 937, 942 (Fed. Cir. 1984) ("The fact that an employee is faced with an inherently unpleasant situation or that his choice is limited to two unpleasant alternatives does not make an employee's decision any less voluntary.").

18. Accordingly, the availability of mediation, administrative hearings, or any other disciplinary review process generally suffices as an adequate alternative to resignation. *See, e.g.*, *Swearnigen-El v. Cook Cnty. Sheriff's Dep't*, 602 F.3d 852, 860 (7th Cir. 2010); (administrative proceeding provided adequate alternative to resignation); *Stone*, 855 F.2d at 174 (same); *Christie*,

518 U.S. at 587–88 (same); *Soloski v. Adams*, 600 F. Supp. 2d 1276, 1307–09 (N.D. Ga. 2009) (contractual right to review prior to dismissal provided adequate alternative to resignation). This is true even if the administrative process is likely to be costly or time-consuming. *See Covington*, 750 F.2d at 943 ("The agency limited Covington's choices between discontinued service retirement, on the one hand, and separation without severance pay and with reinstatement contingent upon a favorable outcome in a costly, time-consuming appeal. The law does permit such a hard choice . . ."); *Christie*, 518 F.2d at 587 ("While it is possible plaintiff, herself, perceived no viable alternative but to tender her resignation . . . [t]he fact remains, plaintiff had a choice. She could stand pat and fight. She chose not to. Merely because plaintiff was faced with an inherently unpleasant situation in that her choice was arguably limited to two unpleasant alternatives does not obviate the voluntariness of her resignation.").

19. After considering all of the evidence, it is concluded that this first factor weighs in favor of Respondent. Like the Plaintiffs in *Stone* and *Christie*, Petitioner was faced with two unpleasant alternatives: resignation or contesting his recommended dismissal through the pre-disciplinary conference and other administrative channels. Petitioner chose to submit his resignation before the pre-disciplinary conference began rather than contest his dismissal. Although it is possible that Petitioner himself perceived no viable alternative but to resign in order to preserve his retirement and other benefits, this does not obviate the fact that he had a choice. *See Christie*, 518 F.2d at 587; *Covington*, 750 F.2d at 943.

20. With regard to the second factor, an employee's education and experience generally weigh more heavily than his access to legal counsel. *See, e.g.*, *Stone*, 855 F.2d at 177–78. In *Stone*, for example, a medical school professor resigned rather than face possible termination at a disciplinary hearing. *Id.* The court found that the professor understood his choices, despite not being able to secure legal counsel prior to his resignation. *Id.* The court explained, "[The professor] was not a naive intern in his first clinical assignment; he was a sophisticated and well-educated hospital administrator with over thirty years experience . . ." *Id.* at 177; *see also Speiser v. Engle*, 107 F. App'x 459, 461 (6th Cir. 2004) (director of county agency not entitled to an attorney at a pre-disciplinary conference).

21. After considering all of the evidence, it is concluded that this second factor also weighs in favor of Respondent. Petitioner contends that he resigned because he believed that he would lose his retirement and other benefits if he were fired. Of course, "[a] decision made 'with blinders on', based on misinformation or a lack of information, cannot be binding as a matter of fundamental fairness and due process." *Covington*, 750 F.2d at 943. But Petitioner did not make his decision with blinders on. Petitioner surely knew that he could challenge and respond to the allegations against him; the pre-disciplinary conference notice stated as much. Petitioner also had more than two decades of experience working at OCME and thus was familiar with administrative procedures. Finally, Petitioner had personal experience with grievance procedures, having grieved his written warning just one year earlier. Thus, as in *Stone*, Petitioner's extensive personal experience far outweighed his lack of legal counsel prior to the pre-disciplinary conference.

22. With regard to the third factor, courts have found that as little as one or two days' notice provides sufficient time for an employee to make an informed choice. *See, e.g.*, *Swearnigen-El*, 602 F.2d at 860 (employee's resignation was voluntary when submitted two days after being placed on leave, before administrative proceedings could begin); *Soloski*, 600 F. Supp. 2d at 1307–10 (one day sufficient for employee to consider his options). In addition, for employees with extensive education and training, periods as short as a few hours may be sufficient. In *Stone*, for example, a professor at a medical school resigned less than one hour after being threatened with disciplinary action. 855 F.2d at 170–71. Although the employee did not secure legal advice during this period, the court nevertheless found that the employee had sufficient time to make a decision because he could have consulted an attorney and did in fact consult a colleague about his decision. *See id.* at 177–78. The court concluded that, although the employee acted under "some time pressure," the employee had sufficient preexisting knowledge to make an informed decision during the limited time available to him. *Id.*; *see also Soloski*, 600 F. Supp. 2d at 1309 (holding that one day was sufficient to make a decision and distinguishing earlier cases in which employees were instructed to resign before leaving the room).

23. After considering all of the evidence, it is concluded that this third factor also weighs in favor of Respondent. Petitioner had as much or more time to consider his options than the employees in *Swearnigen-El*, *Soloski*, and *Stone*. Moreover, although Respondent certainly could have delayed the pre-disciplinary conference at Petitioner's request, it did not have to do so. *See* 25 N.C. Admin. Code 01J .0613(4)(c) (requiring State agencies to provide as much notice "as is practical under the circumstances").

24. With regard to the fourth factor, an employee's resignation is generally considered to be voluntary when the employee engaged in negotiation over the terms of his retirement. In *Stone*, for example, the court cited the fact that a medical professor "dictated the terms of his resignation himself" and "drove a hard bargain" as evidence that the professor resigned voluntarily. *Id.* at 177. Similarly, courts tend to treat resignations as voluntary when the employee is permitted to select the effective date of his resignation. *See, e.g.*, *Knappenburger v. City of Phoenix*, 566 F.3d 936, 941 (9th Cir. 2009) (resignation was voluntary when employee "could and did choose the date of his retirement"); *Soloski*, 600 F. Supp. 2d at 1347 (resignation was voluntary when employee was permitted to delay the effective date of his retirement by three days).

25. After considering all of the evidence, it is concluded that this factor also weighs in favor of Respondent. Like the plaintiffs in *Knappenburger* and *Soloski*, Petitioner was permitted to negotiate a significant delay between the submission of his resignation and the effective date of his retirement. The fact that Petitioner was able to negotiate favorable terms in order to maximize his retirement and insurance benefits suggests that he made a free and informed choice to resign rather than contest his dismissal.

26. In sum, after considering all of the evidence, it is concluded that each factor enumerated in *Stone* supports Respondent's contention that Petitioner voluntarily resigned.

27. In addition to these enumerated factors, two other considerations warrant discussion in this case. First, courts also generally consider resignations to be voluntary when the

employee resigns at his own suggestion, rather than at the employer's suggestion. *See, e.g.*, *Swearnigen-El*, 602 F.2d at 860. In *Swearnigen-El*, for example, the court found that a resignation was voluntary when the employee unilaterally resigned rather than wait for the initiation of disciplinary proceedings. *Id.*; s*ee also Morris v. Scenera Research, LLC*, --- N.C. App. ---, 747 S.E.2d 362, 375–77 (N.C. Ct. App. 2013) (sufficient evidence existed to support court's finding of voluntary resignation on a retaliatory discharge claim, notwithstanding jury findings of termination by employer with regard to other claims, where employee himself suggested resignation as a possibility), *review allowed* 747 S.E.2d 362. Similarly, in *McGriff v. American Airlines, Inc.*, the court found that an employee resigned voluntarily when the employee drafted his resignation letter himself. 431 F. Supp. 2d 1145, 1157 (N.D. Ok. 2006).

28. Here, the Petitioner drafted his own resignation letter prior to the pre-disciplinary conference. No one at OCME or DHHS suggested that he consider retirement or resignation rather than contest the recommendation for dismissal. Moreover, Petitioner presented his resignation letter at the outset of the pre-disciplinary conference before any substantive conversation could begin. These facts further support the conclusion that Petitioner voluntarily resigned his position.

29. Finally, notwithstanding the factors discussed above, the mere threat of discharge may be sufficiently coercive to render a resignation involuntary when the employer lacks just cause to discipline the employee. *See Stone*, 855 F.2d at 167. "If an employee can show that the agency knew that the reason for the threatened removal could not be substantiated, the threatened action by the agency is purely coercive." *Schultz v. U.S. Navy*, 810 F.2d 1133, 1136 (Fed. Cir. 1987). In order to meet this requirement, the employee must show, not only that the employer lacked just cause for discipline, but also that the employer "knew or believed that the termination could not be substantiated." *Christie*, 518 F.2d at 588.

30. It is recognized that the two-year gap between the Boykin autopsy and DHHS' decision to recommend Petitioner's dismissal is potentially problematic. For the reasons stated herein, however, the greater weight of the evidence shows that DHHS management did not learn about Petitioner's conduct until November 2013, and thus could have reasonably believed that just cause existed to terminate Petitioner's employment in December 2013. As a result, the notice of the pre-disciplinary conference did not amount to an unlawful "threat" to discharge Petitioner. This time gap does not negate the conclusion that Petitioner resigned and retired of his own free will.

31. In sum, after considering all of the evidence, it is concluded that Petitioner knowingly and voluntarily resigned from his employment rather than challenging his dismissal. Accordingly, Petitioner has not shown that he suffered an adverse employment action, another necessary element of a Whistleblower claim.

III. Whether Petitioner's Protected Activity Caused the Adverse Action

32. For the reasons explained above, it is concluded that Petitioner did not engage in protected activity or suffer an adverse employment action. Even if Petitioner had engaged in protected activity and suffered an adverse action, however, his Whistleblower claim would still fail because he has failed to show a causal connection between such action and a protected activity.

33. Petitioner has not presented any direct evidence of retaliatory motive by Respondent. As a result, Petitioner must "seek to establish by circumstantial evidence that the adverse employment action was retaliatory" under the *McDonnell Douglas* framework. *Newberne v. Dep't of Crime Control and Safety*, 359 N.C. 782, 790, 618 S.E.2d 201, 207 (2005) (citing *McDonnell Douglas Corp. v. Green*, 411 U.S. 792 (1973)). Under this framework, "once a plaintiff establishes a prima facie case of unlawful retaliation, the burden shifts to the defendant to articulate a lawful reason for the employment action at issue. If the defendant meets this burden of production, the burden shifts back to the plaintiff to demonstrate that the defendant's proffered explanation is pretextual. The ultimate burden of persuasion rests at all times with the plaintiff." *Id.* at 790–91, 618 S.E.2d at 207–08 (citations omitted).

34. Temporal proximity alone may be sufficient to establish a causal connection, but only when the adverse employment decision follows the protected activity "very closely." *Perry v. Kappos*, 489 Fed. App'x 637, 643 (4th Cir. 2012) (quoting *Clark Cnty. Sch. Dist. v. Breeden*, 532 U.S. 268, 273 (2001)). Although there is no bright line rule, courts have found that a lag of as little as ten weeks is sufficient to "weaken significantly" the inference of causality. *See King v. Rumsfeld*, 328 F.3d 145, 151 n. 5 (4th Cir. 2003). If a plaintiff cannot establish causality through temporal proximity alone, the plaintiff must produce other evidence of causation. *Perry*, 489 Fed. App'x at 643; *see also Staley v. Gruenberg*, 575 Fed. App'x 153, 156 (4th Cir. 2014) (holding that temporal proximity alone could not establish causation when an employee failed to produce evidence that her supervisors conspired against her or pursued "trumped up" charges).

35. Here, Petitioner's activity occurred between June 2011 and June 2012, and DHHS management recommended dismissal in December, 2013. The more than one year gap between these actions is far too long to establish causality through temporal proximity alone.

36. Petitioner has failed to produce other forms of evidence of a causal connection. By contrast, as discussed above, the greater weight of the evidence in this case demonstrates that OCME management largely ignored Petitioner's internal reports of his concerns about the Boykin autopsy. It is concluded that the greater weight of the evidence supports the conclusion that DHHS management sought to terminate Petitioner shortly after learning about his conduct in the Boykin autopsy, rather than in retaliation for his internal reports to Dr. Radisch and Dr. Turner.

A. Prima Facie Evidence of Retaliatory Motive

37. "Normally, very little evidence of a causal connection is required" to establish a prima facie inference of retaliatory motive. *See Tinsley v. First Union Nat'l Bank*, 155 F.3d 435, 443 (4th Cir. 1998). "The closeness in proximity of time between the protected activity and the

adverse employment action may create a sufficient inference of causal connection." *Greene v. Swain Cnty. P'ship for Health*, 342 F. Supp. 2d 442, 453 (W.D.N.C. 2004). Courts in the Fourth Circuit typically find prima facie evidence of causality when the adverse event occurs within three months of the protected activity. *Id.* (citing *King v. Rumsfeld*, 328 F.3d 145, 151 n. 5 (4th Cir. 2003) (10 weeks); *Williams v. Cerberonics, Inc.*, 871 F.2d 452, 457 (4th Cir. 1989) (three months)).

38. After considering all of the evidence, it is concluded that Petitioner has not established a prima facie case that he suffered an adverse employment action as a result of his reporting his concerns about the Boykin autopsy to his superiors. Petitioner reported his concerns multiple times between June 2011 (when he first complained to Dr. Radisch) and June 2012 (when he grieved his written warning). The greater weight of the evidence supports the conclusion that no one at the OCME paid significant attention to Petitioner's concerns, much less retaliated against him for making them. More than a year passed between these reports and DHHS' recommendation that Petitioner be dismissed. Although "very little evidence of a causal connection is required" to establish a prima facie case, this gap is far too long to establish a prima facie case of casual connection through temporal proximity alone.

39. Petitioner also alleges that he was constructively discharged because OCME and DHHS management believed that he leaked information about the Boykin autopsy to the media and SBI in October, 2013. The very short time gap between these leaks and DHHS' decision to recommend termination (approximately two months) would, in and of itself, be sufficient evidence to establish a prima facie case of retaliatory motive. As discussed above, however, Petitioner does not allege that he actually leaked the information.

40. North Carolina courts do not appear to have contemplated a situation in which an employer terminated an employee out of a mistaken belief that the employee engaged in protected activity, and neither party addressed this issue at the hearing or in their proposed orders. However, in articulating the elements of a claim under the Whistleblower Act, the North Carolina Supreme Court adopted the reasoning of cases interpreting "comparable" statutes in other jurisdictions. *See Newberne*, 359 N.C. at 788–89, 618 S.E.2d at 206. The court considered Minnesota's act to be one such "comparable" statute. *Id.* (citing *Hubbard v. United Press Int'l*, 330 N.W.2d 428, 444 (Minn. 1983)).

41. In *Stiehm v. City of Dundas*, the Minnesota Court of Appeals held that an employee could not maintain a whistleblower claim under that state's statute when his employer dismissed him under the mistaken belief that he engaged in protected activity. No. A07-1471, 2008 WL 2574974 at *4 (Minn. Ct. App. July 1, 2008). In that case, a city employee claimed whistleblower status because his employer believed that he had reported fraud, even though the employee contended that he had done no such thing. *Id.* In the employee's words, the city "thought they were getting rid of a whistleblower, but terminated the wrong person." *Id.* The court held that the employee could not qualify for whistleblower status because he "simply did not engage in protected conduct under the act." *Id.* (citing *Hubbard*, 330 N.W.2d at 444)); *see also Newberne*, 359 N.C. at 788, 618 S.E.2d at 206 (citing *Hubbard* as persuasive authority when articulating the elements of a claim under North Carolina's Whistleblower Act). The court explained, "Appellant

claimed he was 'perceived' as a whistleblower, but the Whistleblower Act does not provide relief to an employee terminated for being 'perceived' as a whistleblower but who did not actually report any wrongdoing." *Id.*

42. Here, Petitioner's somewhat unusual position is similar to that of the plaintiff in *Steihm*. After considering the wording of the Whistleblower Act, the North Carolina Supreme Court's explanation of the elements in *Newberne*, and the persuasive opinion of the Minnnesota Court of Appeals in *Stiehm*, it is concluded that the Whistleblower Act does not protect employees who do not engage in protected activity, even if they ultimately suffer retaliation due to their employers' mistaken belief that they did.

43. As a result, it is concluded that, even if Petitioner could show that DHHS management sought his dismissal because they mistakenly believed him to be the source of the media and SBI leaks, this would be insufficient to establish a claim under the Whistleblower Act.

44. In sum, it is concluded that Petitioner has failed to produce sufficient evidence to make out a prima facie case that DHHS management recommended his dismissal in retaliation for his internal reports of concerns about the Boykin autopsy. In addition, although Petitioner could establish a prima facie case based solely on the temporal proximity between the media and SBI leaks and his recommendation of dismissal, there is no need to consider this issue because Petitioner does not claim to have been the source of those leaks.

B. Legitimate Reasons for Recommending Petitioner's Dismissal

45. If Petitioner could establish a prima facie case of retaliatory motive—either for Petitioner's internal reports or for the external leaks which he does not claim to have made—the burden would then shift to Respondent "to articulate a lawful reason for the adverse action." *Newberne*, 359 N.C. at 790, 618 S.E.2d at 207. The court does not decide if the employer's reason was "wise, fair, or even correct, ultimately, so long as it truly was the reason" for the adverse action. *DeJarnette v. Corning Inc*., 133 F.3d 293, 299 (4th Cir. 1998).

46. Career state employees may only be disciplined for "just cause." N.C. Gen. Stat. § 126-35; *Hilliard v. N.C. Dep't of Correction*, 173 N.C. App. 594, 597, 620 S.E.2d 14, 17 (2005). Two categories of behavior may provide just cause for dismissing an employee: "unsatisfactory job performance" and "unacceptable personal conduct." 25 N.C.A.C. 1J.0604(b). One current instance of unacceptable personal conduct may provide just cause for dismissal without any prior warning. 25 N.C.A.C. 1J.0608(a); *Hilliard*, 173 N.C. App. at 597, 620 S.E.2d at 17.

47. Unacceptable personal conduct includes "the willful violation of known or written work rules." 25 N.C.A.C. 1J.0614(8)(d). "[T]he employer's work rules *may be written or 'known'* . . ." *Hilliard*, 173 N.C. App. at 597, 620 S.E.2d at 17 (emphasis added). In addition, "a willful violation occurs when the employee willfully takes action which violates the rule," even if the employee did not intend to violate a work rule. *Id.*

48. Although written policies are certainly preferable as a matter of good judgment,

several recent cases support the proposition that unwritten rules are relevant to employee discipline. *See Wilkie v. N.C. Wildlife Resources Comm'n*, 118 N.C. App. 475, 476–77, 484, 455 S.E.2d 871, 877 (1995) (discussing "accepted standards of reporting and performing [employee] work"); *Ramsey v. N.C. Div. of Motor Vehicles*, 184 N.C. App. 713, 719, 647 S.E.2d 125, 129 (2007) (discussing an employee's "good faith belief that his actions were within the accepted pattern and practice of employees" at the agency).

49. After considering all of the evidence, it is concluded that Petitioner violated known, but unwritten, OCME policies regarding the collection and storage of evidence during autopsies. At the hearing, the parties presented conflicting testimony as to whether the OCME had any policies at all regarding the collection of evidence. It is concluded that the testimony that Petitioner violated accepted OCME practices is more credible than the testimony that the OCME had literally no rules regarding the collection of evidence during autopsies. Moreover, Petitioner himself admitted that he would have called another pathologist back into the autopsy room, but chose not to because he did not trust Dr. Nichols. It is concluded that Petitioner violated known OCME practices and protocols, and that OCME and DHHS management could have reasonably pursued disciplinary action against Petitioner for his conduct during the Boykin autopsy.

50. In order to qualify as just cause for dismissal, however, an incident of unacceptable personal conduct must also be "current." *See* 25 N.C.A.C. 01J.0608(a). The North Carolina Administrative Code does not define "current," so the ordinary meaning of that term applies. *See Meads v. N.C. Dep't of Agric.*, 349 N.C. 656, 666, 509 S.E.2d 165, 172 (1998).

51. Most cases involving dismissal for unacceptable personal conduct contemplate lags of a few months or less between the conduct and dismissal. *See, e.g.*, *Kea v. Dep't of Health and Human Servs.*, 153 N.C. App. 595, 570 S.E.2d 919 (2002) (less than one month); *Davis v. N.C. Dep't of Crime Control & Pub. Safety*, 151 N.C. App. 513, 565 S.E.2d 716 (2002) (one month). Even in cases involving lengthy investigations, the time lag typically does not exceed ten months. *See Poarch v. N.C. Dep't of Crime Control & Pub. Safety*, 2012 N.C. App. LEXIS 1191, 741 S.E.2d 315 (2012) (10 months between complaint and dismissal); *see also* 25 N.C.A.C. 01J.0614(6) (disciplinary action deemed inactive 18 months after the last warning or action).

52. When considering whether an incident qualifies as current, the date that the employer's decision makers learned about the incident is more relevant than the date of the incident itself. *See Greene v. Swain Cnty. P'ship for Health*, 342 F. Supp. 2d 442, 453–54 (W.D.N.C. 2004) (finding a dismissal that occurred three months after the employee's misconduct to be proper when the employer dismissed the employee the same day that its full board learned of the conduct).

53. Petitioner points out that he reported his behavior during the Boykin autopsy to his superiors as early as June 2011, more than two years before DHHS recommended his dismissal. Petitioner's position would have merit if Dr. Radisch, Dr. Turner, or other OCME management decided to pursue Petitioner's dismissal. As discussed above, however, the evidence demonstrates that neither Dr. Radisch nor Dr. Turner took any meaningful action to investigate or report Petitioner's allegations about the Boykin autopsy. Instead, the decision to recommend Petitioner's dismissal came from DHHS management after learning of the SBI investigation, the results of the

internal investigation into the Boykin autopsy, and receiving the letter from Dr. Simmons.

54. After considering all of the evidence, it is concluded that DHHS management did not learn of Petitioner's conduct until at least November 2013. As a result, DHHS management could have reasonably believed that Petitioner's conduct during the Boykin autopsy amounted to a "current" incident of unacceptable personal conduct when they recommended his dismissal in December 2013. Thus, Respondent did articulate a lawful reason for recommending dismissal.

C. Pretext

55. Because Respondent has articulated a lawful reason for recommending Petitioner's dismissal, Petitioner bears the burden of showing that Respondent's proffered explanation "was not the true reason for the employment decision." *Tex. Dep't of Comm. Affairs v. Burdine*, 450 U.S. 248, 256 (1981). This burden "merges with the ultimate burden of persuading the court that [he] has been the victim of intentional discrimination. [He] may succeed in this either directly by persuading the court that a discriminatory reason more likely motivated the employer or indirectly by showing that the employer's proffered explanation is unworthy of credence." *Id.* "[A] plaintiff's prima facie case, combined with sufficient evidence to find that the employer's asserted justification is false, may permit the trier of fact to conclude that the employer unlawfully discriminated." *Reeves v. Sanderson Plumbing Prods., Inc*., 530 U.S. 133, 148 (2000).

56. In sum, after considering all of the evidence, it is concluded that Petitioner voluntarily resigned/retired and he has failed to convince me that DHHS management decided to fire him because he raised concerns about Dr. Nichols. Petitioner did not convince me that the reasons stated in the predisciplinary letter were not the real reasons for DHHS management's decision. Top managers at the DHHS were just addressing matters following their investigation.

BASED UPON the foregoing Findings of Fact and Conclusions of Law, the undersigned renders the following:

FINAL DECISION

The Petitioner is not entitled to any relief from Respondent.

NOTICE

Pursuant to N. C. Gen. Stat. 126-34.02, any party wishing to appeal this Final Decision may commence such by appealing to the North Carolina Court of Appeals as provided in N. C. Gen. Stat. 7A-29(a). The party seeking such review must file such appeal within thirty (30) days after receiving a written copy of this Final Decision.

This the 12th day of March, 2015.

_____
Fred Gilbert Morrison Jr.
Senior Administrative Law Judge