STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

PROVIDENCE, SC. **SUPERIOR COURT**

(FILED: December 22, 2014)

LEO BLAIS, RPH	:	
	:	
v.	:	**C.A. No. PC-2012-5791**
	:	
RHODE ISLAND DEPARTMENT OF HEALTH and MICHAEL FINE, M.D. in his capacity as the Director of Health of the Rhode Island Department of Health	:	

DECISION

NUGENT, J. Appellant Leo Blais, R.Ph (hereinafter Appellant or Mr. Blais) appeals the June 17, 2013 decision of Director Michael Fine, M.D. (Director Fine) of the Rhode Island Department of Health, revoking Mr. Blais's license to practice pharmacy in the State of Rhode Island. Jurisdiction in the instant matter is pursuant to G.L. 1956 § 42-35-15.

I

Facts and Travel

On March 14, 2012, Dr. Patrick Kelly (Dr. Kelly), the Chief of Compliance and Regulatory for the State Board of Pharmacy (the Board) (Tr. 2, Nov. 20, 2012), received a call from a mother seeking to file a complaint against Apothecare Pharmacy (Apothecare) for a dispensing error. Id. at 18. The prescription she had received from Apothecare and had given to her child "was labeled to contain Omeprazole, the [generic name] for Prilosec, which is a stomach medication for acid reflux." Id. at 20. However, when she took her child to the hospital, concerned about the baby's recent lethargy, the hospital discovered that the baby's

heartburn medicine contained morphine. Id. at 19-20. Morphine does not belong in Omeprazole. Id. at 20.

After speaking with the girl's mother, Dr. Kelly took the drug that was given to the baby and sent it to the State Toxicology Lab for additional testing. Id. at 21. The result confirmed the fact that the medicine labeled as Omeprazole did contain morphine. Id.; Rhode Island Forensic Science Laboratory Report dated Mar. 22, 2012. Upon obtaining these results, Dr. Kelly's next step was to perform a full inspection of Apothecare in search of what may have caused such an error. (Tr. 35, Nov. 20, 2012.)

Apothecare is "predominantly [a] compounding shop, which means that better than 90 percent of what [it] dispense[s] on a daily basis is made by [the pharmacy] from a combination of bases, active ingredients, [and] raw materials, [which in turn are] custom formulated for a patient." (Tr. 9, Dec. 6, 2012.) Apothecare serves a clientele of "people who have more involved medical cases or . . . have conditions that are not treatable by commercially available drugs or [are in] hospice." Id. at 24. In this case, liquid omeprazole had to be compounded because the child could not swallow pills. Mr. Blais, pharmacist in charge of Apothecare, has been a pharmacist for thirty-three years. Id. at 3. Mr. Blais was President of the Rhode Island Pharmacists Association. Id. at 4. Additionally, Mr. Blais served as a member of the Rhode Island Senate for eighteen years and on the Department of Health Board of Pharmacy for twelve years. At his hearing, Mr. Blais speculated that he had filled close to two million prescriptions, having "received an award from Roche Laboratories . . . in the late 90s for doing a million prescriptions." Id. at 6.

In his role as Chief of Compliance, Dr. Kelly conducts routine inspections as well as "investigat[ions of] complaints of alleged violations or misconduct by pharmacists or

pharmacies[.]" (Tr. 11, Nov. 20, 2012.) In his tenure with the Board, he has conducted hundreds of such inspections. Id. at 76. He informed the hearing officer, Catherine Warren (Hearing Officer Warren), that he would begin these investigations by speaking to the pharmacist in charge, "who is responsible for the overall conduct and operation of the pharmacy . . . [including the actions of] staff pharmac[ists] or technicians or interns[.]" Id. at 14. Dr. Kelly noted that a pharmacy subject to a routine inspection, typically

> "would be in accordance [with applicable regulations], generally drug stock would be organized based either upon some kind of alphabetical system or indication. Everything -- the compounding benches organized, adequate space to effectively discharge duties; records are in order, meaning that they're thorough, complete and available for inspection, and that the pharmacy is clean and led in an organized manner." Id. at 16.

When investigating Apothecare, Dr. Kelly noted that,

> "[t]he pharmacy had -- it looked like card tables set up around the perimeter of the room and in the center of the room. On the side of the room, the tables were held up with cinder blocks. The compounding area on the center table was cluttered. . . . It was disorganized, where you had compound ingredients, papers, what looked to be labels. On the floor of the room, there were multiple totes containing various drugs stored on the floor. There were even some loose tablets underneath the tables, and the stock itself was -- the chemicals were stacked on top of each other. There didn't really appear to be any markers separating off one drug from another drug, meaning [a]isles or shelf tags. Everything was on the shelf in, like, a stacked manner." Id. at 49-51.

Ms. Catherine Cordy (Ms. Cordy), Executive Director of the Pharmacy Board, conducted the investigation of Apothecare with Dr. Kelly. (Tr. 11, Nov. 28, 2012.) She testified that, like Dr. Kelly, she had conducted hundreds of pharmacy inspections in Rhode Island. Id. at 6. Her testimony corroborated Dr. Kelly's assertions regarding the disorder within Mr. Blais's pharmacy. She stated that "there was really no organized pattern for where the drugs were located" and that everything was "very cluttered and disorganized." Id. at 20-21. She also noted

that "medications [were] haphazardly placed on the shelves, piled on top of one another." Id. at 125. Dr. Kelly noted that "[w]hen [a pharmacist] store[s] [drugs] next to each other that maybe look alike, based upon either the container or sound alike based upon the name, stored adjacent to each other and also when the ingredients themselves can similarly look the same, [there exists a definite] concern of . . . a mix-up or switch." (Tr. 53, Nov. 20, 2012)

Mr. Blais testified that the adulterated omeprazole was the result of this disorder at the compounding station. (Tr. 12-14, Dec. 6, 2012.) A "bottle of morphine concentrate, which is a 20 milligram per [milliliter] stock solution used for hospice patients was [likely] left out on the counter and hadn't been returned to stock[.]" Id. at 12-13. Mr. Blais admitted that the morphine and flavored sweetening syrups "were in identical bottles[.]" Id. at 13. He noted that one "wouldn't see the difference in the color, because the morphine solution is red [and] [t]he flavoring solution is a reddish orange[.]" Id. at 14. Mr. Blais commented that part of the problem behind the error was that the pharmacy was "not quarantining inactives and active ingredients." Id. at 13. As such, Mr. Blais testified that a "bottle of morphine was grabbed instead of the bottle of [flavoring] solution . . . [and was] mixed into the stock bottle, shaken up and dispensed." Id.

Upon investigation, Dr. Kelly learned of another child who had received the adulterated drug. (Tr. 39, Nov. 20, 2012.) The child's caretaker informed Dr. Kelly that the boy had become "more tired or lethargic than typical" as a result of taking the drug. Id. at 40. Dr. Kelly confiscated this batch of omeprazole as well as drugs which had expired or had no expiration date. Id. at 59.

In 1999, Mr. Blais was disciplined for a dispensing error. (Tr. 32-33, Nov. 28, 2012.) This dispensing error occurred when Mr. Blais filled a prescription for Haldol, an anti-psychotic

drug, with 5 mg tablets instead of .5 mg tablets as per the written order. Id. at 72; Department of Health Board of Pharmacy v. Leo Blais, Consent Order at 1, Jan. 12, 1999. Fortunately, that mislabeled drug was caught in time by the patient's caretaker and not dispensed. (Tr. 7, Dec. 6, 2012.) For this violation, Mr. Blais entered into a Consent Order providing for a license suspension of six months stayed and an eighteen-month period of probation. Tr. 34-39, Nov. 28, 2012; Second Amended Consent Order, Mar. 16, 2000. Mr. Blais was placed back in good standing with the Board in 2000. (Tr. 39, Nov. 28, 2012.)

At the hearing, Mr. Blais explained that filling the prescription with the incorrect dosage of Haldol was caused by a computer program malfunction that was promptly remedied after the incident. (Tr. 7, Dec. 6, 2012). Additionally, Mr. Blais spoke in detail of the procedures he implemented to safeguard against another mix-up during compounding. Id. at 17-20. With regard to the misbranded drugs, Ms. Cordy noted there was no indication that any expired drug was dispensed. (Tr. 120, Nov. 28, 2012.) Additionally, she explained that the only danger of using an expired drug is that there is "no guarantee that that medication is efficacious" and may be "subpotent[.]" Id. at 17. Mr. Blais noted that the disorder observed by Ms. Cordy and Dr. Kelly at the pharmacy was due to the fact that the investigation occurred on "[o]ne of the busiest days" of the week, (Tr. 21, Dec. 6, 2012), when the pharmacy becomes inundated with orders "awaiting check, packaging and shipping[.]" Id. at 23. He noted that it is critical that the Apothecare's especially vulnerable patients receive their medicine in a timely fashion, especially after the weekend when the pharmacy is closed. Id. at 21-24. As a result, the clutter observed by the investigators was caused by the large number of orders being processed at the time. Id. at 23.

On March 23, 2012, Director Fine issued a summary suspension of Mr. Blais's license to practice pharmacy in accordance with § 42-35-14(c). This summary suspension was the first and

only suspension in the history of Rhode Island's pharmacy licensing regulations for a dispensing error. Subsequently, Mr. Blais and the Board entered into a Consent Order, agreeing to a one-year suspension dating back to the issuance of the summary suspension and a subsequent one-year suspension, stayed pending probation. (Drafted Consent Order, Mar. 22, 2013.) Director Fine rejected this Consent Order.

Nine months later, the Board delegated its authority to hear Mr. Blais's appeal to an administrative hearing officer[1] who held hearings to gather evidence and issue a judgment regarding Mr. Blais's alleged violations. At that hearing, Hearing Officer Warren heard testimony from Dr. Kelly, Ms. Cordy, and Mr. Blais. (Tr. Nov. 20, Nov. 28, and Dec. 6, 2012.) In a carefully crafted, twenty-nine-page decision, Hearing Officer Warren found that:

> "[(1)] The Respondent violated R.I. Gen. Laws. § 5.19.1-21(8)[2] by violating R.I. Gen. Laws § 21-31-3(1)[3] (the drug was labeled Omenparzole [sic] but contained morphine which it should not) and R.I. Gen. Laws § 2[1]-31-15(1)[4] (the drug was labeled Omenparzole [sic] but contained morphine which it should not).
> "[2] [Section 13.4 of Rhode Island pharmacy regulations][5] requires that a pharmacy shall be kept in a 'clean, sanitary and orderly' manner. . . . [T]otes containing drugs on the floor cannot be considered orderly or sanitary. Thus, there was a violation of Section 13.4.

[1] As per its statutory authority, the Board may, in its discretion, have an administrative hearing officer conduct a hearing "for the revocation or suspension of licenses[.]" G.L. 1956 § 5-19.1-5(4). Such was the case here.

[2] "The licensee has violated or permitted the violation of any provision of any state or federal law, rule or regulation governing the possession, use, distribution or dispensing of drugs, including, but not limited to, the violation of any provision of this chapter, chapter 28 of title 21, chapter 31 of title 21, or rule or regulation of the board[.]" Sec. 5-19.1-21(8).

[3] "The following acts and the causing of those acts within the state of Rhode Island are prohibited: (1) The manufacture, sale, or delivery, or holding or offering for sale of any food, drug, device, or cosmetic that is adulterated or misbranded." G.L. 1956 § 21-31-3(1).

[4] "A drug or device shall be deemed to be misbranded: (1) If its labeling is false or misleading in any way." Sec. 21-31-15(1).

[5] Section 13.4 states in relevant part, "The pharmacy shall be . . . kept in a clean, sanitary and orderly manner." R.I. Admin. Code 14-130-001:13.4.

> "[3] [D]rugs without expiration dates are mislabeled under Section 13.3.1[6] so they should have been segregated. Those drugs . . . should not have been on the shelves. Thus, under Section 13.3.1, the compounded drugs without expiration dates are mislabeled and should have been segregated. The failure to do so is a violation of the Regulation." (Hearing Officer Decision at 15-18.)

Based upon these violations, Hearing Officer Warren recommended the imposition of a thirty-month license suspension—fifteen months active and the remainder stayed—with a two-year probationary period and continuing education classes. (Hearing Officer Decision at 26-27.)

In his decision, Director Fine cited the same criteria used by Hearing Officer Warren in determining the proper degree of sanctions and accepted her findings of fact and conclusions of law. (Final Decision at 2-3.) However, Director Fine found that Hearing Officer Warren erred by failing to make any finding "with respect to the potential danger morphine poses to a baby or infant child." Id. at 4. He described this danger as "axiomatic." Id. Director Fine found Mr. Blais's "lengthy explanations of newly installed safety measures [to not be] persuasive." Id. Rather, he noted that Mr. Blais had many chances to improve the organization and procedural infrastructure of his pharmacies; his repeated failure to do so led "a baby and infant child [to] improperly consume[] morphine as a result." Id. Director Fine revoked Mr. Blais's pharmacy license. Id. This license revocation was remarkable in that it was the only one in the history of Rhode Island pharmacy regulation for a dispensing error.

In response to this decision, Mr. Blais timely filed an Amended Verified Complaint on July 16, 2013, appealing Director Fine's decision to revoke his license. Mr. Blais asserts that Director Fine failed to accord the requisite deference to the findings set forth by Hearing Officer Warren and imposed sanctions in excess of his statutory authority. Furthermore, Appellant

[6] Section 13.3.1 states in relevant part, "Any outdated, unusable, or mislabeled medication or products shall be segregated to ensure that no such medications or products are dispensed." R.I. Admin. Code 14-130-001:13.3.1.

argues that Director Fine's decision is clearly erroneous in view of the entire record and constitutes an abuse of discretion. Mr. Blais also contends that the decision was made in violation of constitutional provisions; namely, that the extent of sanctions imposed represents selective enforcement under the Equal Protection Clause of the Fourteenth Amendment and that his license was stripped away in violation of procedural and substantive due process guarantees. Both parties presented oral argument on this matter on November 25, 2014.

II

Standard of Review

This Court "sits as an appellate court with a limited scope of review" when reviewing decisions by administrative agencies such as the Department of Health. Mine Safety Appliances Co. v. Berry, 620 A.2d 1255, 1259 (R.I. 1993). It may reverse, modify, or remand an agency's decision only if the

> "substantial rights of the appellant have been prejudiced because the administrative findings, inferences, conclusions, or decisions are:
> "(1) In violation of constitutional or statutory provisions;
> "(2) In excess of the statutory authority of the agency;
> "(3) Made upon unlawful procedure;
> "(4) Affected by other error or law;
> "(5) Clearly erroneous in view of the reliable, probative, and substantial evidence on the whole record; or
> "(6) Arbitrary or capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion." Sec. 42-35-15(g).

"[E]ven in a case in which the [Superior C]ourt might be inclined to view the evidence differently and draw inferences different from those of the agency[,] [it] may not, on questions of fact, substitute its judgment for that of the agency whose action is under review[.]" Johnston Ambulatory Surgical Assocs., Ltd. v. Nolan, 755 A.2d 799, 805 (R.I. 2000) (internal citations omitted). Indeed, standing in its appellate role, this Court is "limited to an examination of the

record to determine whether 'some' or 'any' legally competent evidence exists to support" the agency decision. Mine Safety, 620 A.2d at 1259 (citing Sartor v. Coastal Res. Mgmt. Council, 542 A.2d 1077, 1082-83 (R.I. 1988)); see also Arnold v. R.I. Dep't of Labor and Training Bd. of Review, 822 A.2d 164, 167 (R.I. 2003) (holding that legally competent evidence is "relevant evidence that a reasonable mind might accept as adequate to support a conclusion, and means an amount more than a scintilla but less than a preponderance") (internal citations omitted.) As such, this Court may not reverse a decision unless it is "totally devoid of competent evidentiary support in the record," Bunch v. Bd. of Review, R.I. Dep't of Emp't & Training, 690 A.2d 335, 337 (R.I. 1997) (internal citations omitted), or any reasonable inferences that can be drawn from the record. Guarino v. Dep't of Soc. Welfare, 122 R.I. 583, 588, 410 A.2d 425, 428 (1980).

With regard to questions of law, this Court conducts its review de novo. Arnold, 822 A.2d at 167. However, this Court must afford an agency "great deference in interpreting a statute whose administration and enforcement have been entrusted to the agency." Town of Richmond v. R.I. Dep't of Envtl. Mgmt., 941 A.2d 151, 157 (R.I. 2008) (internal citations omitted).

III

Discussion

Appellant contends that Director Fine acted in excess of his statutory authority when he revoked Appellant's license to practice pharmacy in the State of Rhode Island because he did not give proper deference to Hearing Officer Warren as required by the statutory mandate of § 5-19.1 and the Rhode Island Supreme Court's holding in Environmental Scientific Corp. v. Durfee, 621 A.2d 200 (R.I. 1993). Specifically, he asserts that Director Fine failed to accord proper

deference in rejecting Hearing Officer Warren's recommendation as to the appropriate sanction after accepting her findings of fact and conclusions of law.

A director of the Department of Health must afford deference to the findings of a hearing officer under a two-tiered system of review as described in Environmental Scientific, 621 A.2d 200. This case held that a hearing officer,

> "[s]itting as if at the mouth of [a] funnel, . . . hears testimonial and documentary evidence from [the] affected parties[.] . . . Just as the funnel narrows, the hearing officer analyzes the evidence, opinions, and concerns of which he or she has been made aware and issues a decision. At the discharge end of the funnel, the [Department of Health] director reviews the hearing officer's findings and issues a final decision. Because the director sits at the narrowest point of the funnel, he or she is not privileged personally to hear or witness the broad spectrum of information that entered the widest end of the funnel. Therefore, the further away from the mouth of the funnel that an administrative official is when he or she evaluates the adjudicative process, the more deference should be owed to the factfinder." 621 A.2d at 207-08.

Simply put, where a hearing officer is able to examine evidence and live testimony first-hand, the law accords more weight to his or her findings than to a reviewing administrative official who does not hear such testimonial evidence. Indeed, this Court "cannot overlook the body of law that elevates the factfinder's role when credibility is in issue." Id. at 209. In such a case, a "director should give great deference to the hearing officer's findings and conclusions unless clearly wrong." Id. (emphasis added).

Environmental Scientific construes the two-tiered system of review such that a director must "ground [his or her] rejection of the hearing officer's findings upon an adequate rationale." Id. at 208. Such an adequate rationale is one that "relies on a previously articulated standard and is supported by substantial evidence in the record." Id. at 209-10. The director's "rationale must

be substantiated by more than mere philosophical differences with the hearing officer." Id. at 209.

Here, Director Fine cited the same standard as Hearing Officer Warren to determine the proper degree of sanctions, that of the four-part test set forth by the Rhode Island Superior Court in Jake and Ella's, Inc. v. Dep't of Bus. Reg., No. NC-01-461, 2002 WL 977812 (R.I. Super. Apr. 22, 2002). This test looks to "the number and frequency of the violations, the real and/or potential danger to the public posed by the violation, the nature of any violations and sanctions previously imposed, and any other facts deemed relevant in fashioning an effective and appropriate sanction." Jake & Ella's, 2002 WL 977812, at *6.

However, Director Fine erred in the application of this test. With regard to the imposition of sanctions, Director Fine "cavalierly shunted aside the hearing officer's conclusions without regard for h[er] factfinding." Envtl. Scientific, 621 A.2d at 209. In imposing the ultimate sanction, Director Fine perceived some inadequacy of Hearing Officer Warren's findings with regard to the danger to the public posed by the violation. See Final Decision at 4 (stating "[Hearing Officer] Warren did not make a finding with respect to the potential danger morphine poses to a baby or infant child[]"). However, the record reflects that Hearing Officer Warren did consider the danger of the dispensing error—stating that the "error caused two (2) infants to receive medicine that erroneously contained morphine[,]" (Hearing Officer Decision at 25), and that Mr. Blais "never disputed that there was a serious dispensing error and never thought it was minor as demonstrated by the immediate action taken to ensure there was never a repeat of the error." Id. at 15. Director Fine himself described the danger morphine poses as "axiomatic." Final Decision at 4; see also Merriam-Webster Online Dictionary (retrieved on Dec. 12, 2014 from http://www.merriam-webster.com/dictionary/axiomatic) (defining axiomatic

as "taken for granted: **self-evident**") (emphasis in original). Hearing Officer Warren's failure to explicitly state the self-evident does not mark her decision as "clearly wrong." Envtl. Scientific, 621 A.2d at 209. Rather, Director Fine's "mere philosophical differences" as to the proper discipline in the wake of such an incident served as the fulcrum upon which he uprooted Hearing Officer Warren's well-grounded sanction, in direct contravention of Environmental Scientific. Id. at 209-10 (holding that a director's rejection of a hearing officer's decision must be based on an adequate rationale supported by record evidence).

Additionally, Hearing Officer Warren noted that at least since 1980, the Board has never suspended a pharmacist for a dispensing error. (Hearing Officer Decision at 24.) Rather, only three occasions—including the Consent Order reached with Mr. Blais in 1999—can be found when the Board went so far as to stay a license suspension pending probation. Id. As such, Hearing Officer Warren sought to impose a sanction commensurate with past discipline and the severity of the violations. See Hearing Officer Decision at 25 (noting that "the sanctions imposed need to address [Mr. Blais's] violations in context of . . . [the Board's] disciplinary history"). In contrast, Director Fine, for the first time in Rhode Island's history, revoked a pharmacist's license for a dispensing error. See Collins v. S.E.C., 736 F.3d 521, 526 (D.C. Cir. 2013) (requiring "consideration of whether the sanction is out of line with the agency's decisions in other cases"). The Department of Health does not allow a pharmacist whose license has been revoked to reapply after a given period of time.

As Ms. Cordy noted, pharmacists cannot be held to a standard of perfection. (Tr. 129-30, Nov. 28, 2012.) Dispensing errors do occur and are expected to be a part of the learning process for a pharmacist. Id. at 130. Mr. Blais has been an upstanding member of the pharmacy community for over three decades. He served as president of the Rhode Island Pharmacists

Association at the time of the hearing and acted as editor of the State Pharmacy Journal for several years. (Tr. 4, Dec. 6, 2012.) Mr. Blais has served on the Board of Pharmacy for the Department of Health for twelve years. Id. The record does not evidence any unwillingness on the part of Mr. Blais to reform his policies at the pharmacy or that this dispensing error was willful. See Ferguson v. U.S. Dep't of Agric., 911 F.2d 1273, 1279 (8th Cir. 1990) (holding that "the distinction between intentional and unintentional conduct is absolutely relevant to the severity of the sanction").

Rather, the record supports Hearing Officer Warren's credibility determination that Mr. Blais took the dispensing error at issue here very seriously and sought to rectify it "[i]mmediately," stating that "there is no excuse" for such a mix-up. (Tr. 18, Dec. 6, 2012.) After the incident, Mr. Blais created a more stringent protocol such that "everything in th[e] batch [for compounding a certain drug] is now quarantined from start to finish[.]" Id. Similarly, with respect to the past dispensing error of Haldol, he promptly sought to fix the computer malfunction causing the miscalculation, and the record supports the assertion that he has not had an analogous error since. Id. at 8-9. Director Fine did not identify any record evidence disputing this implementation of remedial measures. See Envtl. Scientific, 621 A.2d at 207 (holding that a director may only reverse a hearing officer's findings if "there is other, competent evidence in the record to support [such a] conclusion"). Additionally, the expired drugs that were seized by the Department of Health posed no danger to the public health. (Tr. 17, Nov. 28, 2012.) Furthermore, the disorder at the pharmacy resulted from the fact that the investigation occurred on "[o]ne of the busiest days" where the pharmacy becomes inundated with orders "awaiting check, packaging and shipping[.]" (Tr. 21, 23, Dec. 6, 2012.)

Hearing Officer Warren found that Mr. Blais "credibly testified that the 1999 Haldol error was caught and the drug was not dispensed and he reviewed the procedures and discovered the computer had not picked up 'the point' before the five (.5) so the pharmacy contacted the software company [to remedy the problem.]" (Hearing Officer Decision at 20-21) (emphasis added). Additionally, she found that he "credibly testified that Apothecare was able to establish the cause of the [morphine dispensing] error and implemented procedures to avoid such an error in [the] future." Id. at 25 (emphasis added); see Envtl. Scientific, 621 A.2d at 207 (holding that the hearing officer is "an indispensable element of administrative procedure" as factfinder and instructing that this Court "would be remiss if [it] permitted the scope of a hearing officer's role to diminish in light of the function he or she serves in administrative problem solving"). This implementation of corrective measures led Hearing Officer Warren to hold that "there was no evidence that [Mr. Blais] was deficient in many or most areas of the practice of pharmacy." (Hearing Officer Decision at 26.) It is precisely these credibility determinations to which Director Fine must afford due deference. See Envtl. Scientific, 621 A.2d at 208 (requiring deference on the part of a "director sit[ting] at the narrowest point of the funnel, . . . [who] is not privileged personally to hear or witness the broad spectrum of information" encountered by a hearing officer). He cannot simply find—without pointing to evidence in the record to the contrary—Mr. Blais's "lengthy explanations of newly installed safety measures" unpersuasive, (Final Decision at 4), when Hearing Officer Warren, having "the opportunity to weigh the live testimony[,]" made a contrary determination. Envtl. Scientific, 621 A.2d at 207; see id. at 209 (noting "the body of law that elevates the factfinder's role when credibility is in issue"). Accordingly, Director Fine acted in excess of his statutory authority and abused his discretion in revoking Mr. Blais's license to practice pharmacy.

Furthermore, there is no "substantial evidence in the record" for the director to have rejected the findings of Hearing Officer Warren. Envtl. Scientific, 621 A.2d at 210. Accordingly, this Court modifies the agency's decision to impose a fifteen-month suspension and fifteen-month suspension stayed pending two year's probation with continuing education classes as determined by Hearing Officer Warren.

IV

Conclusion

After review of the entire record and consideration of oral argument, this Court concludes that Director Fine's decision was made in excess of his statutory authority and constituted an abuse of discretion. Accordingly, this Court need not and will not discuss Appellant's additional arguments. Substantial rights of Mr. Blais have been prejudiced. As it has been approximately thirty-three months since Mr. Blais's license was summarily suspended, Mr. Blais's license will be immediately reinstated, and the two-year probationary period with continuing education classes shall commence forthwith. See Sakonnet Rogers, Inc. v. Coastal Res. Mgmt. Council, 536 A.2d 893, 897 (R.I. 1988) ("To delay the administrative process further by remanding the case . . . would prejudice the right of the petitioner to a final adjudication of his petition within a reasonable period."); Ratcliffe v. Coastal Res. Mgmt. Council, 584 A.2d 1107, 1111 (R.I. 1991) (similarly declining to remand). Counsel shall submit the appropriate judgment for entry.

RHODE ISLAND SUPERIOR COURT

Decision Addendum Sheet

TITLE OF CASE:	**Leo Blais, R.Ph v. Rhode Island Department of Health, et al.**
CASE NO:	**PC-2012-5791**
COURT:	**Providence County Superior Court**
DATE DECISION FILED:	**December 22, 2014**
JUSTICE/MAGISTRATE:	**Nugent, J.**
ATTORNEYS:	
For Plaintiff:	**Michael A. Kelly, Esq.** **Jackson C. Parmenter, Esq.**
For Defendant:	**Adam J. Sholes, Esq.** **Thomas J. Corrigan, Jr., Esq.**