# DEPARTMENT OF HEALTH AND HUMAN SERVICES
## *OFFICE OF DIRECTOR*

# ACTION REFERRAL

| TO | DATE |
|---|---|
| Wells | 8-29-06 |

| DIRECTOR'S USE ONLY | ACTION REQUESTED |
|---|---|
| 1. LOG NUMBER | [ ] Prepare reply for the Director's signature |
|  | DATE DUE _____ |
| 2. DATE SIGNED BY DIRECTOR  0C0191 | [X] Prepare reply for appropriate signature |
|  | DATE DUE  9-8-06 |
|  | [ ] FOIA |
|  | DATE DUE _____ |
|  | [ ] Necessary Action |

| APPROVALS (Only when prepared for director's signature) | APPROVE | * DISAPPROVE (Note reason for disapproval and return to preparer.) | COMMENT |
|---|---|---|---|
| 1. |  |  |  |
| 2. |  |  |  |
| 3. |  |  |  |
| 4. |  |  |  |

# STATE OF SOUTH CAROLINA
## State Budget and Control Board
### GENERAL SERVICES DIVISION

M. RICHBOURG ROBERSON
DIRECTOR

STATE FLEET MANAGEMENT
140 STONERIDGE DRIVE, SUITE 650
COLUMBIA, SC 29210
(803) 737-0668
FAX (803) 737-1160

WARREN J. MCCORMACK
STATE FLEET MANAGER

August 25, 2006

RECEIVED

AUG 2 9 2006

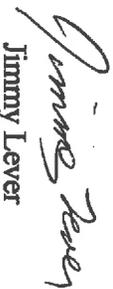Department of Health & Human Services
OFFICE OF THE DIRECTOR

Mr. Robert Kerr
SC Department of Health
& Human Services
1801 Main Street
Columbia, South Carolina 29201

Dear Mr. Kerr:

On August 23, 2006 the Inter-Agency Accident Review Board reviewed vehicle accident/accidents involving your agency. The enclosed memorandum describes the Accident Review Board's findings, and, if appropriate, recommended corrective actions.

I appreciate your prompt attention to this matter.

Respectfully,

Jimmy Lever
Chair, Inter-Agency Accident Review Board

JL/bks

Enclosure(s)

cc: file

**GENERAL SERVICES DIVISION – STATE FLEET MANAGEMENT**
140 STONERIDGE DRIVE, SUITE 650
COLUMBIA, SOUTH CAROLINA 29210-8257

## VEHICLE ACCIDENT REVIEW BOARD DETERMINATION

Memorandum to: <u>Mr. Robert Kerr</u>     Date: <u>August 25, 2006</u>

RE: Employee: <u>JOHNSON, ERNESTINE, SG384</u> Accident <u>Log #3401</u>   Acc. Date <u>4/11/2006</u>
The State Fleet Management Accident Review Board has:

[ ]  Found the above employee **not at fault** in referenced accident.
[X]  Found the above employee **at fault** in referenced accident.
[ ]  Reviewed the Driving Record of the above employee.

### BASED ON THE FLEET SAFETY PROGRAM GUIDELINES THE ARB RECOMMENDS THE FOLLOWING CORRECTIVE ACTIONS:

[ ]  Verbal counseling concerning responsibilities while driving State vehicles.

[X]  Written counseling and eight hour Defensive Driving Course (DDC)* within 90 days of the date of this memorandum.    Failure to attend DDC within 90 days requires suspension of driving privileges until requirement has been met.

[ ]  Review of driving privileges by Agency Director.

[ ]  Three months to 1 year suspension of State vehicle driving privileges.

[ ]  One year to permanent suspension of State vehicle driving privileges. Length: _____
     Length of suspension: _____

[ ]  Driver suspended from operating State vehicles until suspension is lifted by Accident Review board.

[ ]  Driver not wearing seatbelt at the time accident occurred. The State Fleet Safety Program requires that the employee be issued a written reprimand concerning this failure to comply with State policy.

[X]  Assess your agency in the amount of $ <u>$0.00</u>      as provided for in Section I-II-341341 of the Motor Vehicle Management Act.   It is your option to absorb this assessment in your agency's budget or to recover it from the employee.   Unless we hear differently from you within 15 days, you will receive an invoice for the amount shown.   **COMMENTS:**

\*Contact Betty Pearce, DDC Trainer at SFM phone no. (803) 737-1515 for schedule.
**Contact Jimmy Lever at Jlever@gs.sc.gov for information on a Van Driver Safety Course.**
If you agree with the above determination, please take the necessary corrective action then complete and return a copy of this form to me by   <u>September 11, 2006</u>
Action(s) Taken: _____

_(signature)_
**WARREN J. MCCORMACK, STATE FLEET MANAGER**

Date Action(s) Taken: _____