Lincoln-Lancaster County Health Department

In the matter of Edison Tattoo and Body Piercing LLC

Jennifer McRae, for Edison Tattoo and Body Piercing

EDISON'S CLOSING STATEMENT, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

A hearing was convened on Wednesday, March 4, 2026 at the Lincoln-Lancaster Public Health Building. Rick Tast and Nicholas Bussey represented the City of Lincoln. County Attorney Morgan Sanchez was the hearing officer. Jennifer McRae represented Edison. Leighton Fortner, Sharisa Fortner, and Fernando Alcazar were present on behalf of Edison. Testimony was elicited from Angela Elliot, Brock Hanisch and Leighton Fortner. Exhibits 1-15 were received into evidence. Exhibit 11 was redacted, with photographs 20, 21, and 22 being withdrawn from submission due to personal reporting information being present on the photographs.

CLOSING STATEMENT

Edison Tattoo and Body Piercing ("Edison") was shut down and its permit was temporarily suspended by order of the Lincon-Lancaster Health Director on Thursday, February 26, 2026, based on one ear, nose, and throat physician who happen to see five different patients and two different facilities that all claimed they had received piercings from Edison within the month of February. Two of those patients provided Public Health with bottles of aftercare solution supposedly received from Edison. At the time the Health Director ordered Edison to shut down, no testing had been completed nor were results provided to Edison that any contaminant, let alone pseudomonas aeruginosa ("PA"), had been discovered at Edison or that the source of the potential contamination was from any particular practice, protocol, or failure to abide by any particular regulation in the Lincoln Municipal Code ("LMC") or Nebraska State Statute by Edison. A preliminary sample of the aftercare solution made by Edison was obtained by Environmental Health earlier in the day on Thursday, February 26th, but no results were provided to Edison when Public Health returned at close of business between 6:30-7 p.m. that same day. It was not until the hearing on March 4th that the results of the findings from swabs taken from various items of equipment at Edison, the two samples taken from the aftercare solution provided by patients, and the sample of aftercare

solution obtained earlier on Thursday, February 26 was provided to Edison and its counsel. The results of the swab testing showed that the two samples received from patients along with a filing station nozzle and tank from Edison each tested positive for PA. Notably, the bottle of aftercare solution that was obtained from Edison on Thursday, February 26, did not contain PA.

Without verification of client data from Edison to cross reference with the patients alleging infection, all this evidence, which would be inadmissible hearsay in District Court, provides is a potential and circumstantial connection between patients' aftercare solutions and one step in the process of Edison creating its aftercare solution. There was no testimony of the patients aftercare protocol. There was no testimony as to the hygiene of any of the patients alleging infection. The amount of time between piercing and infection is unknown.

PA is an incredibly common bacteria in water that takes 16-24 hours to grow. The sample of aftercare solution taken on Thursday, February 26th did not test positive by Tuesday, March 3rd. It is still unverified whether the five patients were clients of Edison, whether they each took care of their piercings as instructed or advised by Edison, whether they used the solution provided by Edison, and if they did either the follow up or use the aftercare solution, what timeframe they did either or both of those things. The absolute latest date the solution would have been provided to a client, according to the testimony of Angela Elliot, would have been on Saturday, February 14th. As Leighton Fortner testified to, clients are advised that the solution should last for one week and are instructed to return if they run out or need more. February 14th is twelve days from the supposed date of infection, potentially eleven if the patients reported symptoms on the 25th. There is no proof as to when the infected clients were pierced and when each individual's symptoms first started.

The testimony of Leighton Fortner was that the nozzle and tank where PA was discovered at Edison is not the final step in the process of making the aftercare solution, which is also evidenced in the fact that the solution obtained on February 26, 2026 did not test positive for PA. There were simply too many unknowns and variables present on February 26, most of which still existed as of March 4, to give rise to the Health Director ordering the temporary closure of Edison and suspension of its Body Art Establishment permit on February 26th. The Director had much less intrusive and disruptive means of protecting public heath, while allowing for further investigation, that did not require the immediate shut down of Edison's business. Edison respectfully requests that the Health Director reverse the decision to temporarily shut Edison down and allow for the full reopening of its facilities.

FINDINGS OF FACT

1. Five individuals reported to an undisclosed medical physician, at two different facilities, within a very short timeframe, each complaining of complications from piercings. All five alleged their piercings were performed at Edison Tattoo and Body Piercing, Gateway Mall Location, in Lincoln, within the month of February. Only two of the patient's' infections were cultured and later tested positive for pseudomonas aeruginosa ("PA").

2. On Thursday, February 26, 2026, at 12:09 p.m., these allegations were presented to Edison representative Sharisa Fortner in an inspection report authored by Bryan Hurst. The information provided was that a complaint originating from Bryan Hospital was made that 5 people had been treated for PA. All said that they were pierced at Edison in early February. A sample of the saline solution produced by Edison was then obtained for lab testing at that time. *See Exhibit 3.*

3. At no point before the return trip to Edison by Environmental Health personnel was any client information requested or obtained from Edison. At no point during the investigation were client records checked to verify that the patients with infections were clients of Edison. As of the date of the hearing on Wednesday, March 4, 2026, client information from Edison had not been cross referenced with the names of the patients. Edison is working to provide the Health Director and City Attorney with a client list from February.

4. Later, on Thursday, February 26, 2026, four Environmental Health team members returned to Edison to swab various surfaces. A pre-signed letter by the Health Director, dated February 26th, was presented to Edison at this visit, and in that letter, the Health Director determined that based on the allegations, there was a need to further investigate the potential infection transmission and that immediate control measures of suspension of Edion Tattoo and Body Piercing's Establishment Permit and closure of the store was necessary to prevent further disease transmission. *See exhibit 4.*

5. As mentioned in 2., an Inspection Report was given to Edison. However, that was the only part of the report in accordance with LMC §8.08.320.

a. No notice of conditions found were given to Edison.
b. No violations of code or Nebraska Statute were alleged.
c. No specific or reasonable period of time was given for correction of the violations.
d. No statement that failure to correct the violations within the period of time specified may result in immediate suspension or revocation of the permit, as there was no inspection that produced any violation or report of violation.
e. The only information provided in the inspection report was that "This is an ongoing investigation. There maybe further visits to collect samples or more information." *See exhibit 3.*

6. No warning was provided of any particular violation of municipal code or state statute as the reason for the determination that an immediate control measure was necessary to protect public health. No specific conditions alleged to be in violation were set forth. No specific and reasonable period of time was given for correction of such violations. No notice that failure to comply with the warning notice may result in immediate suspension or revocation of the permit. Edison's permit was temporarily suspended based on a potential causal link without notice or providing Edison the opportunity to correct any alleged violation. *See exhibit 4.*

7. Leighton Fortner emailed Rick Tast on Friday, February 27th to request that Edison's non-piercing business activities be allowed to resume as those are separate and distinct from the piercing activities that were the subject of the investigation. *See exhibit 12.*

8. A phone call on Friday, February 27, 2026 from Rick Tast stated that "LLCHD staff will provide you with a list of deficiencies that need to be addressed to bring your permit back into good standing and allow you to resume normal operations." This was after the Director made the decision to close Edison down. *See exhibit 6.*

9. A phone call on Tuesday, March 3, 2026, and a follow up letter sent via email was the notice given to Edison that a hearing would be conducted the next day, Wednesday, March 4, at 10 a.m. *See exhibit 10.*

10. The hearing was held on Wednesday, March 4, 2026. Angela Elliot testified that she received contact from a physician in the community regarding five cases of infections from piercings. Two of the patients provided samples of bottles of aftercare solution, alleged to have been given to the patients by Edison. Those two samples were cultured and tested positive for PA.

11. Ms. Elliot testified that the reporting physician did not report to her or she did not ask (1) whether the patients were given or had followed aftercare instructions, (2) whether the patients' personal hygiene was inquired into, or (3) when the samples of aftercare solution had been provided to the patients.

12. Brock Hanisch testified that as the supervisor of the disease prevention section of Lincoln-Lancaster Public Health, he was contacted by Ms. Elliot after the report of infection came to her in the Communicable Disease department. Mr. Hanisch contacted the Nebraska Department of Health and Human Services to determine the best path forward for testing of samples and swabs taken from Edison and from the patients alleging the infection.

13. Mr. Hanisch testified that the Director ordered the closure and suspension of permit of Edison before he arrived at Edison on Thursday, February 26, 2026. Mr. Hanisch advised Edison of the Director's decision upon the team's arrival at Edison.

14. Mr. Hanisch testified that Andrea was the employee who performed the swab testing of the different locations and instruments. Justin was the employee who labelled the containers of specimens. Mr. Hanisch held individual bags to contain each separate sample swab taken at Edison. Eight swabs were taken of various faucets, nozzles, and tanks, and three specimen cups of water were taken from Edison.

15. Mr. Hanisch testified on March 4th that the swabs from the filing station nozzle (#1) and filing station tank (#10) where the aftercare solution is prepared were the only locations that tested positive for PA when results came in on March 3rd. The bottle of aftercare solution that had been taken from Edison earlier in the day tested positive for a different bacterium that was not of concern for public health implications. The two samples provided by the patients also tested positive for PA.

16. It was not until after the testing was complete that Mr. Hanisch gave representatives of Edison the letter from the Health Director that directed that Edison be closed down and temporarily suspending its permit.

17. Leighton Fortner testified as to Edison's procedure of making its aftercare solution. Edison distills its own water. The distillation tank tested negative for PA. After water is distilled, it is placed into a tank, like sample #10, mixed with Epsom salts, and then pumped through the nozzle (sample #1). After the solution is pumped through the tank and nozzle, it is then autoclaved for further sterilization. After being run through an autoclave, then the aftercare solution is dispensed into individual bottles for distribution to clients. These individual bottles are prepared daily and discarded after seven days.

18. Leighton Fortner also testified that he had to relieve an apprentice from her duties at Edison for being under the influence of drugs while at Edison. That apprentice was relieved within two days of the allegations of infections tied to Edison's aftercare solution.

19. As reflected in Exhibit 12, an email from Leighton Fortner to City Attorney Rick Tast on February 27, 2026, Edison proactively removed all spray bottles and open liquid containers. Edison requested a partial recission of the temporary closure and permit suspension to allow for the non-affected parts of its business to reopen while the investigation into the piercing infection allegations continued. Mr. Fortner requested the reinspection of Edison's facilities on February 27, 2026 in that email.

20. Exhibit 14 was entered into evidence after Mr. Fortner's testimony. Exhibit 14 was a true and accurate photocopy of the aftercare instructions provided to clients of Edison.

21. Exhibit 15 was entered after the close of evidence by agreement. Exhibit 15 is an Environmental Public Health Inspection Report dated 9/3/21, given to Edison that states "LLCHD does not regulate shape of jewelry or type of aftercare solution."

CONCLUSIONS OF LAW

WRONGFUL TEMPORARY SUSPENSION OF BODY ART LICENSE

22. According to LMC §8.02.030, [I]t shall be unlawful for any person, whether they be the owner, lessee, tenant, or occupant...within the city to permit to keep, maintain, or allow to exist on any private property any of the following things, practices, or conditions which shall be hereby declared health and safety hazards:

    (10) Any other condition which is detrimental to or causes an unreasonable threat to the public health or to the environment.

23. According to LMC §8.18.060, All communicable disease reports shall at a minimum include the date and result of the test performed, the name and, when available, date of birth, gender, and address of the individual from whom the specimen was obtained, and the name and address of the health care provider for whom such examination or test was performed.

24. According to LMC §8.18.140, the Health Director may order the closure of any business for the purpose of controlling the spread of disease or for any activity related to controlling the spread of disease. In §8.08.320 the Health Director may issue a warning notice for violations that are determined to pose an immediate health risk. The notice provided to Edison stated a preliminary investigation that established a potential causal link between individuals affected with PA and the customers of Edison.

25. According to LMC §8.08.320, the Health Director shall be permitted to inspect a body art establishment at any reasonable time for the purpose of determining compliance with the provisions of the code.

26. In §8.08.320(d), the Health Director shall record the inspection findings on an inspection report. The Health Director shall furnish the original inspection report to the body are establishment operator.

27. In this instance, the Inspection Report did not record any specific findings of violation in the Report provided to Edison. It stated a potential causal connection between individuals infected and customers of Edison.

28. The Health Director had predetermined the need to further investigate the potential infection transmission, but did not provide Edison with the specific condition alleged to be in violation of any code or statute.

29. The Health Director did not afford Edison a specific or reasonable time period within which to correct the undisclosed specific alleged violation.

30. The Health Director did not provide Edison with a warning that failure to correct the violation within a specified period of time could result in the immediate suspension or revocation of its permit, because there was no warning given, no notice of specific conditions or violations, and no time period granted with which Edison could have corrected violations, had any been disclosed.

31. Neither the LMC or state statute regulate nor mandate the manufacture, disbursement, use, storage, or shelf life of aftercare solution for body piercings.

32. Based upon allegations from a communicable disease report that did not verify the veracity of the source of infection, the status of the reporting patient as a customer of Edison, or the patient's adherence to any given aftercare instructions, the Health Director temporarily shut down and suspended Edison's Body Art Establishment permit. That was not only not the least restrictive means of containing or preventing the spread of an infection, but it was the most aggressive, punitive, and negatively impactful decision against Edison possible at that time with the information available to the Health Director. The information used to shut Edison down was circumstantial and speculative at best.

Edison respectfully requests under LMC §8.08.380(d) that the decision of the Health Director temporarily closing Edison's piercing operations and suspending its Body Art Permit be reversed and Edison be allowed to resume normal operations. Edison requests the reinspection of its facilities as required in LMC §8.08.320(g) to determine Edison's compliance with LMC and whether a public health risk exists to justify the continuing shuttering and suspension of its permit.

Respectfully,
Edison Tattoo and Body Piercing, LLC

Submitted by:

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