

VIRGINIA:

BEFORE THE BOARD OF NURSING

IN RE:

**SIGRID BUTLER, R.N.
License No.: 0001-190381**

ORDER

In accordance with §§ 2.2-4019, 2.2-4021 and 54.1-2400(10) of the Code of Virginia (1950), as amended ("Code"), an informal conference was conducted on behalf of the Board of Nursing ("Board") on March 31, 2015, in Henrico County, Virginia. Ms. Butler was not present nor was she represented by legal counsel. Jane Elliott, R.N., Ph.D., serving as Agency Subordinate for the Board, submitted a Recommended Decision for consideration.

On May 20, 2015, a quorum of the Board met to receive and act upon the Recommended Decision of the Agency Subordinate. Ms. Butler was not present nor was she represented by legal counsel.

Based upon its review of the Recommended Decision of the Agency Subordinate, the Board makes the following Findings of Fact and Conclusions of Law and issues the following Order.

FINDINGS OF FACT

1. Sigrid Butler, R.N. was issued License No. 0001-190381 to practice professional nursing in Virginia on June 10, 2004. The license is scheduled to expire on October 31, 2015. Ms. Butler's primary state of residence is Virginia.
2. By letter dated February 9, 2015, the Board of Nursing sent a Notice of Informal Conference ("Notice") to Ms. Butler notifying her that an informal conference would be held on March 31, 2015. The Notice was sent by certified and first class mail to 42867 Spring Morning Court, the address of record on file with the Board of Nursing. The certified mail receipt was signed and returned to the Board. The Notice sent by first class mail was not returned to the Board. The Agency Subordinate concluded that adequate notice was provided to Ms. Butler and the informal conference proceeded in her

absence.

3. During the course of Ms. Butler's employment with Inova Fairfax Hospital, Falls Church, Virginia ("Inova Fairfax"):

a. Between March 10, 2014 and August 13, 2014, Ms. Butler diverted numerous narcotic medications from numerous patients, as evidenced by the following:

i. On March 10, 2014, Ms. Butler withdrew six Percocet 325mg tablets (oxycodone, Schedule II) for a patient who was prescribed oxycodone 325mg two tablets every four hours as needed. Ms. Butler withdrew two tablets at 16:20 and wasted them at 16:27. Ms. Butler withdrew two tablets at 16:47 and administered them at 18:26, but she did not scan the medication until 19:25. Ms. Butler withdrew two more tablets at 18:23, and she failed to document their administration or wastage. Ms. Butler also failed to document the patient's pain scale.

ii. On May 3, 2014, Ms. Butler withdrew five hydrocodone 325mg tablets (Schedule II) for a patient, who was prescribed hydrocodone 325mg one tablet every four hours as needed. Ms. Butler withdrew one tablet at 7:26, which she scanned at 7:30 and did not administer until 10:32. Ms. Butler withdrew one tablet at 10:21, which she scanned and administered at 11:42. Ms. Butler withdrew one tablet at 12:27, which she scanned at 14:45 and administered at 14:34. Ms. Butler withdrew one tablet at 13:59, which she scanned at 16:28, and failed to properly document administration or wastage. Ms. Butler withdrew one tablet at 17:56, which she scanned at 18:23 and administered at 18:24.

iii. On March 26, 2014, Ms. Butler withdrew three acetaminophen/codeine phosphate 300/30 mg tablets (Schedule III) for a patient, who was prescribed acetaminophen/codeine phosphate 300/30 mg, one tablet every four hours as needed. Ms. Butler withdrew one tablet at 8:24, which she scanned at 8:30 and administered at 10:20. Ms. Butler withdrew one tablet at 10:08, which

she scanned and administered at 10:13. Ms. Butler withdrew one tab at 10:09, and she failed to document its administration or wastage.

iv. On March 26, 2014, Ms. Butler withdrew three Percocet 325mg tablets for a patient, who was prescribed Percocet 325mg, one tablet every four hours as needed for pain. Ms. Butler withdrew one tablet at 13:15 and failed to document its administration or wastage. Ms. Butler withdrew two tablets at 16:07, which she scanned at 18:00 and administered at 17:40.

v. On March 27, 2014, Ms. Butler withdrew six Percocet 325mg tablets for a patient, who was prescribed Percocet 325mg, one tablet for every four hours as needed for pain. Ms. Butler withdrew two tablets at 11:45, which she scanned and administered at 11:49. Ms. Butler withdrew two tablets at 14:45, which she scanned and administered at 16:09. Ms. Butler withdrew two tablets at 18:14, which she scanned and administered at 18:15.

vi. On March 8, 2014, Ms. Butler withdrew eight oxycodone 10mg tablets for a patient, who was prescribed oxycodone 10mg, two tablets every six hours for pain. Ms. Butler withdrew two tablets at 8:40, which she scanned at 8:40 and administered at 9:31. Ms. Butler withdrew two tablets at 10:29, which she scanned at 13:00 and administered at 14:42. Ms. Butler withdrew two tablets at 13:25, which she scanned at 17:00 and administered at 19:26. Ms. Butler withdrew two tabs at 17:12, which she scanned at 20:26 and administered at 19:27.

vii. On April 11, 2014, Ms. Butler withdrew oxycodone 5mg/5ml twice for a patient, who was prescribed oxycodone 5mg/5ml every eight hours. Ms. Butler withdrew 5mg at 8:19, which she scanned and administered at 10:44. Ms. Butler withdrew 10mg at 10:39, of which she wasted 5mg. Ms. Butler failed to document administration or wastage of the remaining 5mg.

viii. On July 28, 2014, Ms. Butler withdrew two alprazolam .25mg tablets (Schedule IV) for a patient, who was prescribed alprazolam .25mg one tablet every eight hour as

needed. Ms. Butler withdrew one tablet at 8:55, which she scanned at 9:00 and administered at 9:45. Ms. Butler withdrew one tablet at 11:32, which she scanned at 14:00 and administered at 13:04.

ix. On July 29, 2014, Ms. Butler withdrew two alprazolam .25mg tablets for a patient, who was prescribed alprazolam .25mg one tablet every eight hour as needed. Ms. Butler withdrew one tablet at 8:50, which she scanned at 8:30 and administered at 10:14. Ms. Butler withdrew one tablet at 14:42, which she scanned at 17:00, the patient's family refused at 16:03, and Ms. Butler wasted at 19:19.

x. On July 28, 2014, Ms. Butler withdrew eight Percocet 325mg tablets for a patient, who was prescribed Percocet 325mg one tablet every four hours as needed. Ms. Butler withdrew one tablet at 8:34, which she scanned and administered at 9:21. Ms. Butler withdrew another tablet at 9:11, and she failed to document its wastage or administration. At 8:52, Ms. Butler also requested an order to change the patient's prescription for one tablet every four hours as needed to two tablets every hour as needed.

xi. On July 29, 2014, Ms. Butler withdrew six Percocet 325mg tablets for a patient, who was prescribed one tablet every four hours as needed for pain. Ms. Butler withdrew two tablets at 8:50, which she scanned at 8:30 and administered at 10:14. Ms. Butler withdrew two tablets at 12:36, which she scanned at 12:45 and administered at 15:48. Ms. Butler withdrew two tablets at 14:43, which she scanned at 17:00 and wasted at 19:18.

xii. On March 19, 2014, Ms. Butler withdrew six Percocet 325mg tablets for a patient, who was prescribed Percocet 325mg one tablet every four hours as needed. Ms. Butler withdrew one tablet at 8:34 which was scanned at 8:34 and given at 9:21. Ms. Butler withdrew another tablet at 9:11, and she failed to document its administration or wastage. Ms. Butler withdrew one tablet at 12:10, which she scanned at 12:00 and administered at 12:19. Ms. Butler withdrew one tablet

at 13:41, which she scanned at 13:00 and administered at 15:10. Ms. Butler withdrew two tablets at 15:04, which she scanned and administered at 15:10. At 21:43, Ms. Butler requested an order to change the prescription from one tablet every four hours to two tablets every four hours.

xiii. On July 4, 2014, Ms. Butler withdrew ten Percocet 325mg tablets for a patient who was prescribed Percocet 325mg two tablets every four six as needed. Ms. Butler withdrew two tablets at 9:39, which she scanned at 9:00 and administered at 13:36. Ms. Butler withdrew two tablets at 12:06, which she scanned at 13:55 and documented as refused. Ms. Butler withdrew two tablets at 13:51, which she scanned at 14:01 and administered at 15:16. Ms. Butler withdrew two tablets at 15:21, which she scanned at 19:05 and administered at 19:06. Ms. Butler canceled the administration entry after the patient refused the medication based on the patient's belief that she had already taken it. Ms. Butler failed to document any wastage. Ms. Butler withdrew two tablets at 8:00, which she scanned at 8:00. Ms. Butler documented that the patient coughed up the pills at 9:46.

b. Ms. Butler forged numerous prescriptions for narcotic medications from eight Inova Fairfax doctors and fraudulently filled those forged prescriptions at multiple pharmacies.

4. During Inova Fairfax Hospital's investigation of her diversion, Ms. Butler resigned effective immediately in an e-mail dated August 13, 2014.

5. During an interview with the investigator from the Department of Health Professions ("DHP") on October 24, 2014, Ms. Butler answered every question about the Inova Fairfax Hospital audit of her medication documentation and administration with "I don't know" or by remaining silent.

6. Ms. Butler admitted to a history of substance abuse in an e-mail to the DHP investigator dated October 25, 2014.

7. During the DHP investigation of this matter, an agent of the Virginia State Police told the DHP investigator that criminal charges against Ms. Butler were pending.

8. Ms. Butler enrolled in the Health Practitioners' Monitoring Program ("HPMP") on October 27, 2014. She tested positive for alcohol on December 26, 2014, submitted a resignation letter on February 13, 2015, and stopped calling the test line on February 16, 2015. As a result of her continued use of alcohol and resignation letter, Ms. Butler was dismissed from the HPMP on March 23, 2015.

9. By letter dated February 12, 2015, Ms. Butler advised the Board of Nursing that she wished to surrender her nursing license effective immediately.

CONCLUSIONS OF LAW

1. Findings of Fact Nos. 3(a)(i) through (xiii) and 3(b) constitute a violation of § 54.1-3007(2), (5), and (6) of the Code and 18 VAC 90-20-300(A)(2)(c) and (e) of the Regulations Governing the Practice of Nursing.

2. Finding of Fact No. 6 constitutes a violation of § 54.1-3007(6) of the Code.

ORDER

WHEREFORE, it is hereby ORDERED as follows:

1. License No. 0001-190381 of Sigrid Butler, R.N. is INDEFINITELY SUSPENDED.

2. The license will be recorded as suspended and no longer current.

3. At such time as Ms. Butler shall petition the Board for reinstatement of her license, an administrative proceeding will be convened to determine whether she is capable of resuming the safe and competent practice of professional nursing. Ms. Butler shall be responsible for any fees that may be required for the reinstatement and renewal of the license prior to issuance of the license to resume practice.

4. This suspension applies to any multistate privilege to practice professional nursing.

Pursuant to § 54.1-2400.2 of the Code, the signed original of this Order shall remain in the custody

of the Department of Health Professions as a public record, and shall be made available for public inspection and copying upon request.

Since Ms. Butler failed to appear at the informal conference, this Order shall be considered final. Ms. Butler has the right to appeal this Order directly to the appropriate Virginia circuit court. As provided by Rule 2A:2 of the Supreme Court of Virginia, Ms. Butler has thirty (30) days from the date of service (the date she actually received this decision or the date it was mailed to her, whichever occurred first) within which to appeal this decision by filing a Notice of Appeal with Jay P. Douglas, M.S.M., R.N., C.S.A.C., F.R.E., Executive Director, Board of Nursing, at Perimeter Center, 9960 Mayland Drive, Suite 300, Richmond, Virginia 23233. In the event that this decision is served by mail, three (3) days are added to that period.

FOR THE BOARD

Gloria Mitchell-Lively
for Jay P. Douglas, M.S.M., R.N., C.S.A.C., F.R.E.
Executive Director
Virginia Board of Nursing

Entered: June 10, 2015

Certified True Copy
By 
Virginia Board of Nursing