

STATE OF VERMONT
SECRETARY OF STATE
OFFICE OF PROFESSIONAL REGULATION
BOARD OF NURSING

IN RE:

RENEE LOUISE TROMBLEY
License No. 025.0008465

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)
Docket No. 2009-499

STIPULATION AND CONSENT ORDER

NOW COMES the State of Vermont, by and through State Prosecuting Attorney S. Lauren Hibbert, and the Respondent, Renee Louise Trombley, LPN, who stipulate and agree as follows:

Board Authority

1. The Vermont State Board of Nursing (the "Board") has authority to issue warnings or reprimands; suspend, revoke, limit, or condition current licenses; or prevent the renewal of lapsed licenses if, after disciplinary hearing, the Board finds that the Respondent has engaged in unprofessional conduct. 3 V.S.A. § 129(a); 3 V.S.A. § 129a; 3 V.S.A. § 814(d); 26 V.S.A. § 1582; the Administrative Rules of the Board of Nursing (the "ARBN"); and the Rules of the Office of Professional Regulation.

Stipulated Facts

2. Renee Louise Trombley (the "Respondent") of Fairfield, Vermont is licensed by the State of Vermont as a Licensed Practical Nurse under license number 025.0008465. This license was originally issued on or about February 3, 2004 and is currently set to expire on or about January 31, 2012.
3. At all times relevant, Respondent was employed as a Licensed Practical Nurse by Prison Health Services ("PHS") and was working as an LPN and Clinical Coordinator at the Northwest State Correctional Facility (the "Facility"), located in Swanton, Vermont.
4. Pursuant to the position description of Clinical Coordinator, Respondent was responsible in part for ensuring the proper flow of relevant information to correctional and health services personnel.
5. On or about October 28, 2009, the Office of Professional Regulation initiated an investigation regarding Respondent following the death of Inmate #1 at the Facility on or about August 16, 2009. Chief Medical Examiner S.S. concluded that the cause of death of Inmate #1 was "hypokalemic induced cardiac arrhythmia due to anorexia/bulimia nervosa and denial of access to medication." Respondent and her employer, PHS, dispute this conclusion.

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6. Hypokalemia is lower-than-normal potassium in the blood.
7. On or about August 12, 2009, Respondent received an email from Dr. D.B. of the Department of Corrections advising that an incoming inmate – not yet named – would be arriving at the Facility on or about August 14, 2009 “with significant eating disorder” In subsequent emails, Dr. D.B. provided further information concerning Inmate #1’s medical history.
8. On or about August 13, 2009, Respondent emailed PHS Acting Medical Director Dr. E.C. to describe Inmate #1 and to advise Dr. E.C. of Dr. D.B.’s belief that Inmate #1 should continue her current therapy. Later on the same date at , Respondent emailed Dr. E.C. to ask what medications Inmate #1 should be administered. In response, Dr. E.C. advised that Inmate #1 should remain on her current prescribed medications.
9. On or about August 13, 2009, after communicating with Dr. E.C., Respondent created a Physician’s Orders for Inmate #1, to be implemented once Inmate #1 was in custody.
10. On the morning of Friday, August 14, 2009, Respondent was scheduled to attend a meeting at the Department of Corrections. When she arrived at the Facility, she learned that one of the LPNs scheduled to work that day was absent. She attempted to cancel the meeting, and when she could not do so, she arranged for temporary nursing staff to arrive at the Facility as soon as possible. When Respondent left the Facility for the meeting, the orders remained on her desk. She did not inform other staff of the orders or the possible admission of Inmate #1 that day, or otherwise act to ensure that the orders would be processed upon Inmate #1’s admission.

Violations

11. The State contends that the act(s), omission(s), and/or circumstance(s) described above constitute grounds for discipline because the Respondent has committed unprofessional conduct in violation of:
 - a. 26 V.S.A. § 1582(a)(3) (Is unable to practice nursing competently by reason of any cause) which includes performance of unsafe or unacceptable patient care pursuant to ARBN Chapter 4, Subchapter 4, Rule II(B)(1); and failure to conform to the essential standards of acceptable and prevailing nursing practice pursuant to ARBN Chapter 4, Subchapter 4, Rule II(B)(2);
 - b. 3 V.S.A. § 129a(b)(1) and (2) (Failure to practice competently by reason of any cause on a single occasion or on multiple occasions may constitute unprofessional conduct, whether actual injury to a client, patient, or customer has occurred. Failure to practice competently includes: (1) performance of unsafe or unacceptable patient or client care; or (2) failure to conform to the essential standards of acceptable and prevailing practice); and

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c. 3 V.S.A. § 129a(a)(3) (Failing to comply with provisions of federal or state statutes or rules governing the practice of the profession).

12. Respondent disputes that the act(s), omission(s), and/or circumstance(s) described above constitute such violations.

Understandings

13. This Stipulation is neither an admission of liability by the Respondent nor a concession by the State of Vermont that its charges are not well-founded. To avoid delay, uncertainty, inconvenience, and expense of protracted litigation of the charges above, the Parties reach a full and final Stipulation pursuant to these Understandings and the Order below. The Respondent does not dispute that the State could prove these charges by a preponderance of the evidence if this matter went to a hearing and agrees that if the charges were proven the conditions below could be imposed as necessary to protect the public.
14. Respondent understands that the Nursing Board must review and accept the terms of the Consent Order. If the Board rejects any portion, the entire Stipulation and Consent Order shall be null and void.
15. Respondent specifically waives any claims that any disclosures made to the full Board during its review of this agreement have prejudiced her rights to a fair and impartial hearing in future hearings if this agreement is not accepted by the Board.
16. Respondent has read and reviewed this entire document and agrees that it contains the entire agreement between the parties.
17. Respondent is not under the influence of any drugs or alcohol at the time she signs this Stipulation and Consent Order.
18. Respondent voluntarily enters into this agreement after the opportunity to consult with legal counsel and is not being coerced by anyone into signing this Stipulation and Consent Order.
19. Respondent voluntarily waives her right to a contested hearing before the Board of Nursing and waives any right to appeal from this Stipulation and Consent Order.
20. Respondent agrees that the Order set forth below may be entered by the Board.

ORDER

Based on the Stipulation above, it is **ORDERED AND ADJUDGED** as follows:

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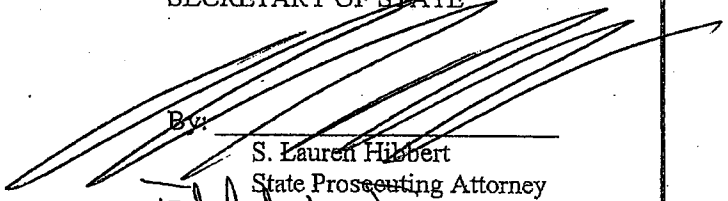
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- A. The Board of Nursing hereby **REPRIMANDS** the Respondent's license to practice nursing.
- B. Notwithstanding any provision above, the Respondent must continue to meet all Nursing Board requirements for maintaining a license, license renewal and license reinstatement.
- C. This Stipulation and Consent Order is a matter of public record and may be reported to other licensing authorities as provided in 3 V.S.A. § 129(a).
- D. This Stipulation and Consent Order will remain part of Respondent's licensing file and may be used for purposes of determining sanctions in any future disciplinary matter.

AGREED TO:

STATE OF VERMONT
SECRETARY OF STATE

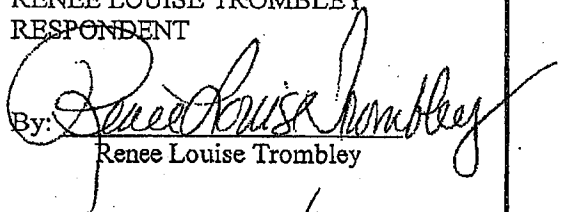
Dated: 9/28/11

By: 

S. Lauren Hibbert
State Prosecuting Attorney

RENEE LOUISE TROMBLEY
RESPONDENT

Dated: 9/28/11

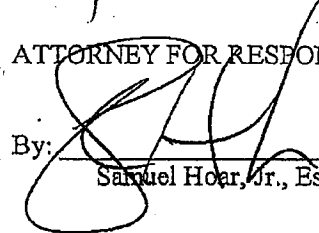
By: 

Renee Louise Trombley

APPROVED AS TO FORM:

ATTORNEY FOR RESPONDENT

Dated: 9/16/11

By: 

Samuel Hoar, Jr., Esq.

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APPROVED AND SO ORDERED:

VERMONT BOARD OF NURSING

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Dated: 10-10-11

By: 300 Ruff
Chairperson

Date of Entry: 10/10/11

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