

MAINE STATE BOARD OF NURSING

IN RE: Kevin F. Griffin, R.N.) DECISION AND ORDER
Licensure Disciplinary Action)

I. PROCEDURAL HISTORY

Pursuant to the authority found in 32 M.R.S.A. Sec. 2105-A(1-A)(D), et seq., 5 M.R.S.A. Sec. 9051, et seq. and 10 M.R.S.A. Sec. 8001, et seq., the Maine State Board of Nursing (Board) met in public session at the Board's offices located in Augusta, Maine on July 18, 2006. The purpose of the meeting was to hold an adjudicatory hearing to determine whether Kevin F. Griffin violated Board statutes and Rules while practicing as a registered nurse and as more specifically stated in the Notice of Hearing dated June 16, 2006. A quorum of the Board was in attendance during all stages of the proceedings. Participating and voting Board members were Acting Chairman Richard Sheehan, M.S., R.N., Betty Kent-Conant, R.N., Diane Dalton, R.N., Karen Tripp (public representative), and Robin Brooks, (public representative). Dorothy Melanson, R.N. recused herself shortly after the hearing began. Jack Richards, Ass't. Attorney General, presented the State's case. Kevin Griffin appeared but was not represented by legal counsel. James E. Smith, Esq. served as Presiding Officer.

Following the determination that none of the Board had conflicts of interest which would bar them from participating in the hearing, the taking of official notice of Board statutes and rules, and subsequent to the opening statement by counsel, State's Exhibits 1-6 were admitted into the Record. The Board then heard the testimony, reviewed the submission of exhibits and considered the parties' closing arguments after which it deliberated and made the following findings of fact by a preponderance of the credible evidence regarding the violations alleged in the Complaint.

II.

FINDINGS OF FACT

A. Failure to Respond to the Board

On November 2, 2005, Kevin Griffin received written notification of the Board's complaint regarding the allegations noted by Maine Medical Center. In that letter, he was informed that the law required him to respond to the Board within 30 days, which he did not choose to do. He stated that he did not respond because he wanted to have "the whole story told" and was going to contact the Board when he got a permanent living address, having been evicted from his apartment. He testified that he had moved approximately 30 times during the past year and therefore could not have provided the Board with an address which would ensure that he received the Board's correspondence.

The Board unanimously found that the licensee did not provide good cause or excuse for his failure to respond to either the Board's correspondence or complaint.

B. Unprofessional Conduct

Kevin Griffin, R.N., was first licensed in the State of Maine as a Registered Nurse on August 21, 1989. His license lapses on September 11, 2006. Nurse Griffin had been employed at Maine Medical Center since approximately 1990 where he became the Director of Nursing on the fifth floor unit which contained 54 beds. He was responsible for supervising 110 employees and also was a supervising nurse in the Dialysis Unit.

On July 15, 2005, the Board received a letter from Martha Riehle, R.N., Associate Vice President of Nursing/Associate Chief Nursing Officer of Maine Medical Center. The correspondence stated that Kevin Griffin had been terminated from employment at Maine Medical Center on June 29, 2005 due to a violation of that hospital's Code of Ethical Conduct which stated: "Any individual who knows of unauthorized handling of controlled substances shall report this information immediately to his or her supervisor or the Compliance Committee." The Board, upon receiving the letter, requested additional information from Nurse Riehle. She responded on August 26, 2005 and supplemented her original letter by stating that "Mr. Griffin was aware of the fact and failed to report that blank medication prescriptions were taken from the Nursing Unit where he is

the Nursing Director. These blank prescriptions were subsequently used for procuring drugs illegally... Upon further review, I learned that there were 67 fraudulent prescriptions. All prescriptions were for Duragesic patches.¹ All prescriptions have been dispensed to the same Nursing Unit, dating from November 10, 2003 until April 26, 2004." The prescriptions were made out to the licensee's sister. Moreover, the slips were in groups ranging in size from three to 25 and in sequential order.

Nurse Griffin testified that he was unaware that his sister, who lived in the same apartment building as the licensee and their mother, was addicted to narcotics until, after the thefts. Apparently, she received between ten and 12 prescription drugs for a variety of ailments and had at one time been treated for substance abuse. When confronted with the theft of the prescription pads, the licensee's sister confessed to him that she had stolen the pads, but stated that she done so from the third floor of the hospital and not his floor. She further told him that she had no blank prescriptions left which was untrue as evidenced by the fact that he found some blank prescriptions from Maine Medical Center at a later date and destroyed them. However, he did not inform the hospital in a timely manner of the thefts so that they could protect the public by investigating further.

The licensee explained his theory of the missing pads as follows. He explained that his sister used to be an employee at Maine Medical Center. As such, she would infrequently appear on the licensee's unit. The licensee explained that on one or more occasions, his sister requested to use the unit's telephone, which was located behind the desk but in very close proximity to the box containing the prescriptions. The prescriptions apparently were stacked individually and not connected to each other by a sealant. However, some prescriptions, according to the licensee, were returned unused and placed on top of the box which would make access much easier. The licensee explained that his sister must have gained access to the area by requesting permission to use the phone and then would have grabbed several slips at a time.

Subsequently, on May 16, 2005, the licensee's sister requested that he drive her to Shaw's Supermarket as she did not see well enough to drive at night. While waiting for his sister to come out of the supermarket, an officer arrived and subsequently arrested her for possession of illegal

¹ Nurse Griffin uses 20 physician prescribed Duragesic patches a month as a result of a past spinal injury. Each patch lasts approximately 36 hours.

prescriptions. Kevin Griffin denied any knowledge that the sister was in Shaw's for the purpose of obtaining narcotics illegally.

Associate Vice President Riehle rendered a contrary opinion from the licensee's regarding the circumstances surrounding the missing prescription pads. She stated both in her letter and in testimony before the Board that the prescription box was located behind the Nursing Station and was not available to non-clinical staff.² She reasoned that given the location of the prescription box, Nurse Griffin could not offer a logical explanation regarding how his sister could have gained access and taken the blank prescriptions especially since, according to Nurse Riehle, the licensee could only recall that his sister visited him only once on the Nursing Unit and the blank prescriptions had been taken six different times. The hospital review staff obviously did not believe Mr. Griffin's explanation and terminated his employment as above noted on June 29, 2005, and Nurse Griffin has not worked since.

The Board weighed several possible findings before reaching the finding that the licensee did not steal drugs or prescription pads from his employer. For example, on the one hand, the employee's sister, although an employee at one time at Maine Medical Center, had not been an employee on the fifth floor. The odds are, therefore, that recently hired staff would not have known her and probably the secretary behind the desk would not have given an unknown individual access to that area especially considering the hospital's confidentiality policy. Moreover, if an individual had requested to use the telephone, staff could easily have removed it from its place and put it on the front counter so that a visitor could use it while standing in front of rather than behind the nursing desk. In addition, other staff members who had been employed on the unit for several years said that they had not seen the sister on the unit for years. The Board also considered that no other prescription pads have been reported missing since the employee was terminated.

On the other hand, the hospital staff voiced no complaints regarding any alleged substance abuse by the licensee. Additionally, the Board believed the licensee's testimony that his sister would drop by periodically if she was in the hospital for an examination or treatment and would also on occasion bring food up to the unit for staff at the licensee's request. With the amount of employees and beds on the licensee's floor, the Board determined that it was not inconceivable that family members or others would have access to the telephone and therefore the prescription pads behind the nurses' desk. Moreover, it would appear that the licensee, having broad supervisory

² According to Maine Medical Center, the box is now in a more secure area.

powers, most likely would have removed individual prescriptions or pads out of the boxes of other units rather than his own. Furthermore, it would have been highly unusual for the licensee to be behind the nursing desk since he had other responsibilities and that fact would most likely have been commented on by staff members. Finally, no one witnessed nurse Griffin stealing prescription pads.

III.

CONCLUSIONS OF LAW

A. The Board, utilizing its expertise, training, and experience, found or concluded by a vote of 5-0 that Kevin Griffin received notice of the Board's complaint and did not file a response to same within 30 days. Therefore, he violated the provisions of 32 M.R.S.A. Section 2105-A.(1-A) which states that the licensee "shall respond" to the Board's complaint. By a vote of 5-0, the Board ordered the following as sanctions for the above violation.

1. Kevin F. Griffin shall receive a **Reprimand** for his failure to respond to the Board's complaint.
2. Kevin F. Griffin shall pay a fine totaling \$200 for this violation by November 18, 2006. The Treasurer's check or money order shall be made payable to: "Treasurer, State of Maine" and mailed to Myra Broadway, Exec. Director, 158 State House Station, Augusta, Maine 04333-0158. The fine is ordered since Nurse Griffin's failure to respond was willful and intentional and without good cause, and a response may have resulted in either a Consent Agreement or some other resolution which would not have required a hearing. This sanction is not as serious as other violations which may result in a maximum \$1500 fine.

B. The Board further concluded that the licensee violated the provisions of 32 M.R.S.A. Section 2105-A.(2)(F) "Unprofessional Conduct. A licensee shall be deemed to have engaged in unprofessional conduct if he violates any standard of professional behavior which has been established in the practice for which the licensee is licensed." The licensee also violated the unprofessional conduct provisions of the rules and regulations of the Maine State Board of Nursing, Chapter 4, "disciplinary action and violations of law," Section 1.A.(6). (Identical to 2105-A.(2)(F).) The Board was of the opinion that Kevin Griffin had to have known of his sister's

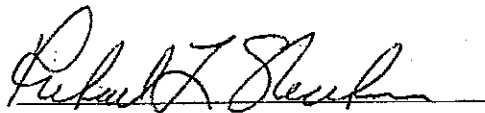
narcotics habit and her practice of stealing the hospital's prescription pads whereas he did not report such information to the hospital in a timely manner. This omission of his professional responsibility resulted in his sanctioning his sister's illegal activity and may have caused harm to both her and others in violation of his profession's standards.

For this violation, the Board ordered the following sanctions:

1. Kevin Griffin shall receive a **Reprimand** for the above unprofessional conduct. (4-1) (The dissenting member would have voted for a suspension of licensure.)
2. Kevin Griffin shall pay the costs of this proceeding not to exceed \$1,500. He shall also pay any transcription costs should he appeal this decision. The costs are to be paid by November 18, 2006. The Treasurer's check or money order shall be made payable to: "Maine State Board of Nursing" and mailed to Myra Broadway, Exec. Director, 158 State House Station, Augusta, Maine 04333-0158. The hearing costs are ordered due to the fact that Nurse Griffin failed to respond to the Board's complaint, which response may have resulted in a Consent Agreement thereby removing the need for this hearing. Moreover, the ordering of costs is consistent with past Board practices in similar situations and the Board's policy that those members of the profession who obey Board statutes and rules should not be held responsible for payment of the costs of those who do not obey such laws. (5-0)

SO ORDERED.

Dated: ²⁰⁰⁶September 22, 2006 ^{YLS}

 10/10/06

Richard Sheehan, M.S., R.N., Acting Board Chairman
Maine State Board of Nursing

IV.

APPEAL RIGHTS

Pursuant to the provisions of 5 M.R.S.A. Sec. 10051.3 and 10 M.R.S.A. Sec. 8003, any party that appeals this Decision and Order must file a Petition for Review in the Superior Court within 30 days of receipt of this Order. The petition shall specify the person seeking review, the manner in which they are aggrieved and the final agency action which they wish reviewed. It shall

also contain a concise statement as to the nature of the action or inaction to be reviewed, the grounds upon which relief is sought and a demand for relief. Copies of the Petition for Review shall be served by Certified Mail, Return Receipt Requested upon the Maine State Board of Nursing, all parties to the agency proceedings and the Attorney General.