

# WISCONSIN DEPARTMENT OF REGULATION & LICENSING



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BEFORE THE BOARD OF NURSING

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IN THE MATTER OF THE DISCIPLINARY	:	
PROCEEDINGS AGAINST	:	
	:	LS0304031NUR
TAMI K. ROBERTSON, R.N.,	:	
RESPONDENT.	:	

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FINAL DECISION AND ORDER

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The parties to this action for the purposes of § 227.53, Stats., are:

Tami K. Robertson, R.N.

408 S. Main Street, # 3

Janesville, WI 53545

Wisconsin Board of Nursing

P.O. Box 8935

Madison, WI 53708-8935

Department of Regulation and Licensing

Division of Enforcement

P.O. Box 8935

Madison, WI 53708-8935

The parties in this matter agree to the terms and conditions of the attached Stipulation as the final decision of this matter, subject to the approval of the Board of Nursing. The Board has reviewed this Stipulation and considers it acceptable.

Accordingly, the Board in this matter adopts the attached Stipulation and makes the following:

**FINDINGS OF FACT**

1. Tami K. Robertson, R.N., Respondent, date of birth March 16, 1961, is licensed by the Wisconsin Board of Nursing as a registered nurse in the State of Wisconsin pursuant to license number 108384, which was first granted September 5, 1991.

2. Respondent's last address reported to the Department of Regulation and Licensing is 408 S. Main Street, Janesville, WI 53545.

#### COUNT I

3. From December 10, 2001 to June 12, 2002, Respondent was employed as a registered nurse in the Odyssey Program at Rogers Memorial Hospital (RMH) in Oconomowoc, Wisconsin. The Odyssey Program is an inpatient extended care program for adolescents with emotional problems.

4. Mr. A, who was then 17 years of age, was a patient on the Odyssey Unit during the time Respondent was employed at RMH. Mr. A was under court order by the state of Indiana to undergo treatment in the Odyssey Program as a result of his history of sexually abusing younger children, including boys.

5. Respondent was a member of Mr. A's primary treatment team and provided psychiatric nursing services to Mr. A. Respondent had never met Mr. A before providing nursing services to him.

6. Odyssey staff occasionally took patients off campus to spend one on one time with them. On one occasion, Respondent took Mr. A to a pharmacy to pick up a prescription. On that trip, Mr. A asked Respondent to kiss him and she did so.

7. While Mr. A was a patient of RMH, Respondent and Mr. A continued to develop a personal relationship, including engaging in sexual intercourse on at least 3 occasions. Two occasions of sexual intercourse took place in a church parking lot and one at RMH in a deserted section of the hospital.

#### COUNT II

8. Respondent's conduct, as set out in paragraph 7 above, violated § 948.09, Stats., Sexual intercourse with a child 16 or older, a class A misdemeanor.

9. § 948.09, Stats., is a law substantially related to the practice of professional nursing.

#### COUNT III

10. Respondent's conduct, as set out in paragraph 7 above, violated § 940.225(2)(g), Stats., Second degree sexual assault/Treatment Facility Employee, a Class BC felony.

11. § 940.225(2)(g), Stats., is a law substantially related to the practice of professional nursing.

#### COUNT IV

12. On April 15, 2002, Respondent met with the Clinical Services Manager of the Odyssey Program to discuss Respondent's concerns about her ability to do her job. They also discussed a rumor that Respondent had a sexual encounter with one of the patients. Respondent denied that this happened. Since the patient also denied that there had been any sexual contact, the matter was dropped.

13. On May 26, 2002, Respondent left work after her shift at approximately 11:00 p.m. and found Mr. A hiding in her van. Mr. A told Respondent that he wanted to get out of RMH to live a better life outside of the facility. Respondent took Mr. A home with her and allowed him to stay in the upper loft of a barn on her property.

14. At that time, Respondent and her ex-spouse had been residing together with their three sons, ages 7, 9 and 14, at Respondent's residence in Footville. Respondent told her ex-spouse that Mr. A was going to be staying with them for awhile. Respondent also explained that Mr. A was a sex offender but that he had recovered and had been released from RMH. Respondent's ex-spouse was not comfortable having Mr. A around their sons but trusted Respondent's judgment and did not question her decision to allow Mr. A to stay with them.

15. On June 4, 2002, the Clinical Services Manager again met with Respondent to discuss, among other things, rumors about Mr. A's escape from the facility and speculation that Mr. A was staying with Respondent. Respondent denied having any contact with Mr. A. Respondent was informed that a warrant would be issued for Mr. A's arrest and that after he was taken into custody, an assessment would be made to determine who may have aided and abetted him. Respondent was also informed that appropriate actions would be taken against that person or persons.

16. Mr. A spent a lot of time on the family computer and often went to the park with Respondent's sons. Respondent's ex-spouse knew Respondent was buying things for Mr. A to the point that the electricity was cut off. He also suspected that Respondent and Mr. A were having sex.

17. Concerned with the safety of their sons, Respondent's ex-spouse called RMH and was informed that Mr. A had escaped from the facility. He then took their youngest son to his home in Beloit and called police to report that Mr. A was an 'escapee' from the RMH Odyssey Unit and that he was staying at Respondent's residence.

18. On June 5, 2002, Rock County deputies went to Respondent's residence to check on the welfare of her children because there was no electricity and to ask her if Mr. A was there. Respondent denied that Mr. A was there. Respondent told the deputies that she had not seen Mr. A but that she had told him where she lived. Respondent gave the deputies permission to search her residence and out buildings.

19. The deputies searched Respondent's residence and did not find Mr. A. After searching the barn in the back yard and checking the upper loft, the deputies found two prescription inhalers bearing Mr. A's name on the labels. They also found a space heater, sheets, blankets, a pillow, cologne, deodorant and a "classmates.com" computer photo of Respondent dated 5/31/02.

20. The deputies told Respondent that they would return the following day to check to see if her electricity was turned back on and to continue to search for Mr. A.

21. On June 6, 2002, five Rock County deputies returned to Respondent's residence and took up positions around the house. One deputy spoke with Respondent and advised her that her ex-spouse would be taking the children until the matter was cleared up. When asked if she had seen or talked to Mr. A since the day before, Respondent stated 'no.'

22. After the deputies checked the barn again, Respondent admitted to them that Mr. A was inside the house, hiding under the bed in the master bedroom. The deputies went to the bedroom and apprehended Mr. A without incident. Mr. A was taken first to the Rock County jail and then transported back to RMH.

23. RMH was notified that Respondent had, in fact, helped Mr. A escape from the facility and that she harbored him in her home. Based on this information, Respondent was terminated from her employment on June 12, 2002.

24. Respondent's conduct, as set out in paragraphs 18 through 21 above, violated § 946.41(1), Stats., Obstructing an Officer, a Class A misdemeanor.

25. § 946.41(1), Stats., is a law substantially related to the practice of professional nursing.

**CONCLUSIONS OF LAW**

1. The Wisconsin Board of Nursing has jurisdiction over this matter pursuant to § 441.07, Stats.

2. The Wisconsin Board of Nursing has authority to enter into this stipulated resolution of this matter pursuant to § 227.44(5), Stats.

3. Respondent, by engaging in sexual intercourse with a patient, has committed misconduct and unprofessional conduct as defined by Wis. Adm. Code § N 7.04(11) and is subject to discipline pursuant to § 441.07(1)(d), Stats.  
[COUNT I]

4. Respondent, by having violated laws substantially related to the practice of professional nursing, has committed misconduct and unprofessional conduct, as defined by Wis. Adm. Code § N 7.04(1) and is subject to discipline pursuant to § 441.07(1)(d), Stats. [COUNTS II, III and IV]

**ORDER**

NOW, THEREFORE, IT IS HEREBY ORDERED that the license of Tami K. Robertson, R.N., as a registered nurse in the state of Wisconsin is hereby REVOKED, effective immediately.

The rights of a party aggrieved by this Decision to petition the Board for rehearing and to petition for judicial review are set forth on the attached "Notice of Appeal Information."

Dated at Madison, Wisconsin this 4<sup>th</sup> day of April, 2003.

Linda M. Sanner, R.N.

**Chairperson**

**Board of Nursing**