Negligent Homicide and the Impact on Nursing

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State v. RaDonda Vaught

Introduction

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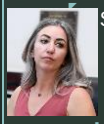

State of Tennessee v. RaDonda Vaught

- Nurse at Vanderbilt Hospital administered Verconium instead of Versed to a patient. Patient was paralyzed, suffered respiratory failure, and died.
- Nurse was charged and convicted of negligent homicide and abuse of an impaired adult.

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Timeline of events

- **October 2015** — RaDonda Vaught, a licensed nurse, begins working at Vanderbilt University Medical Center.
- **Dec. 24, 2017** — Charlene Murphey, 75, is admitted into Vanderbilt with a subdural hematoma.
- **Dec. 26, 2017** — Murphey's condition improves and she is almost ready to leave Vanderbilt. During a final scan in the hospital's radiology department, Murphey is supposed to be given Versed but Vaught accidentally gives a dose of vecuronium.

When VAUGHT went to the Accudose machine to pull the medication to take to CHARLENE MURPHEY, she couldn't find Versed in MURPHEY'S profile. She checked the Medication Administration Record (MAR) in a different computer and found the order was there for Versed. Since she couldn't find the Versed in the Accudose system, she overrode the system, typed in VE, and selected the first medication (Vecuronium Bromide) in the list. The system asked for a reason for the override, but she couldn't recall what reason she selected.

VAUGHT looked at the back of the vial and saw that it needed to be reconstituted but never looked at the front of the vial. She went down with Demeo to the PET Scan Unit and found MURPHEY. She verbally verified who MURPHEY was but could not find a computer to scan the medication. She reconstituted the vial, gave MURPHEY one (1) milligram, and left her with the PET Scan Unit tech. After administering the medication, she never scanned it to put in into the medical record.

After the code was called on MURPHEY and MURPHEY was brought back to the NICU from the PET Scan Unit, VAUGHT informed Dr. Nesley and Lindsey Trantham, Acute Care Nurse Practitioner, that she had given Vecuronium Bromide to MURPHEY. Their response was "I'm so sorry."

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- **Dec. 27, 2017** — Murphey dies after being removed from life support. Neurologists who report the death to the County Medical Examiner do not mention the medication error or Verconium. Cause of death is attributed to the brain bleed.
- **Jan. 2018** — Vanderbilt does not report the medication error to state or federal government or JACHO. Vaught is fired. At some point afterwards, Vanderbilt settles with the Murphey family.
- **Oct. 3, 2018** — An anonymous tip is given to state and federal health officials about the unreported medication error.

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INTAKE INFORMATION

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- **Oct. 23, 2018** — TN. Department of Health decides not to pursue disciplinary action against Vaught because the case "did not constitute a violation of the statutes and/or rules governing the profession."
- **Oct. 31-Nov. 8, 2018** — CMS conducts a surprise inspection at Vanderbilt. CMS issues an investigation report that details the error without mentioning the parties. Vanderbilt is required to provide a plan of correction explaining how it has taken steps to prevent a similar error or face suspension of Medicare payments. The POC is not made public.
- **Feb. 4, 2019** — Nurse Vaught is arrested.
- **Sept. 27, 2019** — TN Dept. of Health reverses its decision and charge Vaught with 3 infractions before the TN Board of Nursing.
- **July 2021** — Nurse Vaught's nursing license is revoked.

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- Prosecution: They did not allege that Vaught intended to hurt Murphey or was impaired in any way. Instead, they alleged that at least 10 mistakes led ex-Vanderbilt nurse RaDonda Vaught to accidentally give a patient a fatal dose of the wrong medication two years ago, including Vaught overlooking a boldfaced warning immediately before injecting the drug.

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➢ Vaught pulled up patient profile in Acudose system and could not find medication prescribed by MD and reviewed/approved by pharmacy.

➢ Failed to contact pharmacy to confirm medication order before overriding the system.

➢ Vaught begins the override:

Warning #1: "Override medications should only be accompanied by STAT orders or when the clinical status of a patient would be significantly compromised by the delay that would result from pharmacist review."

- *Vaught begins the override by typing the letters 'VE' to search for "Versed". "Vecuronium bromide" comes up first on the list as Acudose searches by generic name, not brand name, as the default. Versed is the brand name for the medication "Midazolam".*

Warning #2: System prompts user with a pop-up screen asking for a reason for the override with justifications such as: "Urgently needed such that delay might cause patient harm"; "Prescriber is physically present and can oversee administration"; etc., and clearly states "PARALYZING AGENT" at top of the list. User must select a reason for the override and press another button to continue with the override.

Warning #3: Screen returns to the selected medication "Vecuronium Bromide" with a notation of "PARALYZING AGENT".

Warning #4: Another pop-up screen appears showing an Alert once the "Vecuronium Bromide" is selected, warning that it is a "PARALYZING AGENT" and that the medication "Causes Respiratory Arrest" and that "Patient Must Be Ventilated" and the user must then press another prompt to remove the warning.

Warning #5: User is asked to select quantity of drug and at the top of that screen is another warning for "PARALYZING AGENT" and also a yellow caution sign and highlighted "Alert" appears on the screen.

➢ Vaught then failed to respond to a number of "red flags" between the time she removed the paralyzing agent from the drawer and then administered the drug to the Victim who was awaiting her PET scan.

- **Red Flag #1**: Vecuronium bromide comes in powder form as opposed to liquid form like Versed/Midazolam.
- **Red Flag #2**: The cap for the Vecuronium bromide bottle is red and states "Paralyzing Agent".

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- **Red Flag #3**: Vaught would have had to read the instructions to reconstitute on the Vecuronium bottle yet went forward despite the fact that the bottle said "Vecuronium Bromide" and not "Versed" or "Midazolam".
- **Red Flag #4**: Vaught would have to shake the bottle to reconstitute the medication which is not a process for Versed/Midazolam.
- **Red Flag #5**: Vaught would have to look directly at the red-capped bottle with the inscription "Warning: Paralyzing Agent" and syringe in order to draw exactly 1 ML of medication in order to administer that dose.

- *Vaught was informed that the staff in PET could NOT administer the medication because they were running scans and could not monitor the patient after the medication was administered.*
- *Vaught administered the medication and immediately left the Victim alone in the PET waiting room on a mobile bed.*
- *The Victim would have shown signs of acute Vecuronium intoxication which would have caused paralysis and respiratory failure within minutes after the drug was administered and since Vaught did not follow mandated observation protocol, the Victim was left unattended when showing signs of the onset of respiratory failure.*

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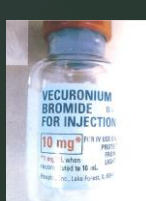

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- Defense: A mistake was made but it didn't rise to the level of criminally negligent homicide. Further, Vanderbilt shares blame. The mistake was made possible because of flawed procedures at Vanderbilt. At the time, they said, Vanderbilt was struggling with a problem that prevented communication between its electronic health records, medication cabinets, and the hospital pharmacy. This was causing delays at accessing medications, and the hospital's short-term workaround was to override the safeguards on the cabinets so they could get drugs quickly as needed.

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- **March 25, 2022 –** RaDonda Vaught is found guilty of criminally negligent homicide and abuse of an impaired adult.
- **May 2022–** RaDonda Vaught sentenced to 3 years supervised probation. She was also issued a judicial diversion, where she can have her records expunged after completing probation.

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Nashville District Attorney's Office said the verdict was not an indictment against the nursing profession or medical community. Prosecutors said the case did not involve a "'singular' or 'momentary' mistake," but rather a series of decisions made by Ms. Vaught "to ignore her nursing training" and fail to follow safety protocols.

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Medication Errors

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- **Adverse Event** - An event in which care resulted in an undesirable clinical outcome-an outcome not caused by underlying disease-that prolonged the patient stay, caused permanent patient harm, required life-saving intervention, or contributed to death.
- **Medication errors** are the leading cause of injury and avoidable harm in health care systems. (World Health Organization, Sept. 2019).

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- In the U.S., 4 in 10 Americans have experienced or know someone affected by a medical error.
- Medical errors are the third-leading cause of death in the U.S., with about 200,000 deaths each year.
- Medical errors in the U.S. healthcare system are estimated to cost more than $17 billion each year.
- The estimated rate of medication errors is between 8% to 25% of all medications given.
- The U.S. Food and Drug Administration receives over 100,000 reports of medication errors annually.

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Impact of Med Errors on Nursing

- Psychological impact
- Civil lawsuit
- Action against license—formal reprimand, probation, fines, loss of license
- Loss of employment
- Criminal charges

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Civil v. Criminal actions against healthcare providers

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Civil

- Civil claims of negligence or malpractice are based in tort and the standard is whether the applicable standard of care was breached.
- Civil claims do not require the nurse to have acted recklessly or wantonly. Only that the actions (or omissions) breached the standard of care.
- Medical professionals have liability insurance to cover claims.
- Damages are limited to financial judgments and, in extreme cases, licensure issues.

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Criminal

- In criminal claims, the state files charges alleging a person broke the law.
- Criminal claims require the state to prove that the defendant voluntarily and intentionally engaged in conduct that is against the law.
- Professional liability insurance does not cover criminal acts.
- Defendant may be fined, jailed, and/or lose their license.

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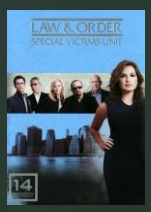
Defendant must be “proven guilty beyond a reasonable doubt”



- What exactly must be proven?
- What is “beyond a reasonable doubt”?

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What exactly must be proven?

- Every crime requires specific delineated factors, that in combination with other factors, make up a specific crime.
- These factors are set out by the various state legislatures (for state crimes) and the Congress of the US (in the case of federal crimes).
- Each of the delineated factors must be proven beyond a reasonable doubt or the defendant is NOT guilty.

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What is "beyond a reasonable doubt"?

- Highest standard that the law requires. Much higher than what is required in civil cases (51%).
- Something less than absolute certainty but more than probable guilt.
- Jury must find there is no other reasonable explanation that can come from the evidence.
- Jury must be virtually certain of the defendant's guilt.
- Government bears the burden of proof, not the defendant.

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Model Penal Code Definitions of Criminal Homicide

Murder

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Manslaughter

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Negligent Homicide

For each version of homicide, the required culpability decreases
As culpability decreases, the available sentence decreases because culpability is thought to relate to blameworthiness

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MODEL PENAL CODE MURDER § 210.2

First Degree Felony

A person acts **purposely** when they deliberately perform an act to cause a certain result

A person acts **knowingly** when they are aware of the probable consequences of their acts

→ (1) Purposely or knowingly
(2) Causes
(3) The death
(4) Of another human being

A **human being** is a person who has been born and is alive →

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MODEL PENAL CODE MURDER § 210.2

First degree felony

- Recklessly
- Causes
- The Death
- Of another human being
- Under circumstances manifesting extreme indifference to the value of human life

Recklessness & indifference to the value of human life are presumed if the death occurs while the person is committing or attempting to commit various delineated felonies

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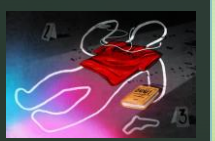
Typical murder cases

- Serial killings (Ted Bundy, Richard Speck)
- Mass murder (Boston Marathon, FedEx facility, Oklahoma City, 911)
- Robberies where death occurs
- Killing rival drug dealers
- Killing rival gang members
- Killing spouse in lieu of divorce
- No reason murders



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Nursing Murder Cases

- Typically, "angel of death" situations
- Orville Lynn Majors, LPN: convicted of killing 6 patients who were demanding, whiny or disproportionately adding to workload. Investigators claim he killed 100-130 people by administering potassium chloride & epinephrine.

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Model Penal Code Manslaughter § 210.3 (1) (a)

Second Degree Felony

1) Recklessly
2) Causes
3) The death
4) Of another human being

A person acts **recklessly** if s/he consciously disregards a substantial and unjustifiable risk that a bad result or harm will occur.

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Typical Voluntary Manslaughter Cases

- Killings that occur as a consequence of:
  - spouse walking in on spouse with paramour.
  - fights
  - repeated episodes of verbal & physical abuse
  - road rage incidents

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Model Penal Code Negligent Homicide § 210.4

Third Degree Felony

A person acts **negligently** when s/he should be aware of a substantial and unjustifiable risk but s/he is not

- Negligently
- Causes
- The Death
- Of a human being

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How can a medical professional be charged with a crime?

- Stealing and misuse of medications
- Abuse of patient
- Recklessly treating patient (gross negligence)

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State of Indiana v. Connie Sneed

- Connie Sneed, LPN, allegedly removed O2 mask from a patient, claiming that she asked if he was tired of fighting and wanted her to remove his O2 mask and let him "go and fly with the angels." Patient died 1 hour and 45 minutes later.
- Nurse Sneed has been charged with practicing medicine without a license as there was no order for her to start O2 or remove O2. She also did not report the change in condition (reduced O2 sats) to the patient's physician.
- Jury trial is currently scheduled for October 4, 2022.

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Other cases

- Delaware: Nurse charged with reckless homicide and involuntary manslaughter after allegedly failed to replaced nursing home resident's trach mask in May 2021.
- California: Nurse charged with involuntary manslaughter for allegedly failing to follow withdrawal protocol for inmate that died.
- Colorado: Three nurses were charged with criminally negligent homicide for administering too much penicillin (filled by a pharmacist) to an infant. 2 of the nurses accepted pleas while the other was acquitted. (1996)

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What is the impact of criminalization of medical errors and mistakes?

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Number of nurses entering profession

- Nursing workforce decreased 1.8% between 2019 and 2021. Decline stemmed primarily from younger nurses leaving the field:
  - The number of nurses younger than age 35 fell by 4% vs 0.5% decline for nurses ages 35 to 49 and a 1% drop for nurses 50 and older.
- 2022: 4.3 million registered nursing licenses but only 3 million registered nurses are employed as registered nurses.

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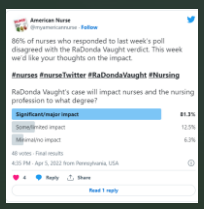

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Lack of honesty and transparency on reporting of errors or near-misses

- Punitive approaches deter error-reporting and endanger patients by allowing latent failures to continue.
- Criminal prosecution has worrisome implications for safety. It can inhibit error reporting, contribute to a culture of blame, undermine the creation of a culture of safety, accelerate the exodus of practitioners from clinical practice, exacerbate the shortage of healthcare providers, perpetuate the myth that perfect performance is achievable, and impede system improvements. Institute for Safe Medication Practices (2019)

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"The criminalization of medical errors is unnerving, and this verdict sets into motion a dangerous precedent….The non-intentional acts of individual nurses like RaDonda Vaught should not be criminalized to ensure patient safety."

----American Nurses Association and Tennessee Nurses Association

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Decades of safety research, including the Institute of Medicine's pioneering report *To Err Is Human*, has demonstrated that a punitive approach to healthcare errors drives problems into the shadows and decreases patient safety. In addition, catastrophic errors are often the result of many factors, and the ability to safely report errors allows for root cause analysis and correction of systemic problems. Vaught immediately reported her error to her supervisors and took responsibility for her actions. This criminal prosecution and verdict will negatively impact the timely and honest reporting of errors. In addition, this case has further demoralized an already exhausted and overworked nursing workforce in the face of existing nurse staffing shortages.

---- American Association of Critical-Care Nurses

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The verdict in this tragic case will have a chilling effect on the culture of safety in health care. The Institute of Medicine's landmark report 'To Err Is Human' concluded that we cannot punish our way to safer medical practices. We must instead encourage nurses and physicians to report errors so we can identify strategies to make sure they don't happen again. Criminal prosecutions for unintentional acts are the wrong approach. They discourage health caregivers from coming forward with their mistakes, and will complicate efforts to retain and recruit more people in to nursing and other health care professions that are already understaffed and strained by years of caring for patients during the pandemic.

-- American Hospital Association

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Because human errors should be regarded as expected events, health care organizations should routinize processes aimed at human error prevention, limit negative consequences when human errors do occur, and support and educate those who have erred. A just culture perspective suggests that responding punitively to those who err should be reserved for those who have willfully and irremediably caused harm, because punishment creates blame-based workplace cultures that deter error reporting, which makes patients less safe.

--AMA J Ethics, 2020;22(9):E779-783

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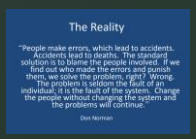
What can be done?

- Institutions should have a procedure for responding to an unanticipated outcome.
- Example: **CANDOR** (Agency for Healthcare Research and Quality-AHRQ-government agency) **C**ommunication **and O**ptimal **R**esolution-



1. Immediate Response
2. Notify Leadership
3. Disclosure Discussion
4. Report Event
5. Follow up

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Changes in nursing education

- Creating a Just Culture within the nursing program.
- Teaching nursing students about human fallibility and medication error prevention.
- Establishing a second victim response team within the nursing program.

Jones J, Treiber L, Shabo R, et al. Just Culture, medication error prevention, and second victim support: a better prescription for preparing nursing students for practice [White paper]. Kennesaw, GA: WellStar School of Nursing, WellStar College of Health and Human Services, Kennesaw State University. 2021

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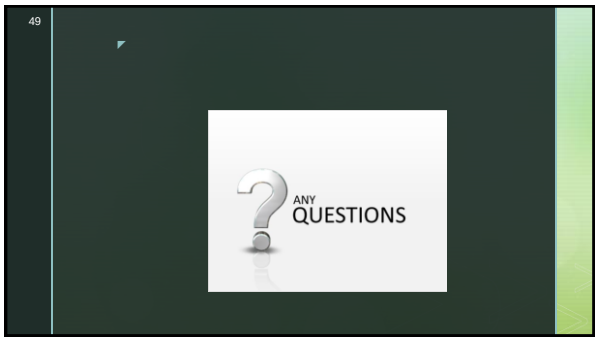

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