Criminal trial begins against Vanderbilt nurse over medication error death

Benjamin Mateus
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Update: "Former Vanderbilt nurse RaDonda Vaught convicted of criminal negligent homicide for medication error"

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Testimony has begun in the trial in Nashville, Tennessee, of a former Vanderbilt University Medical Center (VUMC) nurse, RaDonda Vaught, for the death of a 75-year-old woman, Charlene Murphey, in late 2017.

Vaught, who is 38, was indicted in 2019 on two charges, reckless homicide and impaired adult abuse. The state of Tennessee also revoked her nursing license. However, due to the circumstances created by the pandemic, the criminal trial was delayed until now.

The former nurse has never attempted to deflect or shirk responsibility for her actions, and her account of events has remained consistent over the last four years. But the trial is a vicious effort at scapegoating her to put all the responsibility for the tragedy on her shoulders and save the reputation of Vanderbilt, one of the major medical facilities in the South.

The health care executives who have the final say in safety policies at Vanderbilt were found negligent by the Centers for Medicare and Medicaid Services, but they have not been held to account by the prosecutor's office. Had VUMC implemented safety measures commonplace at other health care facilities, the event could have been avoided.

VUMC quickly distanced itself from the incident. A little more than a week after Murphey's death, Vaught received a termination letter, while the hospital attempted to conceal the event from public scrutiny. In early 2018, VUMC settled out of court with Murphey's family, stipulating that the family could not speak publicly on the matter.

The timeline of events, according to the Tennessee Bureau of Investigation (TBI), is as follows.

Vaught became a registered nurse in February 2015. She joined the prestigious Vanderbilt University Medical Center in October 2015. She was on duty covering the day shift on December 25 and 26, 2017, as the "Help All" nurse in the Neuro Intensive Care Unit.

The patient in question, Charlene Murphey, had been admitted on December 24, Christmas Eve, for a bleed in her brain that led to symptoms of headache and vision loss. Over the next two days, her condition improved. But before discharge, her doctors ordered a special scan in the radiology department that afternoon where she would be placed in an enclosed tube. Being claustrophobic, she was prescribed a Versed sedative to calm her nerves.

The patient's primary nurse was not available at the time. Vaught was assigned to pick up the medication from the dispensing cabinet and administer it in the radiology department to Murphey before her PET scan. At the time, Vaught was also orienting a new employee and was fielding questions about a "swallow evaluation" in the emergency department. When she attempted to withdraw Versed from the automatic medication dispensing cabinet, she could not find the drug listed in the patient's profile.

According to the TBI report, "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."

Due to problems with communication between electronic health records, medication dispensing cabinets, and the hospital pharmacy that were causing delays in administering medications, the hospital was using workarounds that overrode the safeguards built into the medicine cabinets so staff could access drugs quickly when needed. As Vaught explained, "Overriding was something we did as a part of our practice every day. You couldn't get a bag of fluids for a patient without using an override function."

Vecuronium Bromide is a potent paralytic used by an anesthesiologist when they perform intubation procedures, and the drug causes all the muscles to become paralyzed. In some states, it is part of the three-drug "cocktail" used to carry out executions by lethal injection.

Besides the standard of care checks that should have been done, there was no dual verification process to access Vecuronium Bromide at VUMC. Additionally, the requirement that a second nurse sign off on accessing a high-alert medication could have added redundancy to the safety measures. This is standard practice at many hospitals, but not at VUMC.

After Vaught gave Murphey the Vecuronium Bromide, the radioactive tracer used for PET scans was also administered. Murphey was then moved to a waiting area to wait an hour before the scan for the tracer to permeate the body. She was discovered 30 minutes later without a pulse, not breathing and unresponsive.

An emergency code was called, and after three rounds of chest compression, her heart rate and breathing returned. She was intubated and taken to the ICU. However, further evaluation revealed she had suffered an extensive brain injury from a prolonged lack of oxygen with "a very low likelihood of neurological recovery." Later that evening, after speaking with the critical care team, the family agreed that the best course of action was to withdraw all care. Charlene Murphey died in the early hours of December 27, 2017.

Almost 10 months later, an anonymous complainant tipped off the Centers for Medicare & Medicaid Services (CMS), giving an accurate description of the event, and concluding that VUMC had failed to report the event to the state, as required.

On October 31, 2018, CMS conducted an unannounced on-site survey in response to the complaint. In the scathing summary of deficiencies, the agency noted:

> A hospital must protect and promote each patient's rights. This CONDITION is not met as evidenced by: Based on policy review, medical record review, and interview, the hospital failed to ensure patient's rights were protected to receive care in a safe setting and implemented measures to mitigate risks of potentially fatal medication errors to the patients receiving care in the hospital.
>
> The failure of the hospital to mitigate risks associated with medication errors and ensure all patients' received care in a safe setting to protect their physical and emotional health and safety placed all patients in a SERIOUS and IMMEDIATE THREAT and placed them in IMMEDIATE JEOPARDY and risk of serious injuries and/or death.

After the medication error had been recognized, Vaught acknowledged her mistake and asked the charge nurse if she should document what had happened. She was told it was unnecessary and that the electronic medication administration would automatically record it. However, VUMC policy required written documentation of the medical error in the patient record.

The hospital took possession of the syringe and remaining Vecuronium but kept them under wrap. The physician responsible for contacting the Davidson County Medical Examiner failed to inform them that the cause of death was an inadvertent administration of a paralytic agent. As a result, there was no autopsy and the death certificate did not indicate the death was accidental. VUMC also failed to notify the state within seven days of the accident, as required by law.

The CMS report also notes that the information provided to the family indicates that the cause of death was worded as "possibly" being due to a medical error. No documentation of discussions between Vanderbilt and the family is publicly available.

After the story became public in November 2018, the hospital system shifted into damage control mode. John Howser, chief communications officer at VUMC, claimed, "We disclosed the error to the patient's family as soon as we confirmed that an error had occurred." However, according to Gary Murphey, Charlene's son, "The family had never been informed by the hospital that the medication Vecuronium caused [my] mother's death."

Later that moth, CMS threatened to suspend Medicare payments if VUMC did not take immediate action to prevent similar future errors. The hospital submitted a plan that required 330 pages to specify all the changes required.

But as part of the correction plan, to save face with the public, Vaught was singled out for blame. She was publicly identified for the first time when she was arrested February 4, 2019 and charged with reckless homicide carrying a possible jail sentence of more than 10 years. Nashville's District Attorney General Glenn Funk, who brought the charges, is also an adjunct professor of law at Vanderbilt, which is the largest employer in the city.

As Hospital Watchdog noted, "It's only natural to wonder if Vanderbilt, an extremely influential political entity, gave a quiet 'thumbs up' behind closed doors to proceed with a prosecution against one of its nurses. One can reasonably speculate that Vanderbilt's legal, public affairs, and crisis management team may have strategized that blaming the nurse will take the heat off the hospital."

Dr. Zubin Damania, an American physician and social media commentator, wrote on his blog, "This is a shameful act to put this woman, who is already paying the price for her mistake, in prison. If you are going to do that, you should put all of the administrators at Vanderbilt—who are overseeing her, who are overseeing safety, who are responsible for communicating with CMS and with the patient—they should all go to jail."

But neither the prosecutor nor the Tennessee Board of Licensing Health Care has taken any action against the health system.

Beyond the personal aspects of these events, the prosecution of the nurse is sending waves of resentment among nurses who fear the trial will set a precedent. On social media, a nurse working in Florida wrote, "If this poor woman gets prison time with rapists and murderers for administering a wrong medication, I'll change careers. This ruling would strip all joy from working, and it would be constant agony hoping you never mess up."

Another wrote, "I've been a nurse for 35 years. I'm sure it was not intentional. I made a bad medication error 17 years ago and nearly killed a patient. It was a big wake-up call … We are human, and we get rushed, busy and distracted. We are spread too thin. I'm so sorry for this nurse and the patient."

The pandemic has only compounded the crisis in the health care sector. Workers are burned out and deeply exhausted by staffing shortages and additional burdens being forced on them, barely keeping the entire infrastructure from collapsing. "Sentinel events," serious patient safety incidents, have reached their highest level since reporting of them began.

An estimated 7,000 to 9,000 people die each year in the US because of medication errors, and hundreds of thousands of adverse events are gone unreported. The cost of these errors amounts to about $40 billion each year. However, rather than addressing the underlying socioeconomic issues that are at the root of these tragic but preventable medical errors, the capitalist state criminalizes health care workers.

The Institute for Safe Medicine Practices wrote last year, condemning the Tennessee Board of Nursing's revocation of Vaught's license: "Healthcare workers won't want to join a profession where an unintended mistake could end in the loss of their license or even jail time. Also, healthcare practitioners, including nurses, will not want to speak up when they make an error, which will cripple learning, prevent the recognition of the need for system redesign and set the healthcare culture back to when hiding mistakes and punitive responses to errors were the norm."