A discussion with victimized Vanderbilt nurse RaDonda Vaught: An in-depth review of the fatal incident and the ensuing criminal trial

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Part one of a two-part interview. For part two, click here .

It has been nearly two years since former Vanderbilt Hospital nurse RaDonda Vaught was convicted for the accidental death of 75-year-old Charlene Murphey on December 27, 2017. She was found guilty on two counts: criminally negligent homicide and impaired adult abuse. The Nashville, Tennessee jury chose to find Vaught not guilty of the reckless homicide charge aggressively being pursued by the district attorney.

After the verdict was read, Vaught opened to the press and spoke on her ordeal."First, we have not forgotten about Ms. Murphey and her family. Not at all. This is about creating a safer environment so that things like this don't happen again." On the issue of Vanderbilt's role in the death, Vaught said, "I think people deserve some answers to those questions, and they didn't get them in the courtroom. The nursing community is angry and frustrated. Nurses have found their voice, and they're rightfully upset about this, as they should be. Where is the accountability? Where? All this says is that you as a nurse are disposable?"

The conviction and then the sentencing in May made national headline news. Nurses and healthcare workers across the United States and the world rallied to her defense because they understood that the medication error that led to the accidental death of Ms. Murphey was caused by chronic understaffing, inhuman workloads and the subordination of medical care to corporate profits.

At the time, the Socialist Equality Party called on workers to demand Judge Jennifer Smith of the Davidson County Criminal Court suspend her sentence and release her with no jail time. Furthermore, it called on the workers to demand immediate restoration of Vaught's nursing license and her immediate reinstatement at Vanderbilt with full back pay and restitution.

The World Socialist Web Site *was only recently able to contact RaDonda Vaught to discuss her case and the events surrounding the criminal prosecution. She granted us permission to document our discussion. The following interview was edited for clarity and length.*

Timeline of events

•Ms. Charlene Murphey was admitted to Vanderbilt University Medical Center (VUMC) on December 24, 2017, for a possible bleed into her brain caused by metastasis to the brain from her lung cancer. Before her discharge, her physician ordered a PET CT scan to identify cancer deposits throughout the body, scheduled for December 26, 2017. Due to the patient's claustrophobia, the antianxiety drug Versed was ordered to be given before the procedure. Nurse RaDonda Vaught inadvertently administered Vecuronium, a paralytic. Minutes later, Ms. Murphey coded and resuscitation was attempted. However, she suffered irreversible brain hypoxia. That evening, the family withdrew care and Ms. Murphey passed away.

•On the day of the event, VUMC's director of clinical risk management, Diane Moat, RN, JD, and Marcella Lupicia, the associate nursing officer over neurosciences, spoke with Vaught about the incident. Vaught submitted a detailed account of the events.

• After returning from the New Year's holiday, on January 3, 2018, Vaught was handed her termination letter.

•On August 28, 2018, Marie Randolph with the Tennessee Department of Health (DOH), Office of Investigations, conducted a two-hour interview with Vaught to review the details of the medication error and events of December 26, 2017. After the meeting, Vaught was informed that this would not be an urgent issue for the board because she was not considered a threat to the safety of patients, given the accidental and isolated nature of the event. She was specifically told that her case was "at the bottom of the stack and it would likely be several months before it would be reviewed by any board." Vaught confirmed with them that it was "okay" for her to continue working as an RN.

•On October 3, 2018, at around 10:20 a.m., an anonymous complaint was filed in person to the state agency's central office by someone from the DOH, Office of Investigations, stating the specific details outlined in Vaught's interview with Marie Randolph, that ended with the statement "Vanderbilt University Medical Center did not report this sentinel event via IRS to the SSA." The Centers for Medicare & Medicaid Services (CMS) scheduled an on-site inspection at VUMC.

•On October 23, 2018, Vaught received a certified letter from Antoinette Welch of the DOH stating that "after review by the Board's Consultant and a staff attorney for the TN DOH, a decision was made that this did NOT merit further action … this is not a disciplinary action and no record of it will appear in your licensure file."

•On November 5, 2018, Vaught spoke with RN Gail Lanigan of the TN Department of Health Division of Health Licensure & Regulations regarding the events surrounding the medication error at VUMC.

• CMS issued its report on November 29, 2018, and the news of the medication error and patient death was made public for the first time, although the names of the involved parties remain protected.

•The next day Vaught received a phone call from agent Ramona Smith of the Tennessee Bureau of Investigation (TBI), Criminal Investigation Division, Medicaid Fraud Control Unit, to set up an interview. She met with Ms. Smith on December 5, 2018, at TBI's headquarters for a two-hour interview. Vaught was read her Miranda rights before discussions commence.

• On December 7, 2018, RN Shirley Pickering from DOH Office of

Investigations contacted Vaught about a second complaint against her submitted to the Board of Nursing (BON). Vaught met Pickering on December 12, 2018, for a recorded interview in Nashville. Vaught attempted to contact Ms. Antoinette Welch by phone and email to discuss the second DOH investigation but never received a response.

•On February 3, 2019, agent Ramona Smith of TBI informed Vaught she had a warrant for her arrest but did not provide any details of the charges. The bond was set at $50,000 and Vaught was allowed to turn herself in the next day at their headquarters.

• Vaught voluntarily presented herself on February 4, 2019, and was arrested and booked on two felony charges of reckless homicide and abuse of an impaired adult. That same day, the death at VUMC, the CMS report and the names of the patient and Vaught were made public.

• Vaught sought legal representation and retained Peter Striase as her criminal attorney in her defense. Glenn Funk, district attorney in Davidson County, Tennessee, was responsible for the decision to pursue criminal charges against Vaught on the investigation presented by TBI.

•The associate district attorneys assigned to prosecute the criminal case were Chad Jackson and Brittany Flatt. The criminal case was assigned to Judge Jennifer Smith, who presided over all discussion hearings from February to September 2019, the preliminary trial hearings in early 2022, the jury trial in March 2022 and the sentencing in May 2022.

•Administrative charges were filed against Vaught's nursing license on September 17, 2019, by Caroline Tippens, general counsel for the DOH. The charges were: unprofessional conduct, failure to maintain a record and abandoning/neglecting a patient requiring nursing care. In July 2021, these charges were argued in a public hearing in front of the BON, where Vaught was found guilty of all the charges. Her license was revoked and Vaught was fined $3,000 for the charges and had to pay nearly $36,000 in court costs.

Benjamin Mateus (BM): RaDonda, why did you become a nurse?

RaDonda Vaught (RV): Actually, being a nurse is the one thing as a child that I said I would never do. My mom worked in a hospital, but not in any healthcare setting. She worked for central supply and housekeeping. The hospital was cold, smelled funny and the food was terrible. On top of that, the people were all sick. I just thought, I don't ever want to be here. Never saw me as a nurse. I thought of myself doing something different, more artistic.

I was in my late 20s and had completed so many different college classes, but still felt lost. I was considering a career path in genetic counseling, but there wasn't a program anywhere near where I lived or offered a master's program. I looked into ophthalmology, but then I took trigonometry. It was the proudest "C" I ever made in my life and so that changed that.

About that time my adviser pulled me aside and told me I had completed almost all the course prerequisites for a Bachelor of Science degree in nursing, I just needed a couple of other courses. I spoke with my husband about that, and there are so many things you can do in the field. He joked, "On top of that you get to wear pajamas to work every day."

So, I decided to apply and got in. But it wasn't until I was closer to being done with my program that I found myself starting to see myself in a role of a nurse and appreciate that connection that you make with people and an impact that you can have on them. And I knew I wanted to work at Vanderbilt. I had taken plenty of clinicals there.

I really got my start working in the neuro intensive care unit (ICU) on nights. It was an eye-opening experience. These patients have either had massive strokes or brain tumors. Many of them are in a vegetative state. When you are taking care of them, you have no idea what their future holds for them. You can't see the impact of what you are doing for them. After a bit, they would move out of the critical care unit and then you'd move on to the next patient.

And after I got my feet wet and transitioned to the day shift, that was when I really began to understand and appreciate my role as a nurse working in a multidisciplinary team taking care of a unique population impacted by these devastating illnesses. Six months into being on the day shift, I started seeing these same patients that I took care of come back to the hospital for follow-up care. They were walking; they were talking; they were with their families recovering from something that was a traumatic experience. Seeing how these multidisciplinary teams came together to positively change their lives was extraordinary. It was very fulfilling. I began to appreciate and enjoy the process of learning, meeting the patients and supporting through a very difficult time in their lives.

I guess that was a knack that I've always had but hadn't realized where it fit into my life until I became a nurse. I took on that role in caring for people. It didn't matter if they were complete strangers. I treated all of them like I wanted to be treated, like I would have wanted my grandmother to be cared for. It was a very fulfilling job. But not just a job. Something I held very dearly.

BM: How long did you work in the neuro ICU?

RV: I started at Vanderbilt in October of 2015.

BM: That would mean you had only been working at VUMC for two years before the incident with Charlene Murphey. You moved through the ranks quickly as a newer nurse with very challenging assignments. Did you feel prepared or ready for them?

RV: By then, I was already on my third orientee—these are new graduate hires that go through a supervised training process before working independently. So, there must have been something that the leadership saw in me to gain their confidence. I don't know if my age difference had something to do with it. I graduated from nursing school when I was 30.

Granted, I had only been a nurse for a year before starting at Vanderbilt. At this point, three years had passed when the incident happened. I did work nine months in a med surg unit at a smaller outlying hospital before I applied to VUMC. I knew that wasn't the environment for me. I didn't feel safe practicing there and I didn't feel safe about the care that a lot of people were receiving. Most of the nurses were fresh out of school and the seasoned nurses were close to retirement. That's why I applied to VUMC.

The work in the neuro ICU wasn't easy but I felt the supervision was there to give me the support I needed. I think in terms of being a younger nurse, I carried myself a little bit differently than maybe other nurses. Maybe that made a difference. I certainly wasn't cocky or arrogant; I was always striving to learn more things. But our unit had a normal amount of turnover for an academic-associated institution like Vanderbilt that attracts a lot of people for the sake of having it on their resume for a year and then moving on to apply to graduate school or some other advanced practice.

The treatment of Charlene Murphey

BM: Could you recount what happened with Charlene Murphey on December 26, 2017?

RV: Charlene Murphey was admitted to our facility from an outlying hospital through the emergency department three days before. Her CT showed she had a bleed in her head. She was experiencing neurological symptoms and her doctors believed she had a subdural hematoma caused by a mass. They suspected that it was a metastasis from her lung because she had a history of lung cancer. That is a common pathway for such cancers.

She responded well to her treatment with steroids and her treating physician downgraded her level of care to a step-down unit earlier that day. But because her symptoms were severe enough to put her in a critical care unit, they wanted to do a PET scan before her discharge to make

appropriate treatment plans for her. [PET, Positron Emission Tomography, is a whole-body imaging scan using a special tracer administered in the blood to look for cancer. The patients are placed on a narrow table that slides into a large tunnel-shaped scanner. Patients must remain still to get clear images.]

Apparently, there was some conversation with her family and the primary care team earlier during the day about her having severe anxiety with these kinds of scans. But nothing had been prescribed for her to take when she was brought down to the PET scan area. They had given her permission to be off the floor and "off monitors," which meant she didn't need any cardiac monitoring or a nurse to accompany her. The transport agents took her there. The nuclear medicine technician had already injected the radiotracer, which meant the scan had to be done in 45 minutes to an hour. Otherwise, the tracer would be metabolized, and the scan would have to be aborted for another day. The time frame for these things is narrow.

Everything I'm telling you now are from my recollection and things I learned in hindsight. I was the "help all" nurse that day, which means I didn't have any patient assignments and was a resource to "help out" nurses. I got the call from her primary nurse around 2:45 p.m. to go down to the PET scanner and give Ms. Murphey a medication. He [Murphey's nurse] was watching patients for his colleague who was either off the floor or on a break and couldn't come down to administer the medication. I agreed and asked if she needed to be monitored. He said she had orders to be off the floor and didn't need monitoring. I also asked him if the orders for the medication had been placed.

I tried twice to find the drug Versed in the medication dispensing cabinet. And each time I would search for it, it wasn't there under her profile of medications. *[Also known by the generic name Midazolam, a medication used in procedural sedation to treat severe agitation.]* I then went into an empty patient room and pulled up her MAR [Medication Administration Record] and confirmed that the order was there. I wrote it down on a lab bag with a pink sharpie. I grabbed supplies that I would need, including a patient sticker from her chart to identify her, and went back to the automated dispensing cabinet for the third time to try to find the medication.

Again, it wasn't there. At this point, I knew that the order had been placed and verified and acknowledged by the nurse and pharmacy. Everything was appropriate, but they weren't being communicated through the medication dispensing cabinet. This wasn't surprising because we had been experiencing delays in new drug orders for the last two months. In early November we had launched EPIC, the new electronic record system, which was creating delays with random drug orders not coming through.

So, I utilized the override function and I searched for "VERSED." There wasn't an option to choose between the generic and brand name; the system automatically defaults to the generic name. In the meantime, I'm speaking with my orientee—a brand-new nurse who was shadowing me that day—about a swallow study that we were going to do in the emergency department. This was a very busy part of the unit with the medication dispensing cabinet in the middle of everything—the bathroom, the stockroom, the nurse's station, patient rooms and the CT scanner portal behind us; very busy.

I'm having this conversation with him, which I shouldn't have been doing. I typed VERSED and selected the first thing on the screen. The drawer opens and I retrieve the medication which later I realized was the paralytic agent vecuronium. There are no warnings that typically accompany retrieving paralytics, such as a series of warnings that state a physician must be present, and you must be prepared for immediate intubation. None of those things were there. There was no warning that a second person had to witness me pulling this drug.

Vecuronium: A potentially lethal drug

BM: Why was vecuronium being stored in a medication dispensing cabinet?

RV: We stocked a lot of the neuromuscular blocking agents in the neuro ICU. We would do a fair number of intubations on the unit. We also did many sterile procedures such as placing PEG tubes [feeding tubes placed directly into the stomach], tracheostomy tubes and intraventricular drains. We had patients with complex seizures, including those with status epilepticus for whom an agent like vecuronium is preferred because it can rest their body and prevent them from becoming exhausted.

To my knowledge, these paralytic agents that also include succinylcholine and rocuronium are still stocked there because it's something that in the neuro unit we would use more often than probably most other types of units, even in critical care units.

BM: Were there any forms of checks, alarms or warnings that told you the medication you selected was a paralytic and could cause the patient to not be able to breath?

RV: They were not in place. If they had been there, it would have been transcribed in her MAR when I withdrew it because you must acknowledge certain things along the way as you try to select a medication.

To override the automated dispensing cabinet, you have to select a reason so it can dispense the medication you need. And that too would have been printed on or attached to her MAR. Meaning had I selected "override", that information would have been placed on her medication administration record forcing me to acknowledge a warning about it being a paralytic agent. But by then, with all the problems we had been encountering with trying to access these medications, we just picked the first reason that came up on the override list and moved on with it because we're trying to get the work done. The system wasn't working the way we need it to do. All of us were working around these glitches.

Now with respect to paralytic agents, if the process had been working, a second person would have been required to witness me pulling this drug for whatever reason, emergent or routine. That alert is standard across the board. It should have been there, but it wasn't.

BM: And why wasn't it there?

RV: Maybe there was some sort of software issue; it wasn't coded correctly or communicating appropriately? Or maybe the machines were in some form of an override function themselves to make it more accessible for us to get the medications we needed in a timely manner while they were trying to figure out why things weren't communicating.

BM: Wasn't there an email sent to the staff telling them to use the override functions to get your work done efficiently?

RV: I do remember that, but I've never been able to locate it. Obviously, I didn't have access to my email once I was terminated. I know for a fact, however, that this was something that our management staff was aware of and had communicated via email to our staff there that there were system issues going on with overrides and with drug orders coming through in a timely manner. It was understood that's what we had to do. We didn't have another option. You didn't have another option in urgent and emergency situations. What are you supposed to do?

Although this wasn't an emergency situation, it was an urgent one because there was a timeframe involved. She'd already been down there, and the radiotracer had been administered. I didn't know how long it had been since she'd received the medication for the PET scan. They were using a paper chart even at that time. And the last information that I received from her nurse was that they were going to send her back upstairs if she couldn't get the Versed and the PET scan would have to be rescheduled for another day.

Remember, it was the day after Christmas. There were only a minimal

crew of people there. This was going to delay her discharge and treatment plan.

BM: What did the medication look like?

RV: The medication comes in a 10-milliliter glass vial. There was powder in it. The vial that was stocked which I picked up didn't have the usual red cap you see with paralytic agents. It had a gray top, and the cover was also gray. The more common thing that you would expect is that bright red circle that tells you it's a higher-alert medication. Versed doesn't require that designation. Different classes of drugs sometimes would have different color pop tops on them.

I remember when I was at the Board of Nursing (BON) hearing, they showed a different image of vecuronium vial, one with a red cap, and my attorney actually caught that. He said, "Is that the original one, or is this just an example you're giving here?" And it turns out, the one that was in evidence that I had used had a gray cap.

The ISMP [Institute for Safe Medication Practices] has made recommendations to make the practice safer. And one of those is standardizing those colors across the board to make it more difficult to make a mistake. [*The 2016 ISMP report indicates medication errors with neuromuscular blocking agents are not uncommon. A 2009 analysis of 154 events over a five-year period demonstrated that the administration of such agents when they were not the intended drug accounted for approximately half of all wrong drug errors. Look-alike packaging and labeling was listed as one of the top factors for such errors.]*

I saw that the medication in the vial was in a powder form. That should have been a warning to me. Versed vials come in a liquid form. I overlooked it—and it wasn't right on my part—because after Hurricane Maria went through Puerto Rico and took out several drug manufacturing facilities, it forced us to start receiving various brands and different formularies of those drugs that we hadn't used before.

So, now we were receiving medications in powdered forms where we had to reconstitute them in a liquid form before administering them, such as antibiotics, specifically more than anything else. Or if you opened a cabinet looking for one specific item, there were two different-looking forms of the medication although they were the same thing. And seeing different forms of these drugs over several months prior meant you got a little desensitized to that change. I should have noticed it, but I didn't.

BM: Now you have reconstituted the medication. What happened next?

RV: I flushed her IV—she only had a left external jugular access—and I gave her one milliliter (1 mL) of the reconstituted solution. Then I flushed the IV again with normal saline. Fairly standard.

The nuclear medicine technician was waiting there. I assumed she was going to take her directly into the scanner. However, Murphey was taken to a lead-lined room [protecting others against excess radiation] to wait. It was probably 15 to 20 minutes before anyone found her to be unresponsive. She was alone in the room with only a closed circuit television monitoring. There's no audio and it's really a very simple image. There would be no way of knowing if she were unresponsive or just sleeping.

I went to the ED next and then back upstairs to Murphey's room to speak with her primary nurse because I had what I believe to be Versed in a bag in my pocket. I hadn't been able to document that I had given it to her because there were no scanners in the radiology department and didn't want to be running around the hospital with it in my pocket. He could lock it in the safe in her room until she returned. I would then scan her and the drug and document it had been given off the floor at a different time, for the reasons I mentioned. The remaining Versed could then be disposed of safely.

As the "help-all" nurse, I carry a radiophone used to communicate life-alerts. At this point I heard the overhead rapid response to the PET scanner. The patient's family was standing outside the room talking to the case manager and they also overheard the emergency alert. We tried to call the PET scan area but couldn't get an answer. I told them I'd go down to check to see if it was their family or not. They were very concerned. When the charge nurse and I arrived, the response team was there. They had already intubated Ms. Murphey. They had a pulse, and they were going to transfer her back up to the neuro ICU. It took a better part of the hour to get her on the ventilator, stabilize her and place several central lines.

The code was ending. We had reached a point where we had done everything we could. I was drawing another set of labs and went across the hall to tube them to the lab when her primary nurse approached me with the medication bag I had previously given him. He asked me if this was what I gave the patient. I looked at it and said yes it was. He said, "This isn't Versed." I asked him what it was, and he said, "Vecuronium!"

I asked him to give the bag and the entirety of its contents to our charge nurse. I sent the labs downstairs and walked back into the patient's room where our critical care anesthesiologist, resident physicians and two of the critical care nurse practitioners from our neuro unit were debriefing and discussing potential causes for her arrest. Was it a cardiac event? Did she have a worsening of her subdural bleed? Did she have a pulmonary embolism?

I interrupted their conversation and said, "Remember when I was telling you throughout this process that she got a milligram of Versed on board, but it's not documented. Please know that I didn't actually give her Versed. What I gave her was Vecuronium."

At that point I excused myself and left the room. I went to my nurse educator's office who happened to be there that day. I didn't return to the unit to do … I was not in any capacity to function in my role. I spoke to a few different members of leadership, our associate chief nursing officer, risk management, my manager, and I followed their instructions on what I needed to do. I briefly explained what happened, that I had given her the wrong medication. They walked me through the process of filling out an incident report. And when that was done, it was later in the evening, and I left.

After the death of Charlene Murphey

BM: What happened that night when you arrived home?

RV: My husband was overseas, and I didn't have a way to reach him. I came home to an empty house. It's an hour's drive from Nashville to where I live out in the middle of nowhere. At that point she hadn't passed away, but I was already dealing with that certainty in my mind. It doesn't take very long without oxygen to your brain to cause permanent damage. I went over everything again and again asking, "What did I do to her?" All these things were running through my mind. I couldn't sleep.

That was the last day I was supposed to work. I had seven scheduled days off after that. The next morning, I was supposed to get up around 4:30 a.m. and drive to Birmingham, Alabama, to meet family. When I left the house, it kept sitting with me. I needed to know what happened to the patient. I needed someone to tell me she was okay.

I called the unit around five in the morning while I was driving. The charge nurse told me that she had passed. I think I just hung up the phone. I don't really remember. The only other person I knew to call at five o'clock in the morning was my unit manager. I was inconsolable. We talked for a few minutes. And at that point I was already on the way to Birmingham. I didn't want to be alone.

Then, on the day before I was supposed to return to work, I was called in for a meeting. That's when my employment was terminated.

BM: Were you surprised you were terminated?

RV: I was. Let me explain.

After the code, as I was processing what happened, I thought I'm going to lose my job. I felt like I wrote my own future. I thought, "I could have just killed this patient. I'm going to lose my job. I'm going to lose my license. I'm going to go to jail." I said so much to my nurse educator.

But what I kept hearing from my coworkers and my friends that I worked with, the employees in my unit, everyone said that when things like this happen, it's a systems failure. It's a systems issue. No, I don't think you're going to be fired. They shared other examples of events that had happened and none of them seem convinced that I was going to be terminated. Probably punished to some extent, for sure.

I expected ramifications. I didn't know what they were going to be. This is uncharted waters here. I didn't really know what to expect. I had assumed based on what people who had been there longer than me that they didn't think that I was going to be terminated. So, it did come as a surprise.

What I was told by our associate chief nursing officer who oversees the neurology services on the units, she said, "We just want you to know that this is not because of the outcome. We're not letting you go because of the outcome of the patient. We're letting you go because you failed to follow our medication administration policy."

What I've learned since then is that generally when risk management and human resources (HR) come together to decide about terminating an employee after an event, they go through a process. And what they're looking to determine is if that employee is at risk for repeating this same mistake. If it's something they feel they can't correct or can't be fixed through education, training, etc., then they terminate that employment. Otherwise, they wouldn't terminate. Instead, they'd work with that employee to find a solution.

Continued in part two.