

## CRIMINAL CONVICTION FOLLOWING A FATAL MEDICATION ERROR: THE RADONDA VAUGHT CASE

March 29, 2022

On March 25, 2022, a jury in Nashville, Tennessee found a former Vanderbilt nurse guilty of negligent homicide and gross neglect of an impaired adult related to a medication error in 2017. The case could impact virtually all aspects of health care law including employment law, licensure investigations, state and regulatory investigations, medical malpractice lawsuits, and patient safety initiatives.

### FACTUAL BACKGROUND

On December 24, 2017, Charlene Murphey, a 75-year-old patient with a history of cancer, was admitted to Vanderbilt hospital with symptoms of a potential brain bleed. On December 26th, a physician ordered a full-body PET scan. Due to claustrophobia, Ms. Murphey's physician also ordered 1 mg of Versed, an anti-anxiety medication. At the time, Ms. Vaught had been a registered nurse at Vanderbilt for more than 2 years and had been assigned as a "help-all" nurse on the unit. She was asked by another nurse to administer Versed to Ms. Murphey before the PET scan.

Ms. Vaught attempted to obtain the Versed from an automatic medication dispensing cabinet. She could not find the medication in the cabinet and used a system override to obtain the medication. Trial testimony indicated that medication overrides were a fairly common practice in the fall of 2017 due to integration issues between the EMR and medication dispensing machine, but there is some dispute as to how often they were necessary by the end of December. Regardless, Ms. Vaught accidentally obtained a vial of Vecuronium Bromide – a paralytic used during surgery while a patient is intubated – instead of Versed. Ms. Vaught reconstituted the medication and administered what she believed was 1 mg of Versed, but was actually Vecuronium Bromide, to Ms. Murphey at her bedside in radiology. Ms. Murphey was found unresponsive about 30 minutes later. Ms. Murphey was resuscitated but never regained consciousness and died the next day after life support was withdrawn by her family.

While Ms. Murphey was being resuscitated, Ms. Vaught realized she had given the patient the wrong medication. She immediately told the physicians and her supervisor about the error. She reported she had been distracted while obtaining and administering the medication.

### POST-EVENT SETTLEMENT AND INVESTIGATIONS THROUGH TRIAL

Ms. Vaught was fired from the hospital. The Tennessee Board of Nursing initially reviewed the matter and closed it with no finding against Ms. Vaught. The hospital reportedly settled a civil lawsuit out of court with Ms. Murphey's family

in 2018. In October 2018, an anonymous source reported the incident to state and federal authorities. The Centers for Medicare and Medicaid Services (CMS) conducted an inspection at Vanderbilt and issued a Statement of Deficiencies concerning the patient death.

A criminal investigation was also initiated, and Ms. Vaught was indicted in 2019 for reckless homicide (Class D felony) and physical abuse or gross neglect of an impaired adult (Class C felony). The Tennessee Board of Nursing reevaluated the matter and revoked Ms. Vaught's nursing license in July 2021.

The criminal trial began on March 21, 2022. On March 25, the jury found Ms. Vaught guilty of negligent homicide and gross neglect of an impaired adult. She was acquitted of reckless homicide. She will be sentenced on May 13th.

## NEXT STEPS FOR HEALTHCARE SYSTEMS AND PROVIDERS

We are all human and we all make mistakes. Nurses are no exception. Criminalizing nursing mistakes is extraordinarily rare. While unusual, the results of the RaDonda Vaught trial are chilling, particularly for the nursing community. Concerns are being raised about the already existing nursing shortage and potential disturbing effects the case could have on quality initiatives. The American Nurses Association and the Tennessee Nurses Association issued a joint statement on March 25, 2022, noting in part:

*Health care delivery is highly complex. It is inevitable that mistakes will happen, and systems will fail. It is completely unrealistic to think otherwise. The criminalization of medical errors is unnerving, and this verdict sets into motion a dangerous precedent. There are more effective and just mechanisms to examine errors, establish system improvements and take corrective action. The non-intentional acts of Individual nurses like RaDonda Vaught should not be criminalized to ensure patient safety.<sup>1</sup>*

Nurses should continue to be encouraged to report near misses, errors, and adverse events so they can be reviewed and analyzed for system improvements. Healthcare organizations should continue to foster a culture of safety and support reporting nursing and other staff to the fullest extent. Messages of support to frontline nursing staff in the wake of Friday's verdict are highly encouraged.

Without open and honest communications, and participation from nursing and other staff, improvements simply cannot happen. The most effective patient safety improvement solutions come through a systems-based approach, which works to eliminate or reduce the human error component to the extent feasible. For example, mechanisms like scanning a medication and patient armband prior to administration are system-based improvements designed to minimize the risk of harm. Unfortunately, a scanner was not available in the area of this patient's care at the time in question, but it is only one of many examples and one of several failures that occurred in this incredibly unfortunate result.

Many of our clients choose to do this type of systemic analysis through participation with a Patient Safety Organization, which creates a confidential, non-punitive, and legally protected environment for reviewing patient safety improvement data. Analyses constituting confidential and privileged Patient Safety Work Product have the highest protection under federal law. Although, it is important to remember that even participation with a PSO does not eliminate the requirements to report certain errors to state or regulatory agencies where required and applicable and ultimately

cannot shield a provider from civil or criminal liability. However, the information reported in the name of patient safety cannot be used against him or her.

We understand the prosecution and conviction of Ms. Vaught will leave many healthcare providers understandably feeling uneasy. We believe criminal prosecutions of medical mistakes will remain relatively rare moving forward. Please reach out to our [Patient Safety & PSOs](#) or [Risk Management](#) teams if you would like to discuss the case in more detail or if we can assist with any specific next steps for your organization.

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<sup>1</sup> <https://www.nursingworld.org/news/news-releases/2022-news-releases/statement-in-response-to-the-conviction-of-nurse-radonda-vaught/>