Chapter 26.
The Story of RaDonda Vaught.

(This is the complete chapter from the book.)

She worked at Vanderbilt University Medical Center in Nashville, Tennessee, and qualified as a nurse in 2017. Nurse RaDonda Vaught was, by all testimonies, a dedicated, devoted role model and hard-working, competent nurse.

In 2019, one day, RaDonda Vaught was a float nurse based in the hospital's neurological intensive care. Float nurses work in multiple sections of a healthcare facility to alleviate the shortage of nurses. She was on her way to the Emergency Department to conduct a swallow study on a patient when she received instructions to quickly administer *calming medication* to an anxious 75-year-old lady about to undergo a radiological scan. RaDonda was also accompanied by a new nurse she was mentoring and orienting into her new hospital job.

Image no. 1. *Versed* skin cream.

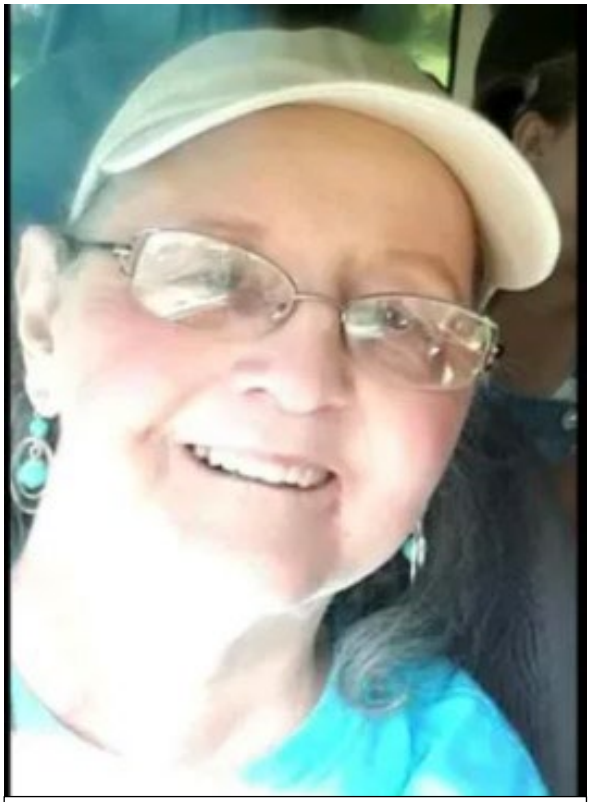

Image no. 2. Patient Charlene Murphey, 75 years old, is now deceased. Photo provided by family.

The physician ordered Radonda to administer an intravenous dose of midazolam to patient Charlene Murphy. **See image number 2**. The physician prescribed the drug by the *brand name* of **Versed**.

The physician failed to use generic prescribing to avoid drug confusion. He ordered midazolam under a *retired brand name* for midazolam, **Versed**. There is no drug currently in the USA with a commercial or generic name of Versed. Versed is an abandoned drug brand name, and the name is now used for a skin cream**. See images number 1 and 7**. That was not a well-known fact.

Image no. 3. The vial of vecuronium and Radonda Vaught's arrest photograph.

Nurse Radonda Vaught had to obtain the drug from an automatic medication dispensing cabinet and entered the full name **VERSED,** as ordered by the physician. The cabinet did not recognize the name and failed to dispense anything, as no such drug existed by that prescribed name. Nurse Vaught then followed the daily "workaround" routine, as was customary in the hospital, to bypass the dispensing machine software. She next searched for drugs with a name beginning with the letters **VE.** She successfully obtained the drug called **VE**curonium. All the time, she was explaining how to operate the medication dispensing cabinet to the new nurse she was mentoring and how to do "**workarounds**" or "**overrides**" were used when the automated dispensing medication cabinet failed. Radonda testified in court that the *nurses were instructed to use "work-arounds" on the dispensing cabinets* to save time, when so needed. The dispensing cabinets did not communicate with the prescribing system, and nurses had to remember the drugs required. There was no pharmacist to help, nor any phone link to a pharmacist for advice. Hospitals use automated Dispensing cabinets to save on pharmacists' salaries. Radonda injected the vecuronium into the patient and then left the patient, expecting her to slowly feel less anxious. Next, she rushed to the emergency department, under time pressure, to complete the next task. Radonda, later in the day, was informed that the patient, Charlene Murphey, a while later had ceased breathing and was in intensive care. The patient was declared brain-dead the following day. She had died. Nurse RaDonda Vaught was immediately fired from her job, and the nursing board revoked her nursing license. She was charged and found guilty of the criminally negligent homicide of Charlene Murphy.

MedPage reported on June 2, 2022, that the President of the Anesthesia Patient Safety Foundation (**APSF**), Dr. Daniel Cole, stated that criminalizing this nurse's mistake was absolutely the wrong approach[1]. He said the hospital should have had other safety systems to save this patient's life.

1. *Barriers should not have existed between the nurse and professional pharmacists when the automated medication dispensing machine failed* to produce a drug upon the nurse's first drug dispensing attempt. A pharmacist should have been in immediate phone contact with the person standing at the medication dispensing machine.

2. High-risk drugs like injection sedatives, such as midazolam, should require a *mandated period of patient vital sign monitoring after administration*, like all anesthesia drugs and injectable sedation drugs. Had Nurse RaDonda remained with the patient, she would have observed the patient's hypoventilation-apnea and paralysis and discovered the drug-swap error with time to save the patient from brain death. In addition, someone injecting sedation should have airway management and ventilation assistance *skills* to be permitted to inject critical drugs like intravenous sedatives
3. The hospital should *not have had the deep "work-around culture"* amongst the nurses that it had to enable them to bypass automated drug dispensing machine failures. The dispensing cabinets needed better-designed s405ystems. Ultra-critical drugs like muscle relaxants needed special precautions, like visual and auditory prompts from the Automated Medication Dispensing Cabinet warning what the drug class was. Automated dispensing machines are cost-saving machines used to avoid having pharmacists on the job at that point. A hospital "*work-around culture*" had become a "**NORMALIZATION OF DEVIANCE**" that set the stage for patient Charlene Murphey's death.

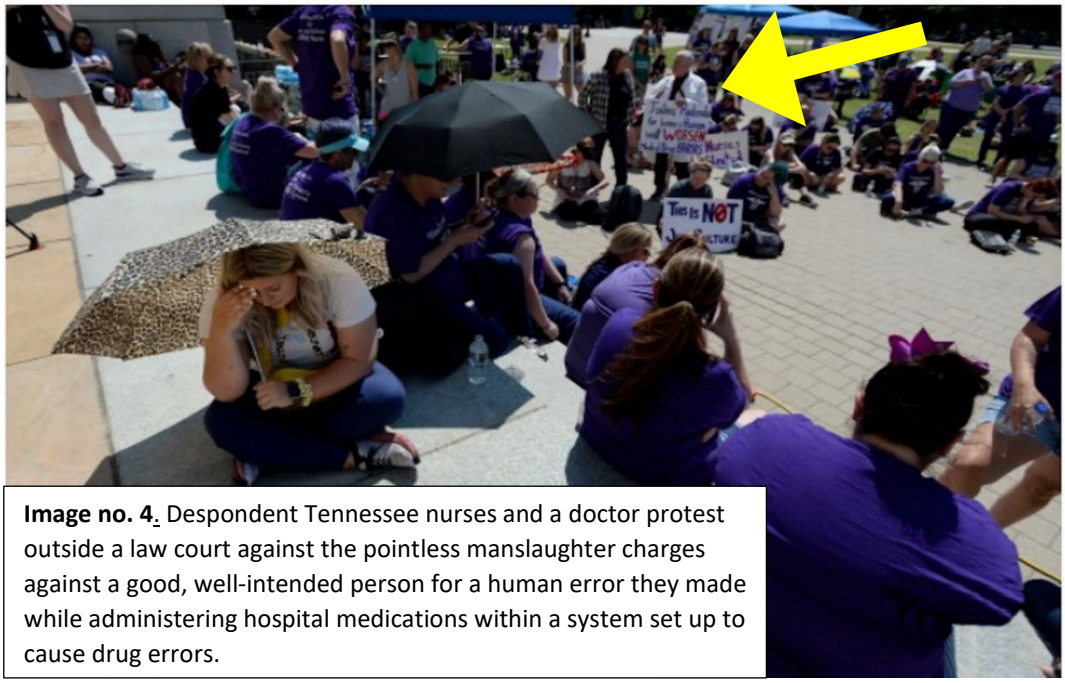

Image no. 4. Despondent Tennessee nurses and a doctor protest outside a law court against the pointless manslaughter charges against a good, well-intended person for a human error they made while administering hospital medications within a system set up to cause drug errors.

Vecuronium is a muscle-paralyzing agent used in anesthesia and the chemical execution of murderers. It is one of the 2 classes of most lethal drugs in medicine when unintentionally injected at the wrong time or into the wrong patient.

Anesthesiologists work in far more complex situations than what Radonda Vaught was working in. Identical to Radonda, they work under time pressure often and experience distractions. Anesthesiologists also have to multitask, keep an ear on dialogue, monitor sounds, and maintain situational awareness of the progressing surgery and evolving patient conditions. Worse for anesthesiologists is that medication administration processes become very automated mental processes, making them unconsciously extra vulnerable to

distraction-caused errors. On average, anesthesiologists recognize a drug administration error once in every 133 anesthetics they perform (The Webster number.)

Some additional systems problems that contributed to the drug error were;

1) The prescribing physician did not use a generic drug name when prescribing. He used an *expired and discontinued Brand name* for the generic drug name midazolam, "**Versed**." Versed is now the name for a skin cream. That created the first step of confusion. There is no world drug called Versed by brand or generic name. **See images no. 1 and 6.** This was the big system flaw that set the stage for Charlene Murphey's death and made RaDonda an unintended agent in the patient's death.
2) The automated drug dispensing machine Radonda Vaught used to obtain the medication did not recognize the requested drug name, "Versed." The Vanderbilt Hospital admitted in court that their automated medication dispensing system was having defects fixed at that time[2].
3) The Tennessee legal system was also pointed out as flawed. The system treated Ms. Vaught's prosecution as legally and ethically justified[3].

On 2022 May 25, the APSF reacted to the case of Nurse RaDonda Vaught's conviction for criminally negligent homicide due to a drug administration error. They stated that such a conviction was counterproductive because it would make healthcare professionals fear retribution and choose not to report errors which, in turn, will handicap the healthcare system in figuring out how to prevent the systems' failures that facilitate such errors. The APSF statement admitted that despite the APSF's existence for 35 years to prevent medication errors, patients still are dying frequently from anesthesia drug swaps in America.

The best journalist article covering this case was by Ashley Perham, who *extensively interviewed the hundreds of nurses and **one anesthesiologist*** who unanimously supported Radonda Vaught and protested outside the Nashville courts on the last day of her trial before her sentencing.[4] They all believed her criminal punishment for making a human error that the hospital system set her up to make despite her best intentions as a diligent, caring person was wrong.

RaDonda Vaught remains barred from nursing and finds employment working on a family farm. The judge wisely listened to testimonials and sentenced Radonda only to 3 years of probation with no jail time to be served. Her career and life were, however, already destroyed. The number of nurses retiring early or abandoning their careers increased after this highly publicized tragedy.

The RaDonda Vaught prosecution provoked much news media and blog commentary. Professional blogger and former surgeon Dr. Chuck Dinerstein described how the hospital covered up the truth behind Charlene Murphy's error-induced death. It took an anonymous tipster to inform the formal authorities, leading to the erring nurse's criminal prosecution without censuring the institution's management for their flawed systems contributing to causing the error. The hospital made a financial settlement with the deceased patient's family on condition of non-disclosure[5].

Image no. 5. Nurses and an anesthesiologist supporting Radonda Vaught outside the Nashville court on the day she was sentenced for criminally negligent manslaughter following an unintended unrecognized human error. It is possible every protestor present on that day had vivid memories of medication administration errors they had each personally once also made, that the institutions never found out about. A culture of Safety is needed. Associated Press Image.

In 2024, Radonda did an interview 5-years after the incident[6]. She tearfully reported how family members of the deceased patient had expressed their forgiveness to her. She also revealed that the big pressure on her on that fateful 2019 day when she injected the wrong drug was because the patient had already been administered a radioactive isotope for the PET scan. Any delay in injecting sedation would have required cancellation of the scan and deferring it to a second attempt the following day. On the second day, a dangerous repeated dose of radioactive isotope would have needed to be injected. Radonda revealed her case had become a *cause celebre* among healthcare workers critical of how Radonda was treated. Also, many nurses privately shared with her their own drug errors that they had recognized but felt highly incentivized to conceal and keep secret because of how Radonda was treated. Therefore, healthcare system fixes to improve patient drug safety would not happen.

This author joined hundreds of nurses in a demonstration outside the Nashville law courts on the day of RaDonda Vaught's sentencing. **Images numbers 4 and 5**. The judge gave the least harmful sentence within his power, following a jury's judgment of her guilt on a homicide charge. She was sentenced to *three years of probation* with no jail time to be served.

The Anesthesia Patient Safety Foundation (APSF) stated, "*We believe the prosecution of the nurse* (RaDonda Vaught) *involved was counterproductive to the pursuit of prevention of harm to future patients . . . .*" May 25, 2022.

This sad case has earned a Wikipedia 5-page article titled "*RaDonda Vaught homicide case*." The deceased patient is named as 75-year-old Charlene Murphy. **See image no. 2.** Wikipedia quoted, "*Healthcare delivery is highly complex. Mistakes will inevitably happen, and systems will fail. It is completely unrealistic to think otherwise.*" There were concerns that the prevailing national American nursing shortage would worsen due to Radonda Vaught's brutal criminal treatment, causing a reduction in nursing recruits and a spike in earlier nurse retirements. The last Wikipedia line quote was, "*A robust culture of safety relies on self-reporting and transparency to drive process improvement, and criminalizing errors instead foments blame and creates fear*."

Notably, the "***The Vanderbilt Hustler***," an official newspaper of Vanderbilt University, wrote about Charlene Murphey's death. RaDonda was reported fired 8 days after Charlene's death. The Vanderbilt Hustler referred to the erroneously swapped drug as "Versed" four times and only once used the generic name of *midazolam* in the article. This reflects it was fully normalized in Vanderbilt University Medical Center (VUMC) not to use the international scientific generic drug name and preferentially, incorrectly, use a brand drug name that no longer existed. Versed is a skin cream product. RaDonda was also trained to use the false brand drug name "Versed" instead of the generic drug name midazolam. The problem was initiated by the prescribing physician ordering the injection of "Versed," while the automated drug dispensing cabinet only listed *MIDAZOLAM*, unknown to the erring nurse. Charlene's death was the end result. Multiple other system factors compounded the error. RaDonda Vaught's one reported statement had much insight, "I don't go to work in a vacuum. I work in a ***healthcare system***."

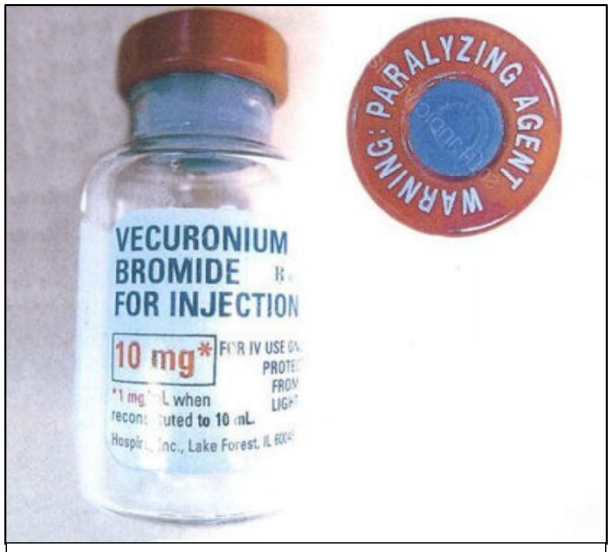

Image no. 6. A well-designed **VECURONIUM** vial of muscle relaxant drug will reduce unintentional vial swap errors. A red top, all capitals printing the drug's generic name, and bold a "paralyzing agent" warning are good drug safety labeling features. However, a distracted, multitasking, rushed healthcare worker can still have **confirmation bias** and unconsciously only glance-read the vial and be vulnerable to mistakenly accepting the vial if they have strong expectations that it is correct. More systems fixes than improved drug labels are needed.

CONCLUSION

It is a universal opinion that criminalizing human error is the worst thing to do. It will not reduce human error in complex, high-risk enterprises. Such criminalization becomes, for generally well-intended good citizens, an incentive to prioritize their survival in employment in the interest of their family and dependents. They will act to conceal the errors they recognize that they make and never report their errors. Medical errors must be collected and grouped to seek the etiological patterns and root causes, and then the error-preventative system changes, and measures must be designed and instituted.

On October 18, 2023, the American Society of Anesthesiologists (ASA) summarized all the key points arguing against the criminalization of anesthesia drug errors, saying: "*A healthy CULTURE of SAFETY and* [the ensuing] *improved patient safety can only occur in organizations that celebrate psychological safety."*

https://hbr.org/2023/02/what-is-psychological-safety

The greater and final goal is to improve patient safety for everyone in the future.

A Medscape physician and nurse panel discussed Radona Vaught's unjust criminal conviction[7]. They emphasized the healthcare institution's liability rather than blaming RaDonda. They advised its leadership to institute a culture of safety. Very ironically, the panel all referred to the swapped-out drug, as ordered, by the wrong name, "Versed." Using the name VERSED is the prime systems error that killed Charlene Murphy. That itself reveals how deeply embedded in American medical culture is the wrong use of drug Brand names. A generic name prescription would have saved Murphey's life. Versed does not exist as a drug by brand or generic name. The automated medical dispensing cabinet was programmed for the name MIDAZOLAM. Less nurse medication administration errors will occur if generic name prescribing is mandatory for all single chemical drug preparations.

The main root cause of the medical error that killed Charlene Murphey was a physician prescribing she be administered "VERSED." Then next, a perfect alignment of holes in a full series of Swiss cheese slices occurred.

Image no. 7. Versed skin

[1] Cheryl Clark. Anesthesiologist group says Hospitals can prevent Fatal Errors like Vanderbilt's. Medpage. June 2, 2022. www.medpagetoday.com

[2] Brett Kelman. CRIME, LAW and JUSTICE: Former nurse found guilty in accidental injection death of 75-year-old patient. March 25th, 2022. 90.5 WESA – Pitttsburgh's NPR News Station. https://www.wesa.fm/2022-03-25/former-nurse-found-guilty-in-accidental-injection-death-of-75-year-old-patient

[3] Eric Vogelstein. The prosecution of RaDonda Vaught: An ethical and legal mistake. Nursing Forum. November 2022'57(6):11571-1574 doi: 10.1111/nuf.12838. Epub 2022 Nov 9.

[4] Ashley Perham. Ex-nurse Radonda Vaught sentenced to 3 years of probation in fatal drug mixup. newspaper: MAIN STREET NASHVILLE. https://www.mainstreet-nashville.com/news/ex-nurse-radonda-vaught-sentenced-to-3-years-of-probation-in-fatal-drug-mix-up/article_cc6de4b4-d2de-11ec-985d-7bdfd60ff2d5.html.

[5] Dr. Chuck Dinerstein, MD, FACS MBA. Thinking Aloud: RaDonda Vaught, RN. American Council on Science and Health. May 24, 2022. https://www.acsh.org/tags/radonda-vaught

[6] Cheryl Clark. Radonda Vaught says some system practices contributed to fatal mistake. Medpage March 14, 2024 https://www.medpagetoday.com/special-reports/features/109178

[7] Glatter RD, et al. Are all medical errors now crimes? Nurse Vaught Verdict. Medscape. 2022, Aril 13. https://www.medscape.com/viewarticle/971634