By Michael R. Cohen, RPh, MS, ScD

VIEWPOINT

# An Injustice Has Been Done: Jail Time for an Error

Eric Cropp is an Ohio hospital pharmacist who was involved in a tragic medication error that cost the life of a beautiful little girl named Emily Jerry. For that, he was punished by a criminal court: 6 months in jail, 6 months home confinement with an electronic sensor locked to his ankle, 3 years probation, 400 hours of community service, a fine of $5,000, and payment of court costs. Eric made a human error that could have been made by anyone in healthcare, given the inherent weaknesses in our manual systems: he failed to recognize that a pharmacy technician he was supervising had made a chemotherapy solution with far too much sodium chloride in it. The final solution was supposed to contain 0.9% sodium chloride, but it contained more than 20%.

I have never met Eric, but I am familiar with many of the underlying conditions that contributed to the error. Some details have been provided in the local and national news media; however, I also have reviewed records stemming from Ohio State Board of Pharmacy hearings. I have heard firsthand accounts from others, including a pharmacist who attended a hearing and listened to testimony about the event at the Ohio State Board of Pharmacy, which permanently revoked Eric's license. I also have been in contact with Eric's attorneys, Richard Lillie and Gretchen Holderman of Lillie & Holderman, and I wrote a letter to the Honorable Judge Brian J. Corrigan in the Cuyahoga County Court of Common Pleas in Cleveland, in support of leniency and avoidance of imprisonment. Regrettably, the judge appears to have given my letter little regard, and it likely had little impact on the outcome of the legal proceedings.

As I learned from the sources above, the details of this tragic error are as follow. When Eric Cropp came to work on the day of the event, he learned that the pharmacy computer system was down. His assistant in the preparation area for intravenous (IV) solutions was a pharmacy technician who, according to press reports, was also planning her wedding on the day of the event and, thus, distracted while working. With the pharmacy computer system down, a backlog of physician orders had developed, increasing time pressures for Eric. A nurse had called requesting Emily's chemotherapy solution immediately, which ultimately may not have been warranted. This added more pressure to Eric's workload. According to a witness at the state board hearing, the chemotherapy was not needed until much later that afternoon. Testimony at the board hearing also uncovered that Eric was working short-staffed that day and had no time for normal work breaks. The technician started to prepare the chemotherapy. We do not know exactly what caused the sodium chloride overdose in this case. However, when preparing IV chemotherapy, some pharmacies remove fluid from a bag when they have to add a large volume of medication to infuse, and then add additional fluid to the bag and titrate with 23.4% sodium chloride injection to bring the final concentration of the infusion to whatever was prescribed (usually not more than 0.9%). Or, they start with an empty bag and follow a similar process. Compounding the solution from scratch is error-prone, and such exactness of base solutions is most often unnecessary from a clinical standpoint. According to one press report, the solution was greater than 20 times more concentrated than it should have been.

Long ago, the Institute for Safe Medication Practices (ISMP) named sodium chloride 23.4% a "high alert" drug, calling for special storage, handling, and check systems—procedures that may not have been in place in Eric's hospital. Communication failures between technicians and pharmacists, IV compounder-related failures, inadequate documentation of the exact products and amounts of additives, and other system issues have contributed to other fatal errors. We have also seen compounding errors and subsequent failed double-checks due to adverse performance-shaping factors such as poor lighting, clutter, noise, and interruptions. As noted above, in this particular case, news reports suggest that Eric felt rushed, causing him to miss any flags that may have signaled an error.

> Eric made a human error that could have been made by anyone in healthcare, given the inherent weaknesses in our manual systems

Eric did not make the error himself. Still, he did not notice that the technician made the error when he checked her work. Such an error is crucial, but we have no knowledge regarding how Eric missed the technician's preparation error other than the fact that he is human and thus prone to human fallibility. I have no doubt that the work pressures and working conditions mentioned above played a significant role. But the price of that error was ever so costly: a little girl named Emily Jerry received an incredibly high and fatal amount of sodium chloride.

Some clinicians will ask, "Why disclose errors and risk going to jail?"

As expected, the child's family was devastated, as was Eric. The Ohio Board of Pharmacy became involved and Emily's mother, Kelly Jerry, participated in the board hearing as a witness for the state. She also appeared later in court. As an articulate but anguished parent, Ms. Jerry was compelling in her quest to have Eric's license revoked, and as of August 14, 2009, even to have him imprisoned. Her emotional testimony has been truly heart wrenching as she holds up a picture of Emily. We can understand parental anger and frustration with the healthcare system and those closest to the error that cost their daughter her life. However, I cannot stand by without speaking out regarding the injustice of throwing healthcare professionals who make mistakes—even deadly mistakes—into the criminal arena when their errors were unintentional, caused by system failures and uncontrollable human factors.

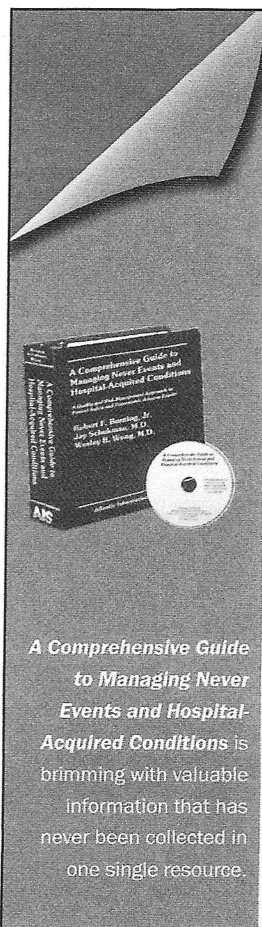
All who work in healthcare can understand how the Jerry family must feel about Eric and the health system. I can't say that I wouldn't feel the same way if I lost a loved one to a medical error. But I fail to see how the Court's action will be effective at anything other than serving a desire to see Eric go to jail as punishment for making the error that led to Emily's death. I have observed that many who have been harmed by medical errors find it possible, even healing, to recognize and forgive human fallibility, especially since human error is not a behavioral choice, and many of the system issues that contributed to the error were beyond Eric's control.

The undeserved harsh treatment of Eric may have a disastrous effect in healthcare. Some clinicians will ask, "Why disclose errors and risk going to jail?" That, in itself, is tragic testimony to the impact of this case, which could cause a horrible backlash against the patient safety movement. In time, if we continue to see the legal system issuing criminal indictments when medical errors occur, we could see young college students avoid legally "risky" professions or tasks within professions like pharmacy, such as preparing IV medications using high-alert drugs.

Many healthcare professionals already fear making that one error that could result in the harm or death of a patient. Escalating application of criminal error laws serves as a reminder that a harmful error—often similar in form to minor mistakes we all make on a daily basis—could also strip away a hard-earned and cherished livelihood, the ability to help others, and personal freedoms perhaps once taken for granted, as has happened to Eric Cropp.

The focus on the easy target in this case makes my colleagues and me wonder whether any regulatory or accreditation agency in Ohio, or anywhere else for that matter, has taken steps to ensure that all hospitals learn from this event and adjust their systems to prevent the same type of error. One good thing that's come from this episode is a law passed in Ohio, Emily's Law, which requires pharmacy technician training and certification, but I am unaware of any other Ohio state action to bring the system failures in the Emily Jerry case to the attention of Ohio hospitals. I also do not know of any visits undertaken by state surveyors to detail expectations for implementing prevention strategies, at least those that have probably been put in place at the hospital where Emily died. If nothing has in fact happened, the death of this little girl is a heartbreaking commentary on healthcare's inability to learn from mistakes so they are not destined to be repeated. PSQH

***Michael Cohen*** *is president of the Institute for Safe Medication Practices. He may be contacted at mcohen@ismp.org.*


**NOW AVAILABLE!**

***A Comprehensive Guide to Managing Never Events and Hospital-Acquired Conditions***

A new resource with current – and upcoming – quality and risk management approaches to patient safety and preventable adverse events to help you increase quality of care, reduce the risk of preventable adverse events and lost reimbursement, and improve patient outcomes.

This 350 page resource contains 14 information packed chapters along with a companion CD. Providers and managers alike will benefit from a variety of valuable features, including:

- Evidence on the preventability of never events and hospital-acquired conditions
- A comprehensive, statistically supported history of the patient safety movement
- Strategies, tips and tools you can use to provide safer quality care to patients
- State reporting requirements you need to know about... and much more

Order your NO-RISK copy today for ***only $287.*** Our 100% Satisfaction Guarantee means that you risk nothing by ordering a copy to review. If, within 30 days, you decide that it is not for you – just return it and receive a prompt, full refund.

**To order, call – 888-303-5639, ext. 215 or order online at www.psqh.com/neverevents.html**