Deadly Dose: Pharmacy Error Kills Infant

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When Alyssa Shinn was born 14 weeks early, she was too tiny and frail to hug.

Her mother, Kathleen Shinn, cradled Alyssa's hands for hours at a time as her firstborn child grew stronger and stronger in neonatal intensive care at Summerlin Hospital in Las Vegas.

Shinn was thrilled when her daughter was born, particularly because she had difficulty conceiving and endured a long and difficult process of in vitro fertilization.

"We were elated when she was born. It was the answer to all our prayers, to everything we wanted," Shinn said.

Her husband, Richard, was equally excited about the birth, calling Alyssa their "miracle baby."

"She was doing excellent," Richard said of Alyssa right after she was born. "She had just come off the ventilator. She was gaining weight. She was starting to take milk. They just gave her a few drops of milk a day, in a little dropper. And everything was good to go."

'Something Was Not Right'

It seemed that everything was fine until the Shinns left the hospital Nov. 8, 2006 late at night to get some rest after another long day at their daughter's side. Shinn woke up at 3 a.m. and called the hospital to see how Alyssa was doing.

"When I called, they told me that she had some shortness of breath, but that she was OK," Shinn said.

But when the couple returned to the hospital at 9 that morning, the Shinns knew instantly that Alyssa was not OK, that in fact, something was terribly wrong. They saw a group of nurses gathered around Alyssa's isolette, which signaled to Shinn that "something was not right."

Richard noticed a drastic change in their daughter's appearance and demeanor.

"She was very lethargic," Richard said of Alyssa. "She was not moving at all and she was always — she was feisty. What we were used to seeing were her legs and arms

going, just a really energetic little girl. And she wasn't moving at all. And the color was leaving her body."

Shinn says she could tell Alyssa was on the brink of death.

"I just knew," she said. "And I just started to cry hysterically, knowing that my daughter Alyssa was going to die."

After confirming that no one else was going to visit Alyssa, physicians turned off the ventilator and the Shinns held their lifeless child for the first time. "We were able to put her in a little dress," said Shinn. "And I got to hold her for the first time."

The Shinns were told that, during the night, Alyssa had received a fatal overdose of zinc from her intravenous nutrition bag, a mistake made in the hospital pharmacy. Pam Goff, the lead pharmacist on duty, was summoned to see her supervisor.

"I just broke down into tears and I started to shake," Goff said. "And I just sobbed uncontrollably. I went back to my desk and started to vomit and cry and shake."

A Fatal Error

The night before, Goff had received a doctor's order for 330 micrograms of zinc, a nutritional supplement to help the baby's metabolism. But when Goff entered the order into the machine that mixes the compound, she entered milligrams — the wrong unit of measurement — on the drop-down menu.

"I put in the 330 and when I went to pick the units … [I] grabbed 330 milligrams per decaliter instead of micrograms per decaliter," said Goff.

This meant that 1,000 times more zinc than had been prescribed was transfused into baby Alyssa.

In July 2007, during an emotional hearing before the Nevada Pharmacy Board, Goff apologized personally and publicly to the Shinns for the first time.

"Nothing I could ever say would ease your pain. I know that," Goff said in court, turning to face Shinn. "And I want you to know that I'm really sorry."

Shinn hugged Goff and said, "Oh, Pam, I know you're sorry."

The pharmacy board and an investigation by Portfolio magazine have raised troubling questions about the hospital's oversight of its pharmacy. Katherine Eban, the magazine's investigative reporter, says she thought the hospital was run inconsistently.

"I think the Summerlin pharmacy operated like a giant temp agency," Eban said. "Staff came and went. There were six pharmacy directors in six years. One of them was even commuting long distance."

In 2006, Summerlin Hospital had just taken back the operation of its pharmacy from a management company — the third in 10 years — that had hired many of the

employees. The night Alyssa received a fatal overdose, the pharmacy was short-staffed, according to Goff.

"It can make it very hectic, and make it very stressful, a stressful situation on everyone that's involved," Goff said of the staffing issues.

'An Entire System Failed'

The investigation revealed that a series of safeguards simply failed. Two other pharmacists neglected to check Goff's calculation. A safety stop on the mixing machine had not been set, and a technician reading the order had replenished the machine 11 times with zinc; using 48 vials of zinc total to fill the baby's TPN bag. Nurses didn't notice that the nutrition bag was much larger than normal.

In sworn testimony, Goff said that the unusually large size of the nutrition bag should have been noticed.

"That would be completely ridiculous," Goff said of the bag's size. "That bag would be four times the size of her."

The pharmacy board fined Summerlin Hospital pharmacy $10,000, fined Goff $5,000 and placed her on one year's probation. Two other pharmacists were fined $2,500 and given 30-day suspensions.

"That day, an entire system failed, from the very beginning to the very end," said Shinn.

"There were multiple failures," Eban said. "There is the failure of supervision. There is the failure of individual pharmacists. Then there was the failure of the environment. A safe pharmacy has to be a very organized, regimented place with very few distractions."

These types of failures raise serious questions about hospital oversight. In November, the newborn twins of actor Dennis Quaid and his wife were given accidental overdoses of the blood thinner Heparin. The babies survived. And in 2006, six premature infants were the victims of a similar mistake at an Indiana hospital. Three of them died.

"Millions of patients a year get improper medication at hospitals," said Eban. "And it can happen under any corporate or not-for-profit structure. And basically, your best protections against that are stability and management, intensive supervision, a good working environment for those professionals. And when you don't have any of those, then you have a recipe for disaster."

Summerlin Hospital reached a confidential financial settlement with the Shinns. The hospital declined a request for an interview but issued a written statement:

"Everyone at the hospital was heartbroken by this tragic event, and words have not been been adequate to express our sorrow to the Shinn family. We've implemented certain very focused changes at the hospital to ensure that this never happens again."

Goff now wears a tattoo on her wrist as a reminder of Alyssa's short life. She hopes it will inspire her to "push forward every day for this little girl."

Since their daughter died, the Shinns have separated. The nursery they'd prepared for their daughter stands as it did the day she was born.

Alyssa, who lived for just three weeks, is buried with other children in the hospital's "Garden of Innocence."