Family Shattered by Blood Mix-Up

Sterling Patient Died After Error by Inova Fairfax Technician

By Avram Goldstein
Washington Post Staff Writer

Tawnya Brown sat in her hospital bed and cried, dreading the moment she had hoped would never come. Soon she would undergo surgery to repair damage from an inflammatory bowel disease, which meant wearing a colostomy bag for three months while she healed.

That wasn't how she wanted to live in the Sterling townhouse she shared with her 8-year-old daughter and husband, who can't work full time because of a heart condition.

"I avoided surgery for eight years, and now I'm going to wake up with a bag," she tearfully told a nurse at Inova Fairfax Hospital. But she knew she couldn't hold out much longer. Even before her 31st birthday in early July, she found it painful to move and had recently lost more than 10 pounds.

So she swept away the gloom with what her husband called a "big cheesy grin." At 5:30 p.m. July 23, she was wheeled into Operating Room 22, and by 8 p.m. an 18-inch segment of her inflamed, perforated intestine had been removed. The surgeon happily told the family that things had gone well.

But before dawn, Tawnya Brown was dead, her life ended because doctors gave her repeated transfusions of someone else's blood type. The tragic mistake has ravaged Brown's family, triggered an investigation by Virginia hospital regulators, prompted new procedures at Inova Fairfax and prompted the resignation of the technician who the hospital says fouled up.

During the surgery, Brown received two pints of A-negative blood instead of her O-positive type. Some people die from as little as one ounce of in-

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"I said, 'You're in the best hands in the world, honey.' That was my last conversation with her."

– **Richard Rally**
father of Tawnya Brown, above

Patient's Family Struggles To Understand Her Death

BLOOD, From B1

compatible blood, while others survive such mistakes, medical experts say.

For Brown, the error was compounded when doctors in the recovery room, seeing her unconscious and bleeding profusely, called for more blood. In three hours, they transfused six more pints of the wrong blood type. A person of Brown's size has total blood volume of about eight pints.

"We're taking full responsibility for what happened," said Candice Saunders, a senior administrator at Inova Fairfax. "We took immediate steps to notify the patient's family."

Brown's father, Richard Rally of Sterling, is aghast. "It strikes me as bizarre and beyond comprehension," he said. "I just can't believe it. She said [Fairfax] was the safest hospital. I said, 'You're in the best hands in the world, honey.' That was my last conversation with her."

Brown's husband, John "Butch" Carroll Brown III, wrestled with what to tell the couple's daughter, a third-grader whose name is being withheld at the family's request.

"How do you tell an 8-year-old that her mother's dead?" he said. "They were closer than any two people. . . . They were inseparable. . . . I went home and slept and tried to figure out how I would deal with this. I told her the truth, that her mother was gone and she wasn't coming back. She started crying. I told her crying is something that she'll do. There's not much you can tell anybody in that situation that's really going to help."

Hospital officials say Brown is the first person to die of a transfusion error at Inova Fairfax. Two patients at Greater Southeast Community Hospital in the District died of similar mistakes last year, when 14 such deaths were reported nationally.

Tawnya Brown was born in western Pennsylvania coal country and moved to Sterling in 1979. She was raised in a warm Italian family, her father said, adding, "We're very close, open and vocal. Everything is more or less out on the table."

As a girl, her teachers loved her for being lively and upbeat; Rally said, but gave her poor grades because she didn't do her homework and tested poorly. She found her niche in computers, "something she could get her hands on," Rally said. Most recently, she was a contract employee on the computer help desk at the Federal Highway Administration office in Sterling.

She met her future husband in 1992. "It was one of those love-at-first-sight deals," Butch Brown recalled. "We met, had our first date the next night, saw a band play in Manassas and the romance started. We were dating for probably 14 or 15 months, and she told me she had a present for me and that she was pregnant. We had our daughter, and it was the family thing."

The two married last year.

Tawnya Brown's health problems started soon after her daughter's birth when doctors diagnosed Crohn's disease, a poorly understood chronic inflammation of the colon characterized by unpredictable flare-ups. Some patients have mild cases, while others are debilitated by abdominal pain, diarrhea, rectal bleeding, weight loss and fever.

Brown managed her illness for years with medication and occasional hospital stays. But early this summer, the pain worsened. Her physician, Paul E. Savoca, diagnosed a perforated colon, admitted her to the hospital for tests July 18 and then recommended surgery.

She had the inside bed in her seventh-floor semiprivate room but found the place too hot. When her roommate was discharged, Brown asked to switch to the window bed, which was closer to the air-conditioning vents and enjoyed a view of Merrifield and Tysons Corner.

According to the family's attorney, Robert T. Hall, a clerk at the nurse's station did not immediately note the bed switch in the computer.

"I don't see the bed change in the medical records," Hall said. "The hospital's

BY JAHI CHIKWENDIU—THE WASHINGTON POST

Butch Brown, at home in Sterling, says he wrestled with how to tell his young daughter that her mother had died. "They were closer than any two people. . . . They were inseparable."

counsel told us the unit secretary was to record the bed change in the computer but hadn't by the time this phlebotomist came" to draw Brown's blood.

Hospital officials declined to comment on the bed switch because they said it is irrelevant.

The day before Brown's surgery, a technician whom the hospital will identify only as an "exemplary" worker went to her room to draw a blood sample so that the correct type would be available if needed during her operation.

The technician collected the sample—only it wasn't from Brown; it was from the patient on the other side of the curtain, in the bed Brown previously occupied, officials said. Hospital spokeswoman Kathleen Thomas said the phlebotomist failed to perform two required identification screens: checking the patient's hospital bracelet and asking the patient to state her name.

"We don't use a patient's room and bed number as a patient identifier," Thomas said. "The error didn't have anything to do with the patient asking to switch beds. The error was that the employee neither asked for this patient by name nor did she check the patient's wristband."

Receiving the wrong blood type can be fatal or cause permanent damage in those who survive it. The immune system attacks the donated blood cells, causing them to burst and leading to low blood pressure, kidney failure and a reduction of blood-borne oxygen to the brain and other organs.

Brown received two units of A-negative blood during surgery, but the transfusion reaction was not noted until the end, when nurse Cheryl Gilberry wrote in the medical record that blood was showing up around Brown's intravenous and other lines. Savoca dictated in a note 20 minutes later that blood was oozing under Brown's skin and that she was in stable but guarded condition.

Matters quickly deteriorated in the recovery room as Brown remained unconscious and was paralyzed, breathing with a mechanical respirator and bleeding everywhere, the records indicate. Doctors pursued several possible explanations, including infection.

About 9 p.m., they gave her two more units of A-negative red blood cells (about 12 ounces each), followed by two units of platelets to promote clotting, three units of plasma, two more units of red cells, more plasma and two more units of red blood—the last at 11:16 p.m., records show.

At midnight, 15 minutes after Brown was moved to intensive care, doctors got the results of a cross-matching and typing analysis of a blood sample from an earlier blood test. It was then they realized that Brown was O-positive.

Roy A. Beveridge, a hematologist-oncologist, wrote in the medical record that he and other doctors then decided to do a total blood exchange, replacing the incompatible type-A blood with type O. That went on from 1:30 to 3:45 a.m. But it was too late. Brown was pronounced dead at 5:24 a.m.

Thomas, the hospital spokeswoman, said the doctors moved as quickly as they could to figure out the mistake: "It wasn't readily apparent that she was having a transfusion reaction. She was experiencing bleeding that could have been caused by a number of different medical conditions."

A representative of Savoca said the doctor was too busy to answer questions about the case.

Thomas and Hall, the Brown family's attorney, said the two sides have agreed on a financial settlement that will be submitted to a judge for approval soon. Under Virginia law, which caps medical malpractice judgments, the most the family could receive in a trial is $1.7 million.

Initially, the hospital offered $1.1 million, Hall said, with a confidentiality agreement limiting what information the family could disclose. The final proposal calls for the maximum amount with no confidentiality agreement, he said.

Much of the money is to be held in trusts for Brown's daughter, to pay for her education and other costs, Hall said. His fee, he said, will be less than the customary 33 percent.

Nancy Hofheimer, Virginia's chief hospital inspector, said investigators who reviewed the transfusion error will decide soon whether to recommend sanctions. "It's a tragic story," she said.

Butch Brown said he bears no grudge toward the hospital workers. "That night, they did everything within their power," he said. "They were honest, and that's kind of hard to find these days."

He knows that nothing can change what happened. "I can waste away with anger, but it isn't going to do me or anyone around me any good. I've got an 8-year-old to think about. She's doing good, but it's kind of hard to read an 8-year-old," he said. "She definitely misses her mommy."

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