

STATE OF ILLINOIS)
) SS:
COUNTY OF COOK)

IN THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS
COUNTY DEPARTMENT - LAW DIVISION

DENNIS QUAID AND KIMBERLY QUAID,)
parents and next friends of ZOE GRACE QUAID)
and THOMAS BOONE QUAID, minors,)

Plaintiffs,)

v.)

BAXTER HEALTHCARE CORPORATION,)
a corporation,)

Defendant.)

2007L013514
CALENDAR/ROOM A
TIME 00:00
Product Liability

Case No.

COMPLAINT AT LAW

COUNTY

STRICT LIABILITY IN A TORT - BAXTER HEALTHCARE CORPORATION

Plaintiffs, DENNIS QUAID and KIMBERLY QUAID, parents and next friends of ZOE GRACE QUAID and THOMAS BOONE QUAID, minors, by and through their attorneys, SUSAN E. LOGGANS & ASSOCIATES, P.C., and complaining of Defendant, BAXTER HEALTHCARE CORPORATION, a corporation, upon information and belief state the following:

1. On and prior to November 18, 2007, Defendant, BAXTER HEALTHCARE CORPORATION, was a corporation authorized to transact business in the State of Illinois and was in the business of designing, manufacturing, distributing and selling medications and its packaging including the drug, Heparin.

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CIRCUIT COURT OF COOK COUNTY, ILLINOIS
LAW DIVISION
DOROTHY FRO
CLERK

2. On and prior to November 18, 2007, Defendant, BAXTER HEALTHCARE CORPORATION, did design, manufacture and sell and distribute a drug known as Heparin.

3. On and before November 18, 2007, 10,000 unit/ml vials of Heparin and 10 unit/ml vials of Hep-lock were designed, manufactured and sold by Defendant, BAXTER HEALTHCARE CORPORATION, to Cedars-Sinai Hospital in Los Angeles, California for use by its medical personnel in the treatment of infants in its hospital.

4. On November 18, 2007, vials of Heparin and Hep-lock, manufactured, supplied and distributed by Defendant, BAXTER HEALTHCARE CORPORATION, were used by nursing personnel and other medical personnel at Cedars-Sinai Hospital for use in the care and treatment of infants at Cedars-Sinai Hospital in Los Angeles, California.

5. On November 18, 2007, minor Plaintiffs, ZOE GRACE QUAID and THOMAS BOONE QUAID were patients in the pediatric unit at Cedars-Sinai Hospital.

6. On November 18, 2007, an order had been given for minor Plaintiffs, ZOE GRACE QUAID and THOMAS BOONE QUAID, to each receive what is known as Heparin flush, which is the administration of 10 unit/ml of Hep-lock. Instead of receiving the prescribed medication, a medical error was made by personnel of Cedars-Sinai Hospital and 10,000 unit/ml of Heparin were administered instead.

7. On or before November 18, 2007, and at the time the vials of Heparin left the control of Defendant, BAXTER HEALTHCARE CORPORATION, the Heparin was in a condition that was an unreasonably dangerous in one or more of the following ways:

- a. Both the 10 unit/ml vial of Hep-loc and the 10,000 unit/ml of Heparin had a blue background color to its label. This fact made them more difficult to distinguish than if they had different background colors. Since a medical error in administration could lead to a dangerous or fatal result, the background colors should have been different;
- b. Both the 10 unit/ml vial of Hep-loc and the 10,000 unit/ml of Heparin had a blue background color to its label. This fact made them more difficult to distinguish than if they had different background colors. Since a medical error in administration could lead to a dangerous or fatal result, the vials should have been in completely distinguishable size and shape.

8. As a proximate result of one or more of the aforementioned unreasonably dangerous conditions of the aforesaid Heparin, minor Plaintiffs, ZOE GRACE QUAID and THOMAS BOONE QUAID, suffered and will continue to suffer injuries of a pecuniary nature.

WHEREFORE, Plaintiffs, DENNIS QUAID and KIMBERLY QUAID, parents and next friends of ZOE GRACE QUAID and THOMAS BOONE QUAID, minors, seek an amount in excess of Fifty Thousand (\$50,000.00) Dollars against Defendant, BAXTER HEALTHCARE CORPORATION.

COUNT II

NEGLIGENCE - BAXTER HEALTHCARE CORPORATION

Plaintiffs, DENNIS QUAID and KIMBERLY QUAID, parents and next friends of ZOE GRACE QUAID and THOMAS BOONE QUAID, minors, by and through their attorneys, SUSAN E. LOGGANS & ASSOCIATES, P.C., and complaining of

1.27.047.2007

Defendant, BAXTER HEALTHCARE CORPORATION, a corporation, upon information and belief state the following:

1. On and prior to November 18, 2007, Defendant, BAXTER HEALTHCARE CORPORATION, was a corporation authorized to transact business in the State of Illinois and was in the business of designing, manufacturing, distributing and selling medications and its packaging including the drug, Heparin.

2. On and prior to November 18, 2007, Defendant, BAXTER HEALTHCARE CORPORATION, did design, manufacture and sell and distribute a drug known as Heparin.

3. On and before November 18, 2007, 10,000 unit/ml vials of Heparin and 10 unit/ml vials of Hep-lock were designed, manufactured and sold by Defendant, BAXTER HEALTHCARE CORPORATION, to Cedars-Sinai Hospital in Los Angeles, California for use by its medical personnel in the treatment of infants in its hospital.

4. On November 18, 2007, vials of Heparin and Hep-lock, manufactured, supplied and distributed by Defendant, BAXTER HEALTHCARE CORPORATION, were used by nursing personnel and other medical personnel at Cedars-Sinai Hospital for use in the care and treatment of infants at Cedars-Sinai Hospital in Los Angeles, California.

5. On November 18, 2007, minor Plaintiffs, ZOE GRACE QUAID and THOMAS BOONE QUAID were patients in the pediatric unit at Cedars-Sinai Hospital.

6. On November 18, 2007, an order had been given for minor Plaintiffs, ZOE GRACE QUAID and THOMAS BOONE QUAID, to each receive what is known as Heparin flush, which is the administration of 10 unit/ml of Hep-lock. Instead of

receiving the prescribed medication, a medical error was made by personnel of Cedars-Sinai Hospital and 10,000 unit/ml of Heparin were administered instead.

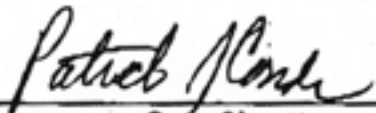
7. On or before November 18, 2007, Defendant, BAXTER HEALTHCARE CORPORATION, was negligent in one or more of the following ways:

- a. Failed to recall the 10,000 units/ml vial of Heparin when it had actual knowledge that prior infant deaths had occurred as a result of medication errors;
- b. Failed to repackage the 10,000 unit/ml vial of Heparin when it knew that fatal medication errors had occurred with children;
- c. Designed, marketed and sold 1ml vials of Heparin Sodium Injection, 10,000 units/ml and the Hep-loc U/P 10 unit/ml vial all in shades of blue as the prominent background color on their label when they knew that such packaging could have caused fatal medication errors;
- d. Failed to issue an urgent warning to all of the healthcare providers that had purchased the product about the fatal medical errors that had occurred and require that such providers initiate mandatory education and also implement safety procedures so a fatal medication error would not occur;
- e. Failed to provide an adequate after market solution to the existing easily confused vials and assure that none of the existing vials were used until the after market solution was implemented.

8. As a proximate result of one or more of the aforementioned negligent acts or omissions of defendant, BAXTER HEALTHCARE CORPORATION, minor Plaintiffs, ZOE GRACE QUAID and THOMAS BOONE QUAID, suffered and will continue to suffer injuries of a pecuniary nature.

WHEREFORE, Plaintiffs, DENNIS QUAID and KIMBERLY QUAID, parents and next friends of ZOE GRACE QUAID and THOMAS BOONE QUAID, minors, seek an amount in excess of Fifty Thousand (\$50,000.00) Dollars against Defendant, BAXTER HEALTHCARE CORPORATION.

SUSAN E. LOGGANS & ASSOCIATES, P.C.



One of its attorneys

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**IMPORTANT MEDICATION
SAFETY ALERT**

**BAXTER HEPARIN SODIUM INJECTION 10,000 UNITS/ML AND
HEP-LOCK U/P 10 UNITS/ML**

February 6, 2007

Dear Healthcare Provider:

This important safety information concerns the potential for life threatening medication errors involving two Heparin products:

- Heparin Sodium Injection 10,000 units/mL
- HEP-LOCK U/P 10 units/mL

Baxter is aware of fatal medication errors that have occurred when two Heparin products with shades of blue labeling were mistaken for each other. **Three infant deaths resulted when the higher dosage Heparin Sodium Injection 10,000 units/mL was inadvertently administered instead of the lower dosage of HEP-LOCK U/P 10 units/mL.**

The currently marketed 1 mL vials of Heparin Sodium Injection 10,000 units/mL and the HEP-LOCK U/P 10 units/mL use shades of blue as the prominent background color on their labels.

Healthcare professionals should be reminded to:

- **Never rely on color as a sole indicator to differentiate product identity.**
- **Always carefully read the product label to verify that the correct product name and strength have been selected.**
- **Always carefully review both the drug name and dose on the label before dispensing and administering these products.**
- **Double-check your inventory as soon as possible, to ensure that there is no mix-up of the products.**
- **Notify all staff of the potential for errors in dispensing and administering these products. It is advised that you provide color photographs (see below) to staff to assist in their understanding of the product similarities.**

Baxter

To assist you in your review of these two labels, a side-by-side color photograph is provided below:



Baxter provides bar codes on its product labels and is considering ways to differentiate the packaging and labels to decrease the risk of medication errors. While Baxter seeks to more clearly differentiate the appearance of these two products, the Food and Drug Administration (FDA) suggests that your institution review your medication identification and administration policies and procedures. Please ensure that all staff responsible for the dispensing and administration of Heparin Sodium Injection and HEP-LOCK U/P products are aware of these medication errors and that the staff are familiar with your policies and