Lewis' Story – “It's Hard to Kill a Healthy 15-Year Old”

Lewis Blackman, was a healthy, gifted 15-year-old. He underwent elective surgery for pectoral excision – a crease in the chest cavity.

Thursday, November 2

Lewis and his family arrive at the hospital at 6 a.m. for the 7:30 operation.

The surgery lasted 2.5 hours longer than the family expected.

The lead surgeon emerges from the OR and says “I had to reposition the metal bar in Lewis' chest four times to get it right. All in all, Lewis did fine.”

Lewis wakes in the recovery room. He tells doctors that his pain is about a “three” on a 1-10 scale.

Lewis is given Toradol (ketorolac tromethamine), a powerful painkiller to ease his chest pain.

Friday, November 3

Nurses and doctors note in Lewis' record that he isn't producing urine.

Lewis is taken to Room 749 in the Children's Cancer Ward. There's no room in the surgery ward.

The surgeon that operated on Lewis leaves the hospital for the weekend.

The nurse tells Lewis and his mother, Helen, that the pain is gas. "There's nothing I can do for gas pain," she says.

"It's the worst pain imaginable," Lewis says to his mother and tells the nurse it's "five on a scale of five."

The nurse tells Lewis and his mother, Helen, that the pain is gas. "There's nothing I can do for gas pain," she says.

In nurses notes that morning, a nurse writes, "gas pains, patient needs to move around." Helen writes in her diary.

Another nurse suggests a bath. She and Helen put Lewis in the tub and sponge him off.

Lewis' belly grows hard and distended, his temperature drops, his skin grows pale and he drips with a constant cold sweat. His eyes are sunken. He's exhausted, in great pain.

Helen calls the nurse a number of times. "She seems convinced that Lewis is simply lazy and not walking enough to dissipate his gas pain," Helen writes in her diary.

During Sunday, Helen repeatedly asks for a doctor.

At 9:26 a.m., Helen's insistence is such that a nurse writes in Lewis' record: "Parent requesting upper level MD." Helen writes in her diary.

At 8:20 a.m., Helen insists, "Let's consider this a heart attack!" She is a doctor herself and is trained in cardiology.

At 8:00 p.m., the chief resident comes to Lewis' room to check him. She writes in the record: "probably Lewis' heart rate is 96. We have to be careful. The nurse notes the same time record Lewis’ heart rate is 126 and that the MD has been made aware of Lewis’ sweating.

Monday, November 6

The MD says the sweating and lowered temperature - 97.7 degrees are "side effects" of the medicine because Lewis is so young.

That night, Lewis' heart rate is 142 beats per minute and his temperature is 95 degrees. At 4 a.m., his heart rate is 140 and his temperature is 96.6.

An aide takes Lewis' vital signs. She can't find any blood pressure.

From 5:30 to about 10:15 a.m., Lewis' record reflects that others try and fail to detect a blood pressure.

Resident nurses believe the blood pressure devices are broken. They try various devices, according to Lewis' medical record.

Doctors record Lewis' death at 12:33 p.m. Monday. 31 hours after Lewis first said he was having horrible stomach pains.
Where did the system fail Lewis and his family?

Use the following questions to guide your analysis of this event. Record your answers and thoughts in the space provided.

1. Where were the system failures in Lewis's care process related to organization, environment, technology, work tasks, health care provider?

2. Where in the process of care did incidents (errors, near misses, adverse events, and harm) occur?

3. Were there opportunities in the process of care to repair physical damage? Repair relational damage? Repair emotional damage?

4. What are the key learning points and how do we learn from this incident to proactively prevent similar incidents from occurring in the future?

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3. Opportunities:
   - To repair physical damage
   - To repair relational damage
   - To repair emotional damage

4. Key learning points for preventing similar events:

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