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King's Bench Walk

Finding of neglect following failure to prescribe anticoagulants to amputee with ischaemic disease

Isaac Hogarth, instructed by Peter Mordecai of Pattinson & Brewer, represented the family of the deceased, Philip Wood, at an inquest before Assistant Coroner Dr Philip Barlow.

The case involved the failure properly to prescribe and administer heparin when Mr Wood was transferred from one ward at St Thomas's Hospital to another. The prescription was mistakenly withheld for three days, and Mr Wood died from a pulmonary embolus.

The Facts

Mr Wood was 68 years old when he was admitted to the hospital with critical ischaemia in his right leg. on 11 January 2017, he underwent endarterectomy in the hope of salvaging the limb, but on 13 January required a below knee amputation (BKA). The intention was that he should continue to receive an infusion of heparin after the BKA. In fact, it was not given. On 16 January he collapsed on the ward and attempts at resuscitation were unsuccessful. The autopsy showed that he had died from bilateral pulmonary emboli, although the source of these was not identified.

Prior to the BKA, Mr Wood had been a vascular patient on the HDU ward. Prescriptions on the HDU ward were managed via an electronic system called Carevue. After the BKA, Mr Wood was stepped down to the vascular ward. On that ward, prescriptions were managed via a system called Medchart. Whilst Carevue was entirely electronic, MedChart prescriptions required both an electronic entry and a physical chart.

After Mr Wood was transferred to the vascular ward, whilst there was a heparin prescription on the Medchart system, the nursing staff considered that to be an error, as there was no physical counterpart. As such, they withheld the heparin, although it still appeared as an active prescription to anyone who checked the Medchart system.

Findings and Conclusion

The Coroner made the following findings as to why there was a failure to give heparin:

1. The post-operative instructions on 13 January 2017 did not state that heparin should be given.
2. Unusually, Mr Wood was stepped down from HDU to the ward after the BKA. The consequences of this were:
    1. He was moved to a different electronic medication recording system (to Medchart, from Carevue).
    2. There was no direct nurse to nurse handover from HDU to the ward.

3. The prescription for heparin was recorded on the Medchart system. However, the heparin was to be given as a variable rate infusion, to be titrated against blood test results. The Medchart system (unlike the Carevue system used on HDU) requires a supplemental paper chart to be completed, setting out the instructions for the variable rate infusion. Without this paper chart the heparin cannot be given. The supplemental paper chart was never created.
4. The fact that heparin was prescribed on Medchart but was not being given was noted by the nurses (who marked it as “withheld”) but not escalated to the doctors.
5. On the weekend ward rounds on 14 and 15 January, the junior doctors checked on Medchart and saw that heparin was prescribed. However, they did not open the further tab which would have shown whether or not it was actually being given.
6. A pharmacy review on the evening of Sunday 15 January did not identify that the heparin was being withheld.
7. On the pre-op ward round on 13 January Mr Patel instructed that heparin should be given after the BKA, but his instruction was not recorded in the medical records.

The Coroner’s conclusion was:

Mr Wood suffered fatal pulmonary emboli following surgery after prescribed heparin was not given. His death was contributed to by neglect.