NHS
Stockport
Clinical Commissioning Group

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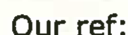

Our ref:

17 November 2020

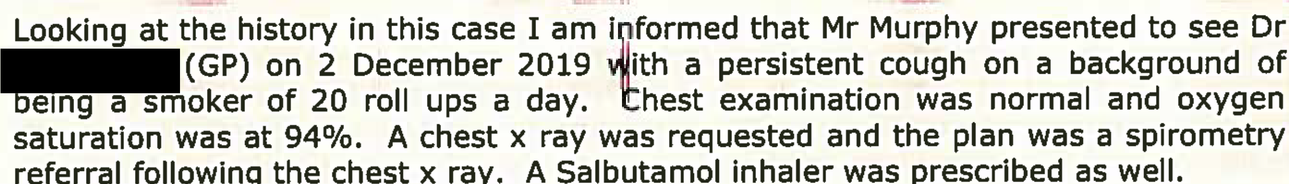
Strictly Private & Confidential
Ms Alison Mutch
H M Senior Coroner
H M Coroner's Office
1 Mount Tabor Street
Stockport
SK1 3AG

Dear Ms Mutch

Regulation 28 - Brian Richard Murphy (DOD 17.02.2020)

I refer to your letter dated 02 October 2020 and I am sorry to learn of the death of the above named; I am mindful that his will be a difficult time for the family and offer my sincere condolences on their loss.

Within the Regulation 28 document you refer to the inquest having heard that the system for referrals for cardiology tests meant that there were delays in tests being carried out which led to patients being referred to the cardiology clinic to see a cardiologist. Thank you for contacting NHS Stockport Clinical Commissioning Group (CCG) in this matter.


Looking at the history in this case I am informed that Mr Murphy presented to see Dr (GP) on 2 December 2019 with a persistent cough on a background of being a smoker of 20 roll ups a day. Chest examination was normal and oxygen saturation was at 94%. A chest x ray was requested and the plan was a spirometry referral following the chest x ray. A Salbutamol inhaler was prescribed as well.

The chest x ray was reported on 6 December 2019 and showed cardiomegaly and signs of interstitial oedema. On review of the patient on 11December 2019 bloods were taken for BNP (marker of heart failure), U&E (Urea and electrolytes), LFTs (Liver function), TFTs (thyroid function) and Lipids. Oxygen saturation was 96% and he had fine bilateral crepitations in his lungs on auscultation.

The blood sample had to be repeated on 16 December2019 showing a BNP of 353 and the recommendation from the Pathology Laboratory was an echocardiogram referral which is the usual recommendation when BNP marker is between 100 and 400. The referral for echocardiogram was made on 17 December 2019.

It was further noted that Mr Murphy's haemoglobin was 99 and so in addition to the referral for echocardiogram, an urgent referral was also made to the Colorectal Team. Mr Murphy was seen by the Colorectal Team on 6 January 2020 and a gastroscopy, flexible sigmoidoscopy and CT thorax / abdomen / pelvis organised.

On 7 January 2020 Mr Murphy had a spirometry identifying that he had Chronic Obstructive Pulmonary Disease (COPD).

By 22 January 2020 Mr Murphy had completed all of his colorectal examinations and was discharged as colorectal cancer had been excluded.

On the 6th February 2020, the echocardiogram report was available, which showed moderate to severe Left Ventricular systolic dysfunction.

Dr [redacted] saw Mr Murphy the same day and noted him to have gone upstairs in the surgery as he had been under the impression that Dr [redacted] was in an upstairs consultation room, despite which he had not appeared breathless. Mr Murphy reported no breathlessness on walking his dog every day. There was no orthopnoea, no breathlessness on lying flat, his oxygen saturation was 96%, pulse was 76 beats per minute and his blood pressure was 135/80. It was also noted that there was no ankle swelling. Mr Murphy was referred to cardiology for his heart failure.

Dr [redacted] was saddened to note that Mr Murphy was admitted to hospital a few days later, on 12 February 2020 and that he passed away on 17 February 2020.

I have reviewed Mr Murphy's pathway and also looked at the timings here and I am satisfied that the patient's care was managed appropriately and in a timely manner. The correct investigations were undertaken in the right order based on the presenting symptoms and were in line with current guidance.

A key question is whether the echocardiogram or any of the other investigations referred to should have been ordered on a more urgent basis but I am satisfied that the GP responded appropriately to the presenting circumstances, ordered the correct tests and that all results were acted on in accordance with agreed patient pathways.

Had the BNP marker been reported as above 400 then this would have generated an urgent referral to the heart failure team and they would have arranged the echocardiogram and follow up direct.

The test has subsequently changed to a NTpBNP for which the values are different:-

BNP Marker Level	Action
Under 400	Unlikely to be heart failure
400 - 2000	Refer for echocardiogram followed by routine referral to Heart Failure Clinic if heart failure identified on echocardiogram
Above 2000	Heart Failure Clinic referral as urgent - clinic to then arrange for the echocardiogram and follow up as urgent

Your report asks for an account of steps that we will be taking in relation to cardiology investigation timescales in order to reduce potentially avoidable deaths. I find myself in an unusual position in that whilst I am keen to respond appropriately to your request, my review identified that there were no delays in this case and that the correct processes and pathways were followed from the point of consultation with the GP through to the ordering of the echocardiogram and referral to specialist cardiology services.

Therefore whilst I can very much appreciate that from the family's perspective there may appear to have been a delay from the point of consultation to the referral into specialist cardiology services, this was not the case. This is because it is necessary for initial investigations to be completed prior to referral, all of which were in this case completed in a timely manner. I do not though under estimate the worry the perceived delay will have caused this family and I am sorry if the investigation process and timeline was not explained at the time.

I hope the above information is helpful to you but if you require any further information please do not hesitate to contact me.

Yours sincerely

Dr [redacted]
Medical Director