THE GLENFIELD SURGERY

[redacted]

23rd June 2016

- Thank for this
- Disclose to IPs

LCS 27/6/17

STRICTLY PRIVATE & CONFIDENTIAL
TO BE OPENED BY ADDRESSEE ONLY
Mrs L C Brown
Assistant Coroner
Leicester City and South Leicestershire
The Town Hall, Town Hall Square
Leicester
LE1 9BG

Dear Mrs Brown,

Re: Michael J Halfpenny

I am writing to you to submit further evidence to you on Mr Halfpenny's inquest.

The matter has been fully discussed with all practitioners in the practice however, it was my colleague [redacted] who saw Mr Halfpenny and requested the ultrasound.

He has reflected on his involvement in Mr Halfpenny's care and has himself produced a significant event analysis. He has also written to the Radiology Department.

I enclose his SEA, rejection letter from Radiology and his letter to Dr Rodgers, Radiologist who rejected the referral.

I also wish to advise that I have discussed the matter with my colleagues at the CCG and this incident has been accelerated to "a serious incident" and will invoke a formal multi-agency review.

Yours sincerely

[redacted]

[redacted]

Encs: SEA; rejection letter; Letter to Radiology

[redacted]
111 STATION ROAD, GLENFIELD, LEICESTER, LE3 8GS
Telephone 0116 2333600 Fax (Medical) 0116 2333602

Significant Event Audit Record

Date of Audit 19.06.2017

Reporter JWT

Initials of Patient MH **Patient Code**

Date of Incident: 09.12.2016

Incident Description: MH was a 77 year old man who presented to myself on 23.03.2016 with a productive cough, SOB and some wheeze in the evenings. I found, on examining him, he had some crepitations in the right side of his chest and duly prescribed him Amoxicillin (5 day course) for a chest infection. As he was leaving the room, MH mentioned to me that both brothers had aortic aneurysms diagnosed and had been treated for these. I decided that instead of booking him another appointment, to save time, I would refer him for an USS to check on this aortic aneurysm and I sent this to Glenfield Hospital, USS Department on 23.03.2016. In my clinical history, I explained that both his brothers had aortic aneurysms at the same age as the patient was then and that both had repair operations although, at this point he had no symptoms, I explained that given his history he needed screening for aortic aneurysm. 3 weeks later, on 14th April, the request was rejected by [redacted], Consultant Radiologist at Glenfield Hospital. However, we did not receive the rejection until 25th April. In all approximately 1 month from my original referral before we knew it had been rejected. At which point, I remember arranging a telephone appointment with MH for 29.04.2017 to discuss this. For some reason MH was not available and I commented on the record that I left a message on the answerphone. Unfortunately, for a reason I cannot explain, I did not further up on this at this point in time and it was then many months later when he presented to one of my partners, NC on 9.12.2016 with abdominal pain. MH was clearly unwell, clammy and appeared to be in severe pain. MH was in a dreadful state so my colleague arranged a 999 ambulance and he was duly taken to the LRI. The ambulance crew were working on a diagnosis of renal colic and administered Morphine. The casualty department was full and the patient then spent 1 ½ hrs in the car park awaiting admission into the LRI. Subsequent events followed on from this and the patient ultimately passed away with a ruptured aortic aneurysm. A Coroner's inquest was held and at the time, it was my partner, NC who was asked to produce a report which he duly did but which focused on his involvement around the referral of the patient. He did not look further back to make any connection from the patient's previous history, up to the point before the day of the inquest when he reviewed the records more thoroughly and at which point he noticed the patient had presented to me with a chest infection but that having mentioned the patient's family history of aortic aneurysm, he had seen that I had referred him for an USS via Anglia Ice and that this had subsequently been declined by the hospital as "Screening not offered"

Discussion Points (issues raised): Men in the UK have an USS for AAA in the year that they turn 65. I think the screening programme started after this patient was 65 however, through my colleagues research, we became aware that patients who have a strong family history of aortic aneurysm can contact the screening department by ringing them directly or be referred directly for screening via their GP. In retrospect, when I saw this patient back in March, I recall seeing him very briefly at the door for the issue around his aneurysm and duly sent off the referral. It is true that I wasn't aware that he should have gone via the screening service and that had he been seen in the normal screening manner then his aneurysm may have been picked up and treatment received, which could have saved his life. Having received the rejection form, I arranged to speak to the patient about this but this conversation never happened and as a result was a failed telephone contact. I do not know why I did not pursue the patient beyond this and I can't explain this even now. It is my normal practice to act upon any rejection letters and failure to do so is very unusual for me. Had the patient been referred via [redacted] to the AAA screening service having received a perfectly clear indication of why I felt he warranted the USS, then the USS would have taken place as I had originally hoped. I do feel [redacted] could have highlighted his reasons for rejection and at the same time sign-posted him onto the appropriate AAA screening service or at least made it very clear to me in his rejection that this patient warranted referral onto the AAA screening service in a more clear way. In this patient's case the true significant event was the delay in admitting him into casualty which was unfortunate and was beyond the control of us as GPs. A poll of the clinicians in the practice was also a quick way of identifying the lack of knowledge amongst my fellow clinicians of the availability of AAA screening and the method by which patients should be referred to this service.

Agreed Action Points:	Responsible Person:
NC originally brought up this case for discussion in our practice meeting. Obviously following which, I was then able to investigate my involvement in the case. I have reflected on how aortic aneurysm should be investigated and have written with my own concerns about the Radiology Departments dealing of my referral in the hope they will reflect upon this and reach their own lessons on this tragic case. I have discussed the case with my partners and have provided this SEA to be sent with my colleagues report to the Coroner. I will ensure a copy of this and my letter to [redacted]. I will alter the way I deal with failed telephone appointments to include sending the patient an SMS message which will show what advice I have given the patient in terms of following up on the missed call which should make the process much more robust. We will produce some posters to put up in our waiting rooms to encourage any patients with a family history of aortic aneurysm to self-refer for screening and we have also mentioned this to our PPG who produce a regular newsletter for inclusion. When sending a copy of my SEA to the Coroner, I will also include the photocopied rejection from the Radiology department. I will be discussing this SEA with my appraiser at my next appraisal. Having been informed of my involvement in this tragic event, I have felt compelled to arrange a meeting with Mrs Halfpenny to express my regret and explain my involvement in his care process.	All doctors to be aware of self-referrals so they can sign-post appropriate risk patients. Our Operations Officer and Patient Services Manager to arrange for an appropriate poster (possibly to obtain one from the AAA Screening Dept) and liaise with our PPG so they are able to include an item in their newsletter

THE GLENFIELD SURGERY

22 Jun 2017 [redacted]

Dr P Rogers
Consultant Radiologist
Department of Radiology
Glenfield Hospital
Groby Road
Leicester
LE3 9QP

Re Mr Michael Halfpenny D.O.B. 27 Sep 1939 [redacted]

Dear Dr Rogers,

I am writing to you concerning a patient at the surgery, Mr Michael Halfpenny. Back in March, I saw him regarding a chest infection and as he was leaving my room he mentioned to me he had a strong family history of aortic aneurysms. In fact his brothers had both had aortic aneurysm repairs at the same age. He was asymptomatic but I felt he needed screening.

I referred him to the ultrasound department on 23rd March 2016. It was noted that the request was received by [redacted] on 23rd March 2016 but it was passed for a comment and was rejected by yourself on 14th April 2016. However, we did not receive the letter of rejection until 25th April 2016. Mr Halfpenny was rejected on the basis that 'no screening was offered'.

Mr Halfpenny, at the age of 76, had missed the National Screening Programme. The patient in question went on to develop abdominal pain and subsequently died of a ruptured aortic aneurysm on the 24th January 2017.

His death has been a matter for the Coroner and one of my partners attended an inquest where several issues were raised. One issue was that the practice had not been aware of the screening structure for aortic aneurysm locally and that we had not received any leaflets or posters from the screening department in order to communicate the screening to patients. As a result, we have taken the liberty of designing our own posters to display in the building.

[redacted]

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When the letter of rejection was received, unfortunately no action was taken. I am unable to explain why this happened because I am normally attentive to any rejections from the department, but obviously we do deal with many reports and results and this one appears to have slipped through. As a result of this occurrence, I took a straw poll of my partners and found that of the 5 doctors within our immediate practice, there was very little awareness of any confirmed route of referral for aortic aneurysm screening. I know this is only a small number of clinicians however, I think it does highlight a potential problem within the general practice community.

As a result of this tragic incident, I have had to reflect on my personal involvement in this case but it does appear from our discussions on this that there are issues that we feel the Radiology department need to be able to reflect upon.

The patient saw me for an entire different reason and this was an addendum to the consultation. Rather than deferring this discussion to another point, I thought I would be helpful in sending in a request for an ultrasound scan.

I had enclosed pretty clear clinical reasoning behind the reason for the screening and I feel that simply to have this request rejected was particularly unhelpful given the serious, underlying clinical implication.

As GPs we are required to deal with many health matters. We are not specialist radiology trained clinicians and we rely upon our secondary care clinicians with specialist knowledge in radiological investigative areas. Given a particular clinical need, we would expect some guidance as to the appropriateness or inappropriateness of a referral but with some sign-posting as to where the referral should be directed if not to that department and also of any further tests that are now available that we could avail ourselves of.

At the heart of the issue, it is a patient and the patient had a clinical need. All of us are surely working towards this and in the spirit of co-operation, I feel you should have given some clarification as to where he should have then been sent, or it does not seem unreasonable that the request could have been passed directly through to the AAA screening department within Glenfield Hospital.

Some form of sign-posting would have made his screening omission less likely and indeed had the original referral been passed through to the screening department, then obviously he would have received the necessary screening and this event may well not have taken place.

Whilst I accept my responsibility within this, I do feel that we cannot know everything about everything and in an ideal world, yes, that would be possible however, reality is that there are certain areas where we might well have ideas of the possible routes of referral but to some extent rely upon our secondary care colleagues to point us in the new direction if that is deemed necessary.

Obviously, this tragic case has caused all of us to read up about the screening and ask searching questions as a result of which, I have personally completed an SEA. My partner, [redacted], who is Chair of the Leicester Medical Committee has included an article in the LMCs newsletter to disseminate learning to the entire GP community. He has also written a formal report for the Coroner detailing his involvement and including a copy of my letter to yourselves as well as my SEA report.

I think that an issue of this magnitude should cause all of us to reflect on how we could have done better by the patient and I would be grateful fi you could reflect upon these comments with your colleagues in the department.

This situation should not have occurred and I feel that we can, with co-operative working, prevent this happening again in the future.

Many thanks.

Yours sincerely

[redacted]

INITIAL	S
SHOW TO	
CONTACT PATIENT	
TELL PATIENT NORMAL	

TELL PATIENT

University Hospitals of Leicester NHS

NHS Trust

Radiology Department
University Hospitals of Leicester

Telephone 0116 258 8765 Option 4

25 APR 2016

[redacted]
Glenfield Surgery
111 Station Road
Glenfield
Leicester
LE3 8GS

Date: 22 April 2016
[redacted]

Dear [redacted]

We have received a referral on the 14/04/16 to make an appointment for the following patient.

Patient: Mr Michael J Halfpenny Date of birth: 27/09/1939
[redacted]

Examination: US Abdominal aorta
Unfortunately, we are unable to proceed with this request at this time and must return it to you for the following reason:
Insufficient clinical details to justify the test (✓)

A recent/previous report answers the clinical question on the request ( )

Patient did not make contact ( )

Clarification is required as to the required the timescale for the test ( )

Signature illegible - unable to indentify referrer ( )

Any other reasons for request rejection:

SCREENING NOT OFFERED

Any further comments about rejection:

Please return a complete referral form via your normal route.

We appreciate your support with this request and would like to offer our apologies for any inconvenience caused.

Yours sincerely,

On behalf of Radiology Department.

E-18463058

Exam Summary for US Abdominal aorta as of Fri Apr 22 11:25:23 BST 2016.

Patient 473617: MR MICHAEL J HALFPENNY
DOB: 27/09/39 NHSNo: 492 645 5595 HospNo: S0112100 ChiNo: none
Telephone: 0116 2339287 Work: Mobile:
Address: 90 CLOVELLY ROAD, GLENFIELD, LEICESTER, LE3 8AB

E-18463058**Event E-18463058:** Uhl - W/L & Vans
Referral Source: Glenfield Surgery, 111 Station Road, Glenfield, Leicester, LE3 8GS
Referrer: TRAYNER JW, GENERAL PRACTICE
Request Date: 23/03/16
Request Category: NHS Patient Patient Type: GP Direct Access Patient
Practitioner: SONOGRAPHY JUSTIFICATION WORK GROUP (JPSON)
Clinical History: both brothers had Aortic Aneurysm at same age both had repair operations .no sx of back ache or collapse but needs screening for AAA

Cross Infection status? : No Known Risk
Patient Allergies : No Known Allergy
Is the patient diabetic? : Yes
Is Patient on Metformin : No
(Information via Order Comms)
Event Comment: Required on 23 March 2016 at 0000
(Information via Order Comms)Requested by: G9611074 - Trayner
ICE Order ID - Exam Code: 25571606 - UAORT(US Abdominal aorta)
Cross Infection status?: No Known Risk
Patient Allergies: No Known Allergy
Is the patient diabetic?: Yes
Is Patient on Metformin: No
SITE: RWE
ROLE: : GP - Imaging
BLEEP: : [NOT KNOWN]

Status History:

Date	Code	Status	Start	End	User
14/04/16	RJ	Rejected			DR P RODGERS
Comment: screening not offered					
23/03/16	RR	Requested/Received			vishal gohil
Comment: Required Date : 23/03/2016, Required Time : 0000, Requested By :					

Exam X-13736340: UAORT: US Abdominal aorta

End of summary.

E-18463058

[redacted]

THE
GLENFIELD
SURGERY

[redacted]

13th June 2016

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Mrs L C Brown
Assistant Coroner
Leicester City and South Leicestershire
The Town Hall
Town Hall Square
Leicester
LE1 9BG

Dear Mrs Brown,

Re: Michael J Halfpenny

I am responding further to your request for a response to your report of Regulation 28.

I can confirm that after attending the inquest, I wrote up the case as a significant event and the practice has taken a number of actions to try and prevent such a circumstance in future.

Our Managers have been in touch with the Aortic Screening Department and have confirmed that men over 65 who have missed a National Screening Programme can self-refer and that patients under the age of 65 who have a family history of aortic aneurysms can be referred by the practice.

The screening department does not produce any appropriate communication materials with patients and the practice has taken the liberty of designing its own posters for display in the building. We have also had a discussion with our Patient Participation Group which will be including an article in the next edition of the newsletter and we are displaying the information on our television screens within the waiting areas.

In order to disseminate learning to the wider GP community, I have taken the liberty of including a significant event analysis to our locality group which includes a number of practices that work within the South Leicestershire area.

[redacted]

[redacted]

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As Chair of the LMC, I am also intending to include an article in the LMC (Local Medical Committee) newsletter to disseminate learning to the entire GP community within Leicestershire.

For your information, I enclose a copy of our significant audit report, the posters we are intending to display which will be A3 in size.

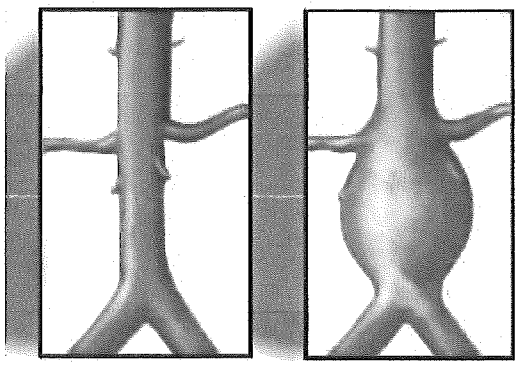
Please let me know if there are any further queries.

Yours sincerely

[redacted]

Encs

AORTIC ANEURYSM SCREENING



Normal Aorta Aortic Aneurysm

An aortic aneurysm is an enlargement of the aorta. They usually cause no symptoms until they rupture. They are most commonly located in the abdominal area aorta, but can be located in the thoracic area.

Because the abdominal aorta is such a large vessel, a ruptured abdominal aneurysm is a life- threatening event

Screening

Men aged over 65 are far more likely to have an abdominal aortic aneurysm (AAA) than women or younger men – so any man registered with a GP will receive a letter inviting him for a one off screening when he turns 65.

Men aged over 65 who have not already had a screening can request a scan by contacting their local AAA screening service **directly on: 0116 258 6820**

What happens during a AAA Screening?

Screening involves a simple ultrasound scan of the stomach (abdomen) which takes about 10 – 15 minutes.

What if I do not fit the criteria for a scan but have a family history of AA?

If you have a family history of AA but you are **under** 65 and have not been screened, your GP can refer you for an ultrasound.

Please inform the receptionist if you wish to be referred due to a family history.

Why aren't women or younger men screened?

Women and younger men are not invited for screening because 95% of ruptured AAAs occurs in men aged 65 and over and it is not part of the national programme.

Significant Event Audit Record

Date of Audit 28.5.2016

Reporter NC

Initials of Patient MH **Patient Code**

Date of Incident 9.12.2016

Incident Description:
MH was a 77 year old man who presented to me as the On Call Doctor on Friday 9th December 2016. Using telephone triage and his wife booked an appointment at 16.50, I spoke to her at 17.20 and she said her husband had significant abdominal pain and she was thinking of taking him to casualty. As I could see him more quickly I suggested he come to the surgery and I saw him at 17.30. When I saw him he was clearly unwell, clammy and complaining of left loin pain. He looked dreadful so I arranged for reception to call a 999 Ambulance and he was duly taken into the Leicester Royal Infirmary. The Ambulance were using a working diagnosis of renal colic and administered Morphine. The casualty at the Royal Infirmary was full and the patient spent 1 ½ hours in the car park awaiting entry into the Infirmary. Subsequent events followed and this patient ultimately passed away with a ruptured aortic aneurism. A Coroner's inquest was held whereby I had to produce a report. I focused on my personal contact with him in my report however the day before the inquest I made a more thorough analysis from this patient's record. In March 2016 he presented to a colleague with symptoms of a chest infection but the patient mentioned that he had a strong family history of aortic aneurism (both his brothers had them repaired) and the examining doctor requesting an uss via Anglia Ice. However this uss request was declined by the hospital as "screening not offered".

Discussion Points (issues raised):
Men in the UK have an uss for AAA in the year they turn 65. I think the screening programme started after this patient was 65. However through my research I became aware that patients who have a strong family history of AA can contact the screening department either themselves or via their GP and can be included in the screening scans. I think the doctor whom he saw in March 2016 was not aware of this and hence did not signpost the patient appropriately. It is possible that had he signposted the patient for the AA scan his life would have ultimately have been saved. In this patient's case however the true significant event is the delay in admitting him into casualty which was beyond the control of us as GPs.

Agreed Action Points:	**Responsible Person:**
I brought up this case as a discussion point in our practice meeting. We will produce some posters to put up in our waiting room to encourage any patients with a family history of AA to self refer for screening and we will also mention this fact to our PPG who produce a regular newsletter for inclusion within their newsletter.	All drs to be aware of self referrals so they can signpost appropriate risk pts. Our operations manager & patient services manager to arrange for an appropriate poster (possibly to get one from the screening dept & also liaise with our PPG so they can include an item in their newsletter