REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

1. Director, Tameside and Glossop Integrated Care NHS Foundation Trust, Tameside General Hospital, Fountain Street, Ashton-under-Lyne, Lancashire, OL6 9RW
2. Director, Pennine Care NHS Foundation Trust, 225 Old Street, Ashton-under Lyne, Lancashire, OL6 7SR

1. CORONER

I am Adrian Farrow, Assistant Coroner, for the Coroner Area of Greater Manchester South

2. CORONER'S LEGAL POWERS

I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

3. INVESTIGATION and INQUEST

On 1st July 2019 an investigation was commenced into the death of Gordon Fenton, aged 70. The investigation concluded on the 6th March 2020 and the conclusion of the inquest by the jury was that the medical cause of death was:

1a. Pulmonary embolism
1b. Deep Vein Thrombosis
1c. General Debility
II. Urinary Tract Infection.

In summary, the findings of the jury were that Mr Fenton died at Tameside General Hospital on 29th June 2019, having been admitted there on 22nd May 2019. He was subject to detention under the Mental Health Act 1983 on the Hague Ward (Pennine Care NHS Foundation Trust) and, periodically at Tameside General Hospital (Tameside and Glossop Integrated Care NHS Trust). The jury found that the quality of information sharing between the two NHS Trusts was inadequate and prolonged the treatment of the urinary tract infection and that the interaction and engagement between the medical professionals and urology department led to ineffective treatment for Mr Fenton.
The narrative conclusion of the jury was that Mr Fenton died in hospital whilst he was detained under the Mental Health Act from complications which arose in the course of treatment for urinary tract infection in which treatment was ineffectively managed between the mental health and medical wards

4. CIRCUMSTANCES OF THE DEATH

Mr Fenton was a fit and active 70 year old. He had a history of mental illness stretching back to his early adult life, but there had been no recent significant psychiatric history. He had an enlarged prostate and was prescribed medication for it. On 14th May 2019 due to urinary retention, he was referred by his GP to Tameside General Hospital ("TGH"), where a catheter was inserted. He reattended at TGH on 16th May and was admitted overnight due to a urinary tract infection before being discharged home.

By 20th May, Mr Fenton had suffered a serious deterioration in his mental state and he was referred back to TGH where a diagnosis of possible delirium or acute mental health problems was made and with intervention from the Pennine Care Trust ("Pennine Care") psychiatric team, he was discharged home again on 21st May with a view to care by the community mental health and district nursing teams.

On 22nd May, Mr Fenton's mental health had further deteriorated and he was admitted back to TGH and placed under a s3 Mental Health Act section by Pennine, where he was transferred. Although located on the same site, TGH and Pennine Care operate in separate buildings and as separate Trusts.

The staff on Hague ward (Pennine Care) were primarily trained in psychiatric and mental health rather than medical care. In particular, they did not routinely deal with acute medical problems or the specific management of patients fitted with catheters and in particular, did not undertake trials without catheter or change catheters.

A trial without catheter was advised by TGH microbiologist on 6th June, but this did not take place because of the absence of expertise on Hague Ward. Mr Fenton was transferred to A&E at TGH on 7th June when blood was observed in his catheter bag. He was treated and returned to Hague Ward on 8th June.

On 9th June, blood was observed in the catheter bag again and in accordance with correspondence between Hague Ward and the TGH Urology department (to whom Mr Fenton had been known since 2016) he was seen in the urology clinic on either 10th or 11th June when a further attempt of trial without catheter was advised to be undertaken. The Consultant on Hague ward felt unable to make a firm diagnosis of Mr Fenton's mental health until progress was made in treating the urinary tract infection, which could have been an underlying or contributing cause.

On 11th June, Mr Fenton, in a state of distress, removed his own catheter. He was again transferred from Hague ward to TGH A&E, where he was subsequently admitted and was placed on Ward 31, where he stayed until 20th June. He had 1:1 care from the Hague ward staff whilst on ward 31 at TGH, but that was not 24-hour cover.

A trial without catheter was attempted on 18th June, but that was unsuccessful. The replacement catheter was of a size which the consultant urologist confirmed may have contributed to the continuation of the urinary tract infection. The evidence was unclear as to whether a similar-sized catheter had been inserted in A&E at TGH after Mr Fenton had removed the catheter on 11th June.

Hague ward were resistant to Mr Fenton returning to them without input from the urology department. The on-call urology registrar, acting on the information provided by ward 31 advised that the catheter remain in place until Mr Fenton was seen at the scheduled haematuria clinic appointment on 25th June. On that basis, Mr Fenton was transferred back to Hague ward.

Mr Fenton's behaviour was problematic. On 25th June, at the haematuria clinic, the catheter was found to be inappropriately small in size and blocked. His prostate was inflamed. A

longterm, large gauge catheter was fitted with a plan to have a trial without catheter after 3 months. A urine sample revealed continuing urinary tract infection.
On 27th June, Mr Fenton slipped off the bed in Hague ward and fell during a family visit, banging his head. He was transferred to TGH A&E for a CT scan and assessment.
Although the CT scan was clear, there were signs of urosepsis. He was transferred into the care of the Acute Medical Unit and blood samples revealed serious infection and urinary retention.
His condition was monitored and treatment given for the infection, but at about 2.55am on 29th June, Mr Fenton suffered a seizure and then went into cardiac arrest and died.
The post-mortem autopsy revealed a pulmonary embolism which had originated in a deep vein thrombosis in Mr Fenton's right calf, which had arisen as a consequence of the general debility from the period of urinary infection.

5. CORONER'S CONCERNS

During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you.

The MATTERS OF CONCERN are as follows. –

1. The inquest heard that there was a particular tension in relation to shared care between Pennine Care NHS Foundation Trust and Tameside and Glossop Integrated Care NHS Trust for patients who are subject to psychiatric care, who have acute medical problems.
2. There does not appear to be a reliable and consistent method of sharing medical records and information between the two Trusts.
3. There does not appear to be a formalised decision-making process in place involving both Trusts to review the treatment plan to determine the optimum medical and psychiatric care to suit the particular patient's needs.

6. ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe your organisation has the power to take such action

7. YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 18th June 2020. I, the coroner, may extend the period.

Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.

8. COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to [redacted] on behalf of the family.

I am also under a duty to send the Chief Coroner a copy of your response.

The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.

9. **Adrian Farrow**
   HM Assistant Coroner
   23.04.2020