	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Chief Executive of Trafford Council and the Chief Executive of Greater Manchester West Mental Health NHS Foundation Trust**
1	**CORONER** I am Joanne Kearsley Area Coroner for 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
3	**INVESTIGATION and INQUEST** On the 5th April I concluded the Inquest into the death of Dennis Bennett date of birth 24.07.1939 who died on the 07.02.2016. The cause of death was 1a) Dementia I recorded a natural causes conclusion.
4	**CIRCUMSTANCES OF THE DEATH** The Court heard evidence that the deceased had a history of dementia and on the 29th November 2015 was admitted in accordance with Section 2 Mental Health Act to the Moorside Unit under the care of Greater Manchester West Mental Health Trust. (GMW). The deceased was shortly after his admission transferred to Wythenshawe hospital for medical treatment before being returned to the Moorside Unit on the 6th January 2016. At this time he was admitted under Section 3 of the Mental Health Act for ongoing treatment for his mental health. The treatment plan was initially for him to be well enough to be discharged to nursing home care. However on the day of the nursing home assessment his condition deteriorated and he was no longer well enough to be discharged. By the 13th January he was for end stage palliative care and following a meeting with the family the plan was that he would remain on ward in the Moorside unit. On the 14th January the Consultant made an urgent Deprivation of Liberty Safeguarding Application to Trafford Council. As this was an urgent application

	the application commenced on the 14th January. At this time the deceased was in act still being detained under S3 of the Mental Act and this was not rescinded until the 15th January 2016. The urgent application expired on the 21st January 2016 at which time GMW contacted Trafford Council as the standard authorisation had not been considered. It was the understanding of GMW (albeit the witness from GMW who had responsibility for safeguarding in the Trust was in fact employed by Trafford Council) that the urgent application continued until the best interest assessments could take place and the deceased despite now being on end stage palliative care was subject of DOLS at the time he died. Another employee of Trafford Council provided evidence that when he was asked for advice from the Trust the position of the Council was that there was no DOLS in place following the expiration of the urgent authorisation until such time as the standard application had been processed.
5	**CORONER'S CONCERNS** The concerns noted by the Court during the course of the Inquest are as follows: 1. The Trust staff completed an application for an urgent DOLS at the same time as the deceased was already subject to detention under Section 3 of the Mental Health Act. 2. There was a lack of understanding as to what occurred at the conclusion of the urgent application and conflicting evidence was heard from two employees of Trafford Council. 3. The decision to apply for a DOLS was initially made at a time when the decision was for him to be moved to nursing home care. Indeed the evidence provided by the family was that a DOLS application was necessary so that he could be moved to the nursing home. There appears to be a lack of understanding as to the fact that DOLS are place specific. 4. The deceased was then on end stage palliative care and entirely compliant with treatment there was little consideration as to why a DOLs was applied for as opposed to treating the deceased in his best interests. Whilst in this case the application did not impact on his care or treatment there is a concern that a lack of understanding and differing information may and could impact on other patients.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have 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 7th June 2016 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 the following Interested Persons namely, **the family of Mr Bennett.** 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	**12.04.2016** **Joanne Kearsley Area Coroner** Jkearsley