**H M Coroner**
Manchester South

23 May 2016

Chief Coroner's Office
1st Floor Tomas Moore
Royal Court of Justice
Strand
London
WC2A 2LL

Our ref: JK/HC/00331-2016

Dear Sirs

**RE: Dennis BENNETT (Deceased)**

Please find attached a copy of the response to the Regulation 28 Report received from the Chief Executive of Greater Manchester West Mental Health NHS Foundation Trust.

Yours faithfully

Miss J. Kearsley
**Area Coroner**

John S Pollard Ll.B. Hons, Senior Coroner

Joanne Kearsley Ll.B. Hons Grad.Dip Psych, Area Coroner

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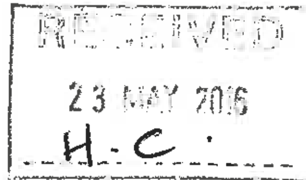


Our Ref:BH/kearsley19.05.16

19th May 2016

Miss Kearsley
Manchester South Coroner's Court
1 Mount Tabor Street
Stockport
SK1 3AG

Dear Miss Kearsley

**Re: Regulation 28: Dennis Bennett (Deceased)**

I am responding to the Regulation 28 you issued to the Trust on 11th April 2016. Whilst Mr Bennett's death was expected on the ward and the concerns you raise are not related to his death, or his care, or treatment, you note that there is a concern that a lack of understanding and differing information about the Deprivation of Liberty (DoLs) process may and could impact on other patients.

For ease I will answer each concern separately.

You note that 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.

The use of DoLs is rare within the Moorside Unit and Bollin/Greenway Ward. In order to ensure staff have a good understanding of the DoLs process and its relationship to the Mental Health Act senior clinical staff will be provided with further bespoke training about DoLs which will incorporate the concerns you raise.

A further concern was raised that 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.

In order to avoid any further miscommunications and because the use of DoLs on the Moorside Unit is rare the Mental Health Act Administrator has been asked to ensure a summary email is sent to the Council when taking advice. This will ensure any miscommunications are picked up by either party promptly and allow for the correct information to be communicated.

Nationally it is reported that there are an increasing number of situations in which an application for standard and urgent authorisation for DoLs has been made by the Managing Authority but the Supervisory Body has not granted the standard authorisation by the time the urgent authorisation has expired.

This situation is not provided for in the legislation or code of practice. Therefore, there is no straightforward legal solution to the problem.

**The Trust is committed to safeguarding children, young people and vulnerable adults and requires all staff and volunteers to share this commitment.**

**Greater Manchester West Mental Health NHS Foundation Trust, Trust Headquarters, Bury New Road, Prestwich, Manchester M25 3BL Tel: 0161 773 9121.**

Staff completing applications will be asked to consider the following if this situation arises again.

Apply to extend the urgent authorisation.

The Head of Operations will write to the Supervisory Body to ask them to set out their reasons for the delay and will also enter into discussion at a senior level to resolve the situation.

As patients' needs change frequently further consideration will be given to whether it is appropriate to use the Mental Health Act as the least restrictive option.

Similarly, the patients care plan will be reviewed to establish if aspects of the care plan can be amended to make them less onerous and, therefore less likely to amount to a deprivation of liberty.

The patient will be referred for an Independent Mental Capacity Advocate (IMCA) with the possibility of them engaging a solicitor to ensure that the patient's rights are safeguarded.

You also note that the decision to apply for a DoLs was initially made at a time when the decision was for Mr Bennett 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.

I can confirm that in order to ensure all staff have an increased knowledge about DoLs the staff group have been asked to complete a DoLs training package which includes this information. The completion of this training is mandatory and will be monitored by the ward manager.

The additional bespoke training being delivered to senior clinicians will also include this information.

If a DoLs is undertaken in the future, an explanatory leaflet will be given to the patient's family to reaffirm any verbal explanations that have been given. It can often be a difficult time for families and carers and it is hoped that by giving supportive information it may help families better understand the reasons why a DoLs is being applied for, the parameters of this as well as informing them of the patient's rights.

Finally, you note Mr Bennett was then on the 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.

The decision to place the patient on a DoLs rather than act in his best interests whilst initially appears incorrect, has been reviewed by the Trust Social Care lead and the Directorate Social Care Lead and is considered to be available to the clinicians providing care and treatment in this particular case.

The Deprivation of Liberty safeguards provides a legal framework to deprive someone of their liberty whether they are making attempts to leave or not and does not have capacity to make an informed decision (Mental Health Act 1983 Code of Practice 13.45).

The Trust's Clinical Improvement Lead Nurse for Dementia, Older People and Carers Services is currently undertaking a review of end of life care. She has been asked to build into the review consideration of the most appropriate legal framework to use.

I hope this response provides assurance to you and Mr Bennet's family that GMW have taken the learning from the inquest very seriously and have put in place measures to ensure safe and effective services.

Yours sincerely

**Bev Humphrey**
**Chief Executive**