NHS
Greater Manchester
Integrated Care

E: [redacted]

Date: 22nd 2025

Private & Confidential
Joanne Kearsley
Senior Coroner for the area of Manchester North
Manchester City Coroner's Office and Court
Exchange Floor
The Royal Exchange Building
Cross Street
Manchester
M2 7EF

Sent by email to: [redacted]

Dear Ms. Kearsley

Re: Regulation 28 Report to Prevent Future Deaths – Mark Anthony Fernandez

Thank you for your Regulation 28 Report dated 4th March 2025 regarding the sad death of Mark Anthony Fernandez. On behalf of NHS Greater Manchester Integrated Care (NHS GM), We would like to begin by offering our sincere condolences to Mr. Fernandez' family for their loss.

Thank you for highlighting your concerns during the inquest which concluded on the 17th of February 2025. On behalf of NHS GM, we apologise that you have had to bring these matters of concern to our attention. We recognise it is very important to ensure we make the necessary improvements to the quality and safety of future services.

During the inquest you identified the following matters of concern for investigation and response by NHS Greater Manchester (NHS GM): -

> **The referral to the specialist service did not provide adequate information as to his level of care needs to help assist the service conduct an appropriate examination.**

An investigation into this matter of concern has been undertaken by [redacted], Associate Director Quality & Safety (Oldham) and [redacted], Assistant Director Patient Services, both of NHS GM. I understand that separate matters of concern have been directed to Northern Care Alliance, Oldham Social Services and Oldham Independent Mental Health Advocate and that they will be provided their responses.

To ensure learning and service improvements have been put into practice:

- A locality practice review process has begun in partnership with key stakeholders to lead forward improvement work in Oldham for patients who have a learning disability and complex needs to improve the care experience for our most vulnerable patients and residents. Learning from the

review will be shared across Greater Manchester.

- Staff have been reminded via a Take 5 Briefing (attached with this letter) of their responsibilities towards patients with learning disabilities and complex needs.
- Staff have been reminded via a Take 5 Briefing (attached with this letter) of the importance of Safeguarding vulnerable patients and the responsibilities and mechanisms of making referrals.
- As a health and care system, we recognise the importance of Hospital Passports. Staff have been reminded to be immediately aware of and seek out whether a Hospital Passport is held, regardless of whether or not one is noted on the patient records, Trust or community systems or is available at any given presentation to services for care.
- Compliance with the Oliver McGowan mandatory training and completion rates are being monitored at Directorate and Trust levels.

Learning from this PFD will be shared specifically with the GM acute hospitals and the wider health and care system through the NHS GM Assistant Directors of Quality networks.

I hope that the above actions and the outline of the locality review show that NHS Greater Manchester is taking appropriate action to learn from the sad death of Mr. Fernandez.

Please contact me if I can be of further help/

Best wishes

[redacted]

[redacted]
Interim Deputy Chief Executive Officer and Chief Nursing Officer
NHS Greater Manchester

4th Floor, Piccadilly Place, Manchester M1 3BN
Tel: 0161 6257791 **www.**gmintegratedcare.org.uk