Northern Care Alliance
NHS Foundation Trust

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29 April 2025

Ms Joanne Kearsley
HM Senior Coroner for Manchester North
Rochdale Coroner's Court
Floors 2 and 3
Newgate House
Rochdale
OL16 1AT

Dear Ms Kearsley

Re: Inquest into the death of Mr Mark Anthony Fernandez

I write with regard to the inquest into the death of Mr Mark Anthony Fernandez which concluded on 17 February 2025 in which you issued a Regulation 28 report to Prevent Future Deaths.

As you recorded in the Record of Inquest, Mr Fernandez sadly died at the Royal Oldham Hospital ("the Hospital") on 18 April 2024, which falls under the Northern Care Alliance NHS Foundation Trust ("the Trust"), following admission on 1 February 2024. May I take this opportunity to express my sincere condolences to the family of Mr Fernandez and to his long-term carers.

The Trust is always open to the opportunity to review, and where possible, strengthen its processes. I hope the below offers assurance to both you and Mr Fernandez's family and carers that the Trust takes these concerns seriously and has put in place a number of steps and actions since Mr Fernandez's death.

I will address your concerns raised in the Regulation 28 report in turn as below:

1.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

The referral / Hospital Passport

On 16 January 2024, a referral was made from [redacted], Consultant Orthopaedic Surgeon at Rochdale Infirmary, to the Sarcoma Service at Manchester Royal Infirmary. The referral related to a suspicious mass in Mr Fernandez's left groin.
[redacted] made the referral following Mr Fernandez's attendance at the Emergency Department on 14 January 2024. A suspected cancer upgrade referral was sent by the Emergency Department to the orthopaedic team and was virtually reviewed by [redacted] before he sent the referral to the

Sarcoma Service. A Hospital Passport was not included with the referral nor was reference made to its content. Mr Fernandez had arrived at the Emergency Department on 14 January 2024 unaccompanied and there is nothing in the documentation to suggest that he came with his Hospital Passport. Consequently, [redacted] was not aware as to its content and potential assistance to the Sarcoma Service in accommodating their examination of Mr Fernandez on 1 February 2024.
The Trust acknowledges that the referral did not provide sufficient information regarding Mr Fernandez's presentation and the accommodations that would be required to ensure a full examination could take place. It was evident however that the lack of information regarding Mr Fernandez's presentation within the referral indicated the need to increase the awareness amongst Trust staff regarding the adjustments and support required by patients with a learning disability. The Trust has improved its processes about the utilisation and awareness of Hospital Passports as I describe below.

Review of the Learning and Disabilities and Autism policy and Enhanced Patient Observation ("EPO") policy

There is a Learning and Disabilities and Autism Policy available on the Trust Policy Hub providing guidance including a Summary Sheet and Emergency Care and Admission Pathway. The Policy also references Hospital Passports in its advice regarding reasonable adjustments required in triage and on admission. The Trust will review this Policy with reference to your concerns and in particular regarding how additional guidance can be provided with regard to specialist referrals.
A review of the policy will be undertaken by the Lead Nurse for the Learning Disability Acute Liaison service within 3 months of the date of this letter, incorporating a review of the Enhanced Patient Observation ("EPO") policy to provide assurance that the policies are equally cognisant of the needs of people with learning disabilities and the requirement of active use of Hospital Passports, and 1 Page Profiles (e.g. Traffic Light Hospital Passport, My Health Passport, What Matters to Me 1 Page Profile, This is Me).

Share Learning Take 5

An educational Share Learning *Take 5* has also been prepared to increase awareness regarding patients with learning disabilities. This was presented to the Oldham Care Organisation patient safety summit on 9 April 2025 and divisional governance meetings in the month of April 2025. It was also shared with the other Care Organisations within the Trust on 10 April 2025.
The *Take 5* highlights the need to avoid diagnostic overshadowing and encourage those caring for a patient with a learning disability to have regard to their unique needs. It reinforces the current policy about the importance of communication with patient's carers and family and how to adapt communication with the patient themselves. The *Take 5* also signposts to the Trust Learning Disability Acute Liaison team which is on hand to offer guidance and support with regard to all aspects of care and support required for patients in this cohort.

Oliver McGowan training

The Oliver McGowan Mandatory Training on Learning Disability and Autism aims to save lives by ensuring the health and social care workforce have the right skills and knowledge to provide safe, compassionate and informed care to autistic people and people with a learning disability (NHSE, 2025). The Trust has mandated the part 1 e-learning programme to all staff with 97% compliance across the organisation to date. Ongoing development is in progress to complete training of the trainer for Tiers 1 and 2 of the programme during 2025.

2. *The Hospital Passport was not utilised*

Provision and use of Mr Fernandez's Hospital Passport

The Trust acknowledges the importance of Hospital Passports in informing the care and treatment of patients with a learning disability.

The Trust is aware of the evidence of [redacted] that a Hospital Passport accompanied Mr Fernandez into hospital on 1 February 2024. From its review of the notes the Trust found nothing to suggest that Mr Fernandez did, in fact, arrive with this document. He arrived unaccompanied via ambulance and following his transfer from the Emergency Department to the Acute Medical Unit all notes were scanned into the symphony system. The Hospital Passport was not included within these notes.

From its review of the notes the Trust concludes that the Hospital Passport must have been provided at some point within the next 4 days as contact was made to his care home residence on 5 February (the Hospital Passport being the only documentation containing these contact details). The Hospital Passport was scanned on Mr Fernandez's transfer to ward F8 and would have been located in his 'end of bed' notes in accordance with the Trust Learning Disability and Autism Policy as it would be accessible to all members of the MDT.

The Learning Disability team documented five attendances on Mr Fernandez during his admission and the Trust's review of the notes confirms that this input was appropriate, informing the treating team as to Mr Fernandez's normal baseline, communication preferences etc. It was however, noted during this review that there was not enough contact with Mr Fernandez's care provider. This was most likely as a consequence of the initial absence of the Hospital Passport and these contact details being unknown until its arrival to the Hospital.

The Trust's review determined that Mr Fernandez's care was not impacted by the initial absence of the Hospital Passport. Notwithstanding this however, the Trust recognises that it's proper utilisation depends on hospital staff being immediately aware as to the need for this document to accompany a patient with a learning disability or if one is not available to create one.

Patient Care Alert ("PCA")

The Trust therefore prepared a Patient Care Alert ("PCA") for immediate learning, which was circulated amongst clinical and non-clinical staff on 17 April 2025 and was also shared at the PSIRF (patent safety incident response framework) Assurance Group on 24 April 2025, covering the following actions:

1. Hospital systems containing next of kin contact details must be checked for accuracy and updated on a patient's arrival to the hospital. The Emergency Department Lead Nurse will raise this at an Emergency Department reception team meeting so that patient contact details are confirmed and if a patient has arrived by ambulance, cross referenced with the PRF (patient report form) on arrival.
    a. Where any demographics/next of kin details have been updated, the reception team must leave a comment to highlight the details which have been updated;
    b. Where it has not been possible to confirm demographics/next of kin details, the reception team must put a note within the record with a request for the details to be checked by the nursing team. This will enable omissions to be picked up in real time and actioned by the nurse in charge;
    c. A monthly audit will be undertaken for patients presenting by ambulance and via the waiting room, to ensure compliance with the above process.

2. Hospital staff to make contact with care providers and ensure a Hospital Passport is available as soon as possible

3. A prompt will now appear on the '*patient status at a glance*' board (the bed board) when a Hospital Passport is available and in use. This will reiterate the policy provision with regard to the visibility and prominence of Hospital Passports. The board features a learning disability symbol and staff can include written confirmation of "*Hospital Passport in place"*.

Daily safety huddles
Further to the PCA, any patient with a learning disability/Hospital Passport will automatically be 'red flagged' during daily safety huddles for nursing staff. This adds a further layer of awareness of this cohort of patients and their specific needs. The senior nurse (ward manager) will have oversight of vulnerable patients.

In Patient Assessment and Accreditation System ("IPAAS")
Nursing teams' adherence to Safeguarding / Learning Disability Policy is assessed part of the In Patient Assessment and Accreditation System ("IPAAS") and mini IPAAS. Action plans are implemented for any areas that do not achieve green status. IPAAS includes:

- Evidence of active safeguarding champions, covering dementia, learning disability and fall/EPO in safeguarding IPAAS file;
- All elements of safeguarding mandatory training compliance equal to or greater than 90%, (evidence provided in mandatory training data base and local records);
- Safeguarding Adults Level 1, Level 2, Level 3;
- Safeguarding Children Level 1, Level 2, Level 3;
- Prevent Basic, Prevent WRAP, Oliver McGowan;
- Robust documented evidence of relevant relative/carer/patient/IMCA involvement in best interest discussions and meetings in accordance with the Mental Capacity Act 2005 ("MCA"). Outcomes and actions from these are clearly recorded, evidenced by review of documentation and discussions with staff.
- Patients with a learning disability or autism, cognitive impairment, dementia etc. have had a relevant Passport of Care completed within 48 hours of admission (Traffic Light, My Health Passport, This is Me). If not required, this is clearly documented within the patient's notes. Staff can call significant others and complete over the phone if unable to visit. This is evidenced by review of documentation and discussions with staff.
- Patients with a learning disability, cognitive impairment or those living with dementia have the appropriate alert symbol displayed on their PSAG (patient safety at a glance)/bedside board and are wearing a blue wrist band. This is evidenced by review of appropriate patients and PSAG boards, and discussions with staff.
- Where a patient has a learning disability or is subject to the EPO policy the appropriate alert symbol is in use. This is evidenced by observing the PSAG board.
- Patients with a cognitive impairment, dementia, learning disability or autism have had the appropriate care plan implemented, on an individualised basis, and the elements within this are being followed. This is evidenced by reviewing documentation and observing practice.

Share Learning Take 5

As I have referenced above (§**1**) the Share Learning *Take 5* presentation includes education as to the Hospital Passport and its importance in assisting treating teams to identify problems quickly.

The Share Learning *Take 5* presentation was presented at the Oldham Care Organisation Nursing and Midwifery Professional Forum on 23 April 2025. The forum, chaired by the Oldham Care Organisation Director of Nursing, includes senior nursing staff, ward managers, lead nurses and midwives, assistant directors of nursing and midwives from both community and acute hospital settings. Expectations and the standards for checking of Hospital Passports and communicating with relatives/carers was discussed, as well as access to the Learning Disability team for support and advice.

Senior Nurse Walkabout

The 'Senior Nurse Walkabout' took place on 25 April 2025 and focussed on patients with a learning disability, review of safety huddle 'red flags' and Hospital Passports. A spot check audit was completed focusing on the following four points:

- How many patients with a learning disability were on the ward?
- Were all the patients with a learning disability identified on the safety huddle?
- Did patients with a learning disability have a Hospital Passport?
- Was the Hospital Passport up to date?

Any shortfalls / non-compliance with the utilisation of Hospital Passports were addressed in real time and sharing of good practice will be discussed in the post-walkabout briefing. Going forward there will be a quarterly focus on patients with a learning disability on the Senior Nurse Walkabout.

The Enhanced Patient Observation ("EPO") policy review and audit tool

The EPO Policy outlines the approaches to the provision of holistic person-centred care. The current policy is under multi-disciplinary review to ensure it reflects the changes in Through 2024/25, a collaborative approach aimed at improving the effectiveness of therapeutic observations of care, using the least restrictive approaches. An EPO audit tool was developed September 2023 to support role modelling by senior staff and to improve assurance across the Trust. The tool was further developed to support the oversight of the quality of the EPO process. In addition, the improvements to the Safecare system has supported monitoring of the numbers of patients on EPO. The tool has been further modified to support improvements in quality for identified, current learning points particularly identified with the EPO process from recent IPAAS assessments.

This work is underpinned by promotion of This is Me/Hospital Passports to better understand the needs of our most vulnerable patients. A series of targeted and bespoke bitesize training sessions have been provided by the Enhanced Care team (bringing together falls prevention, dementia specialists and the AD for Healthcare behaviours) to frontline staff and managers, promoting a strength-based approach to EPO. This approach has been shared with interest with an NHSE Enhanced Therapeutic Observation of Care (ETOC) advisory group and recognised as a programme of good practice.

3. ***A best interest decision was made without taking into account the views of the long-term carers and social services and their knowledge of him as an individual***

The best interests decision making process in April 2024

The Trust acknowledges the evidence provided by [redacted] as to the composition of the best interest meeting held on 12 April 2024. It also acknowledges that this meeting/decision making process ought to have included Mr Fernandez's carers (and any other professional with an interest in his welfare). It

is acknowledged that this would have enabled the best interest decision to be better informed as to his wishes and feelings on that matter.

The Trust's conclusions as to the utilisation of the Hospital Passport contributed to this omission but it also accepts that further education as to its adherence to proper best interest decision making under the Mental Capacity Act 2005 ("MCA") is necessary.

MCA training

The Trust commissioned 4 education sessions on incapacitated consent in early 2025 which outlined the requirements of section 4 of the MCA and importantly why the views of care staff for an individual in Mr Fernandez's circumstances would be essential to a holistic appraisal of his best interests. At the time of writing over 650 staff are currently registered to attend these sessions.

The Trust Level 3 safeguarding adult mandatory training programme has a significant focus on the MCA and its application in practice. Current organisational compliance with Level 3 Safeguarding adult training is at 95%. MCA and Deprivation of Liberty Safeguards (DoLS) training have been better defined to support the application of MCA beyond the requirement for application of a DoLS authorisation to ensure the MCA is more effectively considered for a wider group of patients, including those with learning disabilities. The application of the MCA is essential to the EPO procedures to ensure the least restrictive option of observation and support is provided.

MCA audits

Mental capacity ward audits have been reviewed and updated with the roll out of a new audit tool commenced from April 2025. The Trust safeguarding adults team have worked with the clinical audit team on the audit programme, and safeguarding practitioners are delivering MCA audit training to lead nurses across the Trust. The audit is in development, working alongside frontline staff to improve compliance and auditable sample sizes.

Audit findings for quarter one will be reported via local care organisation steering groups, the Trust Safeguarding Committee and Experience Group in Quarter 2 of 2025/26.

Summary of Actions and Impact on Patient Care

In response to the concerns raised, the Trust has initiated a series of targeted actions, including a review and strengthening of the Learning Disability and EPO policies, enhanced staff training on the Mental Capacity Act, increased visibility and utilisation of Hospital Passports, and improved communication with care providers. These changes are supported by audit mechanisms and safety huddles to ensure consistent practice. Collectively, these measures will improve the identification and support of patients with learning disabilities, ensure timely and informed decision-making, and enhance the delivery of safe, personalised care. All actions will be completed and embedded within 3 months to ensure lasting improvements in patient outcomes.

Further Review

The Coroner advised in her summing up that the matter needs to go in for a LeDeR review urgently. I can confirm that Mr Fernandez's death was referred to LeDeR by the Trust the following day, on 19 April 2024. We have since contacted LeDeR again for an update and are told that the review was on hold pending the inquest process and will now resume.

I hope the above offers you reassurance of the Trust's ongoing commitment to managing patient safety risks and to continually improve the care and services we provide.

Please do not hesitate to contact me if you require any further information in relation to our response or if you would like me to share the PCA or other documentation referred to above.

Yours sincerely

[redacted]

[redacted]
Chief Executive Officer