REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted], OBE, Chief Executive, Northern Care Alliance NHS Foundation Trust, Mayo Building, Salford Royal Hospital, Stott Lane, Salford, M6 8HD 2. [redacted] Director of Adult Social Care (DASS), Oldham Council, Level 4 Civic Centre, West Street, Oldham, OL1 1UH 3. Oldham Council IMCA service, [redacted] Director of Adult Social Care (DASS), Oldham Council, Level 4 Civic Centre, West Street, Oldham, OL1 1UH 4. [redacted] and [redacted], Co-Chair, NHS Greater Manchester Integrated Care Partnership Board, NHS Greater Manchester, Tootal, 56 Oxford Street, Manchester, M1 6EU
	CORONER I am Joanne Kearsley, Senior Coroner for the Coroner area of Manchester North
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013
3	**INVESTIGATION and INQUEST** I opened an investigation into the death of Mark Anthony Fernandez on the 30th October 2024 and the final Inquest hearing took place on the 17th February 2025 before HM Joanne Kearsley. A conclusion of natural causes was returned.
4	**CIRCUMSTANCES OF DEATH** Mr Fernandez was born with cerebral palsy and complex medical needs. He had been in the care of Oldham Social Services since he was a child. He was not able to speak and registered blind. Since 2008 he had been residing at a supported living home with full time carers. His care package was provided by Comfort Call. His carers had a wealth of knowledge and understanding as to how Mark communicated, what he liked and disliked, his feeding regime and all aspects of his care and health needs. They also facilitated weekly visits with a close family member who received similar care. During the day on the 1st February Mr Fernandez had attended the specialist sarcoma service at Manchester Foundation Trust ("MFT") following a referral from Rochdale Infirmary. Limited information had been provided as to his level of disability and as such the court heard that a very limited examination was conducted whilst he remained clothed and in his chair. If MFT had been aware they indicated they would have had the opportunity to obtain a hoist and would have requested bloods before attendance. They indicated they had now changed their practices. On the 1st February 2025 Mr Fernandez was admitted to Royal Oldham hospital at 8pm in the evening with suspected meningitis (a rash had become evident). His carers forwarded his hospital passport and also sent further copies to the hospital following his admission to a ward. Investigations highlighted he had recurring infections and despite treatment, including the insertion of a PEG, he remained in hospital until his death on the 18th April 2024. On the 12th April 2024 following a best interests meeting he was placed on end of life care.

	The carers and social services involvement in Mark's life was overlooked and their views and knowledge of Mark was not taken into account in the best interest decision-making process. The court heard that in 2020 the carers had successfully presented evidence against the introduction of a DNAR, at a best interests meeting.
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:- **Greater Manchester Integrated Care Board and Northern Care Alliance** 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. **Northern Care Alliance, Oldham Social Services, Oldham Independent Mental Capacity Advocate** 1. The hospital passport was not utilised. 2. 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.
6	**ACTION SHOULD BE TAKEN** **In my opinion action should be taken to prevent future deaths and I believe each of you respectively 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 29 April 2025. 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:- Comfort Call, CCH Group, Cardinal House, Abbeyfield Road, Nottingham, NG7 2SZ 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 from. 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	Date: 4 March 2025 Signed: