Wirral University Teaching Hospital NHS Foundation Trust
Arrowe Park Hospital, Arrowe Park Road, Upton, Wirral,
Merseyside CH49 5PE [redacted]

NHS
Wirral University Teaching Hospital
NHS Foundation Trust

[redacted]
Chief Executive's Office

André Rebello OBE
Senior Coroner Liverpool and Wirral Area

[redacted]

4th November 2021

Dear Mr Rebello

Re: Reg 28 Report (after) HAYUNGA-MACHA U T [redacted]

I am writing in response to the Report to Prevent Future Deaths, referenced above, which was received on 20 September 2021, via email. This report raises concerns relating to why Uyapo Theodore HAYUNGA-MACHA was left alone, whilst awaiting assessment, following attendance at the Emergency Department (ED), at this organisation, on 4 December 2020.

I understand that we had no involvement in the inquest; in view of this I thought it was useful to share the following information with you:

We were made aware of Mr Hayunga-Macha unfortunate death early in March 2021. As we understood, at that time, he had left the emergency department before being assessed, and had not been seen until found deceased, we reported the attendance as a Serious Incident, in line with the NHS Serious Incident Framework. I have enclosed a copy of the Serious Incident investigation report with this letter, for your information. The investigation identified a number of gaps in our care including:

- A failure to commence the Trust's Mental Health Pathway and a failure to undertake a risk assessment to establish if Mr Hayunga-Macha was suitable for sitting in the waiting room.
- A delay in undertaking a triage assessment, in line with national guidance
- A failure in recognising that Mr Hayunga- Macha would be classed as high risk due to his previous history of mental health illness.
- A failure to implement the organisations missing person policy to ensure appropriate notification to our internal security team and the police.

As a result of the investigation an action plan was developed and delivered by the Acute Division within the Trust, the following actions have been either undertaken or are underway:

1. **Ensure the ED Team are aware of the missing patient protocol and when it needs to be used.** The Lead Nurse for the ED has raised awareness with staff, within the department, through a series of discussions at the department's safety huddles. In addition the missing patient policy and documentation has been incorporated into the new staff induction programme. These actions were completed in June 2021.

2. **Further education and training for staff in relation to dealing with Mental Health patients and appropriate use of the Mental Health Unit (MHU).** The Clinical support Workers who provide care and support for patients within the MHU have completed an online Mental Health training session

from "We Can Talk". In addition Cheshire Wirral Partnership is able to provide training to all staff, and this is currently being taken forward by the Lead Nurse within the ED.

3. **Improved communication between ED and security regarding police enquiries.** Discussions have been undertaken to ensure that when the Trust's onsite security are contacted by the Police regarding a Missing person, there is communication with the Emergency Department.

4. **Ensure a standardised handover process to alert initial assessment / triage staff when a patient is placed in the waiting room as "fit to sit" by Ambulance Triage Nurse (ATN).** All patients who arrive under the care of the North West Ambulance Service are now triaged by the ATN. This is a change in practice; previously, if patients were directed to the waiting room on arrival, as considered "fit to sit", they would have been booked in by the administrative team, at the main reception and would have waited to undergo initial triage assessment. The ATN now completes a triage assessment on arrival for all patients, including those presenting with a mental health concern. If this assessment finds the patient able to sit in the waiting room, the rationale for this decision is documented. The ATN is responsible for verbally handing over a patient to the nurse either in charge of initial assessment within the MHU, or the triage nurse if the patient is to be placed within the waiting room.

   The Emergency Department leadership team have arranged for an audit of 50 patients per month to be undertaken to provide ongoing assurance around assessment/observations and triage of patients, who arrive via the ambulance service, the results of which are shared at the Trust's Patient Safety and Quality Board.

   Unfortunately there are times when our MHU is full. A process has been developed to ensure that this is escalated to the Tactical Commander (TC) and the Shift leader, who are then responsible for decisions regarding either stepping someone out of MHU to create space, or where to place patients who are just arriving. Overnight if the TC is not on site, the decision is made by the senior Dr and Shift Leader. This process has been communicated to all staff.

Following the identification of the serious incident, contact was made with Mr Hayunga-Macha's step father to offer our sincere condolences, offer apologies and inform them of the Trust's investigation. Further contact, by letter, was made post the investigation to ascertain if the family wished to receive a copy of the investigation report; however I understand that no response was received at that time. We have recently contacted the family again and have since met with them to discuss the investigation and the actions taken to date.

I would also like to make you aware of a broader piece of work currently underway within the Trust relating to the care of patients with mental health illness. You will be aware of the impact of the current pandemic on the population's mental health and the associated increasing demand for services. In response we have established a Mental Health Transformation Group which is currently being led by the Interim Chief Nurse. This Group has identified the following areas for further focused work:

- Mental Health Strategy including - CQC regulated activity for the provision of care and treatment for patients under the Mental Health Act
- Escalation of patients with Mental Health Conditions
- Mental Capacity Act and Best Interest Training
- Paediatric mental health system and processes
- Mental Health Training (inclusive of de-escalation training)
- Contract monitoring and understanding service need and provision

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The Group membership includes representatives from Cheshire and Wirral Partnership NHS FT and NHS Wirral CCG, in acknowledgement of the need for partnership working. The Group is in the early stages of development however leads for each of the areas above have been identified and work has commenced.

I hope the investigation report and the above points provides you with assurance that we have taken appropriate action to investigates the events leading to Mr Hayunga-Macha, leaving our organisation before being assessed and have reduced the risk of such events reoccurring in the future. However, please do not hesitate to contact [redacted], Legal Services Manager, via [redacted] if you require any additional information.

Yours sincerely

[redacted]
Chief Executive