Regulation 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

1 Cheshire Wirral Partnership
2 Wirral University Teaching Hospital
3 North West Ambulance Service

1 CORONER

I am Andre REBELLO, Senior Coroner for the area of Liverpool and Wirral

2 CORONER'S LEGAL POWERS

I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

3 INVESTIGATION and INQUEST

On 12/04/2021 I commenced an investigation into the death of Uyapo Theodore Hayunga-Macha aged 28. The investigation concluded at the end of the inquest on 20 September 2021. The cause of death found was:

I a Consistent with Immersion/Drowning

I b

I c

II

The conclusion of the inquest was:On 4 December 2020 Uyapo Theodore HAYUNGA-MACHA went missing from Arrowe Park Hospital before he could be seen to be assessed for his mental health. there was no financial activity on his accounts since then. On 9 March 2021 Theo was found having drowned in Morpeth, Dock Birkenhead. It remains unclear as to how he ended up in the water.

4 CIRCUMSTANCES OF THE DEATH

On 4 December 2020 Uyapo Theodore HAYUNGA-MACHA went missing from Arrowe Park Hospital before he could be seen to be assessed for his mental health. there was no financial activity on his accounts since then. On 9 March 2021 Theo was found having drowned in Morpeth, Dock Birkenhead. It remains unclear as to how he ended up in the water.

5 CORONER'S CONCERNS

The MATTERS OF CONCERNS are as follows: (brief summary of matters of concern)
On 3 December 2020 Merseyside Police were called to Theo were it was apparent that he was suffering from poor mental health. An ambulance was called and Theo agreed to be taken to Arrowe Park Hospital. It is reported that whilst waiting for Triage that he left without being seen.

Why was he not being looked after? And why was he left alone when waiting for assessment?

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) 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 by 15 November 2021. 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.

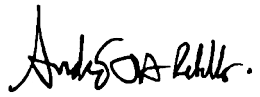
8 COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to Theo's family

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 form. 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



Andre REBELLO
Senior Coroner for
Liverpool and Wirral
Dated: 20 September 2021