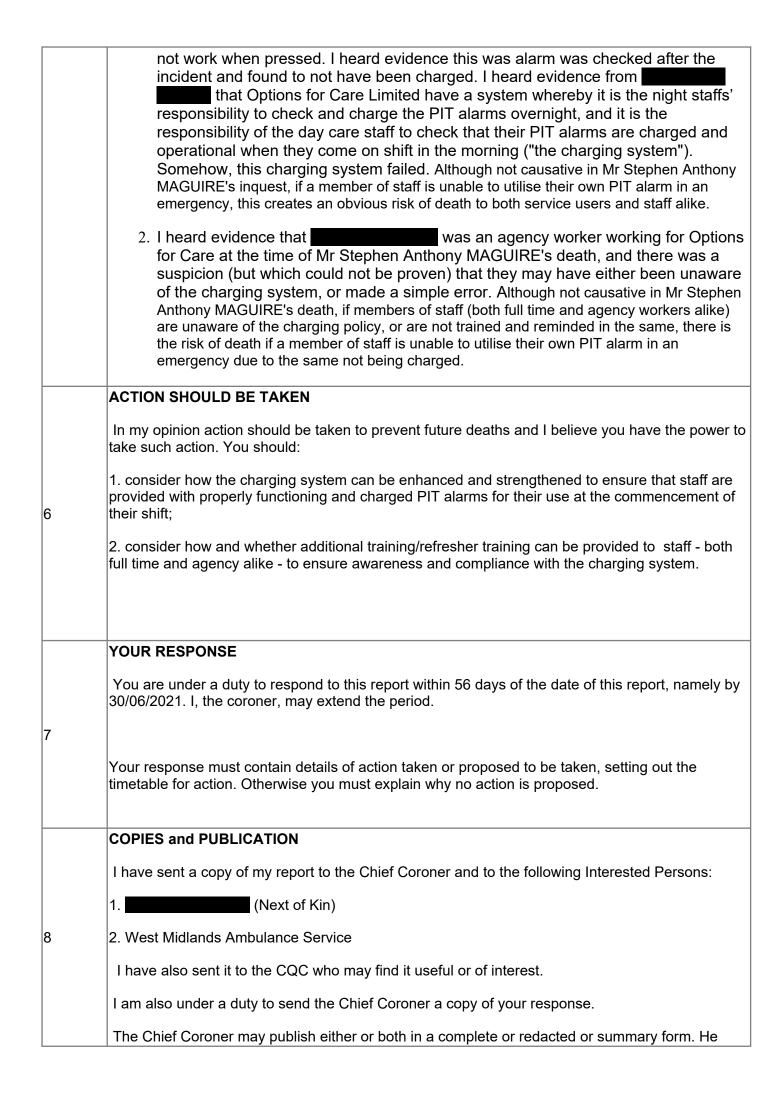
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
	THIS REPORT IS BEING SENT TO: Manager of Options for Care Limited
1	CORONER I am Adam Hodson, Assistant Coroner for Birmingham and Solihull districts.
	CORONER'S LEGAL POWERS
2	I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
	INVESTIGATION and INQUEST
3	On 21 September 2020 I commenced an investigation into the death of Stephen Anthony MAGUIRE. The investigation concluded at the end of the inquest on 27 April 2021 . The conclusion of the inquest was that Mr Stephen Anthony MAGUIRE died due to an accident.
	CIRCUMSTANCES OF THE DEATH
4	Mr Stephen Anthony MAGUIRE was detained at Dartmouth House 70-72 Handsworth Wood Road, Handsworth Road, Birmingham (run by Options for Care Limited) pursuant to s.3 Mental Health Act 1983 for treatment of chronic treatment resistant paranoid schizophrenia. At lunchtime on 14/09/2020, Mr Stephen Anthony MAGUIRE was in the lounge area with other residents where he was seen to be about to start eating his lunch, when he got up from the table, walked a short distance and then collapsed. Staff began CPR whilst an ambulance was summoned, and it was noted his chest was not rising with ventilation. He had a difficult anatomy due to a large tongue and adipose neck, and upon examination using laryngoscope, paramedics reported that his airway presented as a Cormack-Lehane grade 4 view. Multiple and repeated efforts were attempted to troubleshoot and clear his airway in accordance with Joint Royal College Ambulance Liaison Committee Guidelines. A period of roughly 30 minutes passed where he was without oxygen before video laryngoscope revealed a mass of chewed meat at the base of his tongue deep in his larynx. Despite the obstruction being removed with forceps and resuscitation being continued, he was deemed to have sustained an unsurvivable brain injury due to suffering 30 minutes of absolute hypoxia. Treatment was stopped, and he died at 13:40 on 14/09/2020.
	Following a post mortem, the medical cause of death was determined to be:
	1a CHOKING
	1b
	1c
	III
	CORONER'S CONCERNS
5	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. –
	1. I heard evidence that the PIT alarm used by staff member,



9 Signature: Adam Hodson		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	A. He