	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: [REDACTED] - Manager of Options for Care Limited**
1	**CORONER** I am Adam Hodson, Assistant Coroner for Birmingham and Solihull districts.
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 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.
4	**CIRCUMSTANCES OF THE DEATH** 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** **II**
5	**<u>CORONER'S CONCERNS</u>** 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, [REDACTED], did

	not work when pressed. I heard evidence this was alarm was checked after the incident and found to not have been charged. I heard evidence from [redacted] that Options for Care Limited have a system whereby it is the night staffs' responsibility to check and charge the PIT alarms overnight, and it is the responsibility of the day care staff to check that their PIT alarms are charged and operational when they come on shift in the morning ("the charging system"). Somehow, this charging system failed. Although not causative in Mr Stephen Anthony MAGUIRE's inquest, if a member of staff is unable to utilise their own PIT alarm in an emergency, this creates an obvious risk of death to both service users and staff alike. 2. I heard evidence that [redacted] was an agency worker working for Options for Care at the time of Mr Stephen Anthony MAGUIRE's death, and there was a suspicion (but which could not be proven) that they may have either been unaware of the charging system, or made a simple error. Although not causative in Mr Stephen Anthony MAGUIRE's death, if members of staff (both full time and agency workers alike) are unaware of the charging policy, or are not trained and reminded in the same, there is the risk of death if a member of staff is unable to utilise their own PIT alarm in an emergency due to the same not being charged.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action. You should: 1. consider how the charging system can be enhanced and strengthened to ensure that staff are provided with properly functioning and charged PIT alarms for their use at the commencement of their shift; 2. consider how and whether additional training/refresher training can be provided to staff - both full time and agency alike - to ensure awareness and compliance with the charging system.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 30/06/2021. 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 the following Interested Persons: 1. [redacted] (Next of Kin) 2. West Midlands Ambulance Service I have also sent it to the CQC who may find it useful or of interest. 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	**5 May 2021** Signature: **Adam Hodson** **Assistant Coroner for Birmingham and Solihull**