	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1) Birmingham and Solihull Integrated Care Board** **2) The Health and Safety Executive**
1	**CORONER** I am Emma Brown, Area 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 6 September 2024 I commenced an investigation into the death of Neville Daniel Elisha MCKENZIE. The investigation concluded at the end of the inquest. The conclusion of the inquest was that death was due to accidental choking as a consequence of cognitive impairment.
4	**CIRCUMSTANCES OF THE DEATH** **Mr McKenzie died at City Hospital, Birmingham on the 25th August 2024 as a result of the effects of a cardiac arrest caused by an incident of choking on the 13th August 2024 at his care home. Mr McKenzie was recognised to be at risk of choking because his dementia meant he would eat quickly and put too much food in his mouth. Consequently, his care plan was for him to be supervised eating and encouraged to sit and eat slowly. On this occasion he had eaten his lunch under the general supervision of staff and left the dining room without giving any cause for concern. A short time later he was witnessed to be choking by staff who immediately commenced manoeuvres to try and remove the food from his airway but this was unsuccessful and he went into cardiac arrest. He received CPR and was successfully resuscitated by paramedics and transferred to hospital but had suffered an un-survivable brain injury.** Based on information from the Deceased's treating clinicians the medical cause of death was determined to be: **1a Hypoxic brain injury** **1b Cardio respiratory arrest** **1c Choking** **1d** **II Dementia**
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. The inquest heard evidence from [redacted], Director of Operations for 1st Care Limited, the company which owns Acorn Care Home where Mr McKenzie was a resident. [redacted] explained that since Mr McKenzie's death they have purchased a number of anti choking devices and provided training to all staff on the use of them as part of their first aid training. This arose from investigations and research carried out by 1st Care Limited to try and avoid a fatal incident occurring again. Prior to Mr McKenzie's death 1st Care Limited had no knowledge of the availability of these devices. [redacted] explained that there is no legal or regulatory requirement for Care or Nursing Homes to have these devices available. 2. [redacted], who has considerable experience working in health and social care, said she was concerned that there was not wider knowledge of the existence of these devices particularly for homes that have a high volume of residents with choking risks like Acorn Care Home. 3. I heard evidence that the devices are relatively inexpensive and do not require extensive training. 4. [redacted]' evidence was that she felt the devices could save lives in the event of choking incidents and the fact that most homes would not have them, even those with a high risk resident cohort, was creating an avoidable risk of deaths. 5. It was my finding that there is not wide knowledge of the availability of these devices in care settings and if more homes had them it is likely that deaths from choking could be reduced.
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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 21 March 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: [redacted] (daughter of the deceased and Acorn Care Home. I have also sent it to the NHS England and 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	**24 January 2025**

	Signature:  **Emma Brown** **Area Coroner for Birmingham and Solihull**