Her Majesty's Coroner for the
Northern District of Greater London
(Harrow, Brent, Barnet, Haringey and Enfield)

North London Coroners Court,
29 Wood Street,
Barnet EN5 4BE

Telephone 0208 447 7680
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	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Ministerial Correspondence and Public Enquiries Unit Department of Health and Social Care 39 Victoria Street London SW1H 0EU
1	**CORONER** I am Andrew Walker, senior coroner, for the coroner area of Northern District of Greater London
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 the 21st day of October 2019 I opened an investigation touching the death of Simon Anthony Delahunty aged 46 years old. I opened an inquest on the 29th October 2019. The inquest concluded on the 30th January 2020. The conclusion of the inquest was "Suicide contributed to by the circumstances within his life". The medical cause of death was 1a Hypoxic Brain Injury, 1(b) Hypoxic Cardiac Arrest and 1(c) Overdose of Oramorph ,Midazolam, Paracetamol beer and Vodka..
4	**CIRCUMSTANCES OF THE DEATH** On the Second of October 2019 Simon Anthony Delahunty took an overdose of medication prescribed for another patient who had recently died at the address. The medications were part of end of life care that had been left at the the address . It is likely that Mr Delahunty's actions were impulsive as he had made arrangements to stay for some time at this address.
5	**CORONER'S CONCERNS** 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. – There are no arrangements or guidance concerning the collection or disposal of unused end of life prescription medication.

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6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organization] 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 the 19th May 2020 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;- The 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	**24-3-2020**