HM Senior Coroner
for Wiltshire and Swindon

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Chief Executive/Managing Director** **Home Group Limited** **One Strawberry Lane** **Newcastle-upon-Tyne** **Tyne & Wear** **NE1 4BX**
1	**CORONER** I am Ian Singleton, Area Coroner for Wiltshire and Swindon
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 14 December 2023 I commenced an investigation into the death of Christopher John O'Donnell and I opened an Inquest into his death on 30 September 2024. On 18 July 2025 I concluded Christopher's Inquest. I found the medical cause of death was as follows: 1a. Asphyxia due to Airway Obstruction by Vomit 1b. Drug Toxicity By way of a conclusion, I recorded a short form conclusion of drug related and as to when where and how (by what means Christopher came by his death) I provided the following: Christopher John O'Donnell (Chris) lived in supported living accommodation at Canal House, [redacted]. Chris had a past medical history which included drug and alcohol abuse, together with mental health issues, for which he had been prescribed medication. In November 2023, Chris admitted that he had not taken his medication for some months, leading to a noticeable return of his paranoia and persecution complex, resulting in Chris believing wrongly, that it was not safe for him to remain at Canal House., but he had no alternative accommodation to go to. On the 12 December 2023, Chris was found deceased in a communal lounge at Canal House, having consumed a substantial, but not fatal amount of his methadone medication, that he had been allowed access to, notwithstanding the recognised risks, which had led to him vomiting and being asphyxiated by his airway being obstructed by vomit.
4	**CIRCUMSTANCES OF THE DEATH**

	Having considered the evidence, I found the following facts in relation to the circumstances of Chris' death. Chris' death was drug related in that the post-mortem confirmed that he had taken a substantial, but not necessarily fatal amount of his prescribed Methadone that led to his central nervous systems including breathing and heart rate being slowed down. Common side effects are nausea and vomiting with the vomit being aspirated causing obstruction of Chris' airway leading to asphyxia and death. I found that the following factors more than minimally contributed to his decision to take that medication. Firstly, that Christopher had suffered for a number of years with drug and alcohol abuse and with his mental health, for which he had been prescribed medication. Christopher had stated that he had stopped taking the medication leading to a return of paranoia and a persecution complex leading to Chris believing it was not safe for him to live at Canal House, [redacted] but Chris did not have any alternative accommodation to go to on 12 December 2023. Secondly, that Chis had a stockpile of Methadone in his room which he had access to as from 11 December 2023 and consumed one half of, leading to the sequence of events that caused his death, despite the risk of that stockpile, being recognised beforehand. During the course of the Inquest, I heard evidence from [redacted] a Mental Health Support Worker at Canal House that she had had a discussion with [redacted] Christopher's Recovery Co-Ordinator with the local Substance Misuse Team, that Chris had a stockpile of Methadone medication in his room and that she was concerned at the risk that it posed. In evidence [redacted] said that she had spoken to Christopher about agreeing to giving up the medication and returning it to a pharmacy but as he had not consented, that had not happened. She also believed that she had raised it with her manager, but the view was, that as Christopher had not consented to the medication being confiscated there was nothing they could do.
5	**CORONER'S CONCERNS** The issue that I had was that there appeared to be no basis for or consideration of the supported living accommodation provider, taking action to provide safeguarding for Christopher by removing the excess medication so that it was not within his control. I was informed by [redacted] that the supported living accommodation provider did not allow staff to hold any medication even if it was done with the intention of providing safeguarding to someone, who by all accounts, was undergoing a mental health crisis. I would hope that the organisation will review its policies as to what action (if any) it can take when it is made aware of a risk to a resident, rather than to only take action with the resident's consent.

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 Monday 15 September 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 Person, Family of Mr O'Donnell

	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. She may send a copy of this report to any person whom she 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.	Dated 21 July 2025 Signature _____ Ian Singleton HM Area Coroner for Wiltshire & Swindon