Coroner ME Hassell
HM Senior Coroner
Inner North London

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] **Co-Chairs, London Association of Directors of Public Health c/o Haringey Council, 10 Station Road, Wood Green, London, N22 7TR** [redacted] **Chief Medical Officer for England, Office for Health Improvement and Disparities, Department of Health and Social Care, 39 Victoria Street, London SW1H 0EU**
1	**CORONER** I am Sarah Bourke, HM Assistant Coroner for the coroner area of Inner North 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 22 March 2025, Assistant Coroner Lambert commenced an investigation into the death of Eden Dante Henry aged 29 years. The investigation concluded at the end of the inquest on 15 June 2026. The conclusion of the inquest was that the medical cause of death was: 1a acute methamphetamine toxicity

	1b substance misuse disorder I returned the following narrative conclusion. Eden Henry was 29 years old and had a significant history of crystal meth addiction. In Autumn 2024, he underwent a 6-month rehabilitation placement and then moved to local authority hostel accommodation on 13 March 2025. Eden was concerned about relapsing into substance misuse. Communication between the substance misuse service, the rehab and the hostel were not fully documented in the period prior to Eden leaving rehab. Eden was at high risk of relapse, and it is unclear what measures were in place to monitor and support him by substance misuse services. In addition, Eden's substance misuse worker and his hostel keyworker were on leave during the immediate transition period. On 20 March 2025, Eden was noted to have a badly shaved head. Workers at the hostel were concerned about possible relapse. There is no evidence that this was escalated to Eden's substance misuse service or his hostel keyworker that day, which was a missed opportunity to engage with Eden prior to the weekend. Eden's hostel keyworker became aware of his changed appearance at 5 pm on Friday 21 March when he was seen leaving the premises. At 10.30 that night, Eden was observed on CCTV walking around the hostel naked. Eden was told by the concierge to return to his room, or the police would be called. Eden was found barricaded in his room the following morning. He had taken a fatal amount of crystal meth prior to his death.
4	**CIRCUMSTANCES OF THE DEATH** In addition to the circumstances set out in the above narrative conclusion, the evidence established the following. Crystal meth is a highly addictive drug which disproportionally impacts gay men. When high on crystal meth, users can display disinhibited and risky behaviours. Where users relapse following a period of abstinence, crystal meth use can rapidly escalate. Eden's behaviour when intoxicated on crystal meth had caused problems in previous hostels, where he had experienced homophobia from other residents. Eden successfully completed a 6-month rehab placement in a project working on an abstinence only model. The project had a high level of support and regular drug testing. Eden was ready to move to follow on accommodation on completion of the rehab programme, but the project's follow-on accommodation was located away from Eden's support networks. Eden therefore decided to return to Camden where he was housed by the Local Authority under the Adult Pathway. This supports single homeless adults with support needs, including substance misuse. Owing to Eden's past experience in hostels, he was accommodated in a scheme which is normally aimed at

	individuals who are at the end of their recovery journey and aiming to move to independent living within 6 to 9 months. This accommodation was chosen because of its self-contained accommodation and limited shared space with other residents.
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 could 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) Eden had been staying at a highly supportive rehab facility. He was at high risk of relapse on leaving rehab. The move to hostel accommodation with a much lower level of support increased the risk of Eden relapsing into crystal meth use. This was compounded by the absence of both his housing and substance misuse keyworkers at the point that he left rehab and moved into the hostel. 2) The needs and presentation of crystal meth users may not fit easily within mainstream drug treatment and housing services. Historically mainstream services have tended to build services and develop staff training around the presentation and needs of opiate and/or crack cocaine users. The behaviour of individuals whilst under influence of crystal meth can present challenges for services. In addition, as a disproportionate number of crystal meth users are gay men, they may experience homophobia whilst using mainstream services. 3) The provision of substance misuse services and hostel keywork support on a Monday to Friday daytime working model can mean that specialist support is not available at key times. Given crystal meth's associations with the club scene and nighttime economy, users are most vulnerable to relapse and resultant problematic behaviour during the night and at weekends. In Eden's case, signs of potential relapse were noted by hostel staff early on Thursday morning but were not escalated to his hostel keyworker prior to drug services closing for the weekend on Friday evening.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation 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 31 August 2026. 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: Family of Eden Henry Change Grow Live Camden London Borough of Camden Spitalfields Crypt Trust 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 who 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	**SARAH BOURKE** **HM Assistant Coroner** **Inner London North** **6 July 2026**