West London Coroner Service
25 Bagleys Lane, Fulham, London, SW6 2QA
Tel: 0208 753 6800 Email: ealingandhillingdoncoroners@lbhf.gov.uk

Date: 16th August 2021 [redacted]

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: Grassy Meadow Care Centre
CORONER

1 I am **Mrs. Lydia Brown** for **West London**
CORONER'S LEGAL POWERS

I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and
2 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
INVESTIGATION and INQUEST

On 28 January 2021 I commenced an investigation into the death of Kumbulani MTOMBENI. The investigation concluded at the end of the inquest . The conclusion of the inquest was death due to suicide

The cause of death following post mortem examination was
3
1a Methadone Toxicity

1b

1c

II
CIRCUMSTANCES OF THE DEATH

4 Found deceased at his home address [redacted], Hayes, Greater London on 25 January 2021. His actions and final communications indicated he intended to take his own life. He had a very high level of methadone, a drug not prescribed to him.
CORONER'S CONCERNS

5 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. -

In the deceased's possession was a [redacted] of methadone in the name of [redacted]. Evidence was given at inquest that Mr [redacted] was one of your residents until he died last summer. Mr Mtombeni was a member of your staff and at times had worked as a senior carer and had responsibility for and access to the residents prescribed medications.

(1) Can you explain how the methadone was in Mr Mtombeni's possession?

(2) Were any audits performed that demonstrated missing medication and if so, what actions were taken?

(3) What actions will now be taken in the light of the findings at inquest?

ACTION SHOULD BE TAKEN

6 In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.

YOUR RESPONSE

7 You are under a duty to respond to this report within 56 days of the date of this report, namely by 11th October 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.

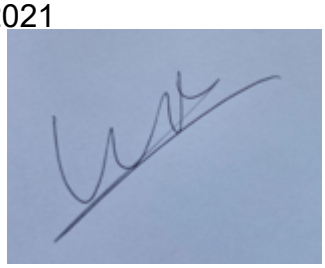
COPIES and PUBLICATION

8 I have sent a copy of my report to the Chief Coroner and to the following Interested Persons [redacted], [redacted], [redacted], [redacted]. 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.

24 June 2021

9 Signature 

Lydia Brown Area Coroner for West London