Ashton Lodge Care Home
95 The Hyde
Colindale
London
NW9 6LE
[redacted]

HM Coroner
Mr Andrew Walker

Date: 16/09/2025

Dear Mr Andrew Walker,

Re: Response to Regulation 28 Report to Prevent Future Deaths

Thank you for the opportunity to respond to the Regulation 28 Report to Prevent Future Deaths, issued following the inquest into the death of Mrs Evelyn Chancellor.
First and foremost, I would like to extend again our sincere condolences to Mrs Chancellor's family. At Ashton Lodge, we are fully committed to learning from all incidents and ensuring the highest possible standards of safety and care for our residents.

1. Resident Supervision at the Time of the Incident

At Ashton Lodge, we are committed to delivering safe, compassionate, and person-centred care, including appropriate supervision in communal areas.
On the day in question, Mrs Chancellor was in the main lounge with five to six other residents. A member of staff was present in the lounge and providing active supervision. The staff member remained in the same room at all times but briefly turned their attention to prepare a drink for another resident; an essential care task carried out while remaining in the same room and maintaining general oversight of the environment. This momentary redirection of focus reflects the normal operational demands of communal care settings, where staff are required to respond to the needs of multiple residents simultaneously.
We would like to respectfully clarify that this was not a case of absent supervision. Rather, it reflects the nature of communal care environments, where staff are often required to meet the simultaneous needs of multiple residents. While we strive to maintain visibility of all residents at all times, it is not operationally or clinically feasible to provide uninterrupted one-to-one supervision for every individual unless a formal risk assessment and funding arrangement (e.g., CHC- Continuing Healthcare) has identified such a need.
At the time of the incident, Mrs Chancellor was not assessed as requiring 1:1 supervision.

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2. Supervision – Clinical and Operational Context

In communal areas where residents have not been assessed as requiring one-to-one supervision, it is considered safe and appropriate for staff to engage in routine tasks such as preparing refreshments, while maintaining general oversight of the environment.
As discussed during the inquest, constant 1:1 supervision for all residents in communal areas is not the standard practice in residential or nursing home settings.
Staffing at Ashton Lodge follows safe practice standards and risk-based frameworks, including maintaining appropriate staff-to-resident ratios. On the day of the incident, the numbers of members of staff was sufficient.

3. Governance and Preventative Measures

At Ashton Lodge, we are fully committed to providing safe, high-quality care through proactive, evidence-based practice. Falls prevention is a key component of this approach, and we have consistently implemented comprehensive measures to assess, manage, and reduce risk for all residents. This includes regular multifactorial risk assessments, personalised care planning, environmental adaptations, and staff training—all aligned with national guidance and regulatory standards.
While the risk of falls can never be entirely eliminated in a frail, elderly population, it can be responsibly managed and mitigated through evidence-based practice, an approach we have consistently taken at Ashton Lodge.
Ashton Lodge operates within a robust governance framework to reduce the risk of falls and ensure timely responses to residents' needs. This includes:

- Comprehensive falls risk assessments on admission and routinely thereafter
- Mandatory staff training on falls prevention and response
- Daily environmental safety checks
- Use of assistive technology as appropriate
- Immediate post-fall reviews and MDT (Multidisciplinary Team) debriefs
- Monthly falls governance meetings to analyse incident trends and adapt protocols accordingly

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Following this incident, we have implemented additional steps to further reduce risks:

- Reinforced staff awareness on maintaining visual oversight during minor tasks (e.g., preparing drinks)
- Adjusted staff routines to enhance monitoring during peak communal area usage
- Reviewed staff deployment to optimise visibility and supervision in shared spaces
- Provide targeted refresher training on falls prevention and shared-space supervision.

4. Medical Cause of Death – Clinical Clarification

We feel, in hindsight, that the hospital could have investigated Mrs Chancellor's head injury more thoroughly before discharging her back to the care home. Following her fall, we noted that she was returned to us without what appeared to be a full investigation of the injury, despite the associated risks given her multiple comorbidities, severe frailty, anticoagulant therapy, and the fact that she was receiving end-of-life care.
The hospital informed the nursing home that Mrs Chancellor was well and discharged her without further investigation or consultation with the family or the care home. The deterioration in her condition was only identified later. Despite stating that surgery was not possible, the hospital did not involve the family or the nursing home in the decision-making process. Furthermore, the nurse in charge was informed that an X-ray would be conducted prior to her first discharge, which did not occur.
We also respectfully note the conclusion in the inquest findings that the death was "caused by a fall in a care home."
While it is undisputed that Mrs Chancellor experienced a fall, *as previously mentioned,* she was a clinically frail individual, with multiple comorbidities, receiving end-of-life care and was on anticoagulant medication. Following her readmission to hospital, a CT scan revealed an intracranial bleed. However, evidence presented during the inquest highlighted that the fall was of very low impact and that Mrs Chancellor appeared clinically well after her initial hospital attendance. It was noted that an individual without her level of frailty and complex comorbidities would likely have survived such a minor fall. Her subsequent deterioration and death were considered to be the result of her overall clinical condition, rather than the fall alone. The intracranial haemorrhage must also be understood within the context of her severe frailty, multiple comorbidities, and anticoagulant therapy.
It was the expert opinion that her death should be viewed as resulting from natural causes, due to a complex interplay of clinical vulnerabilities rather than trauma alone.

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5. Conclusion

We support the intent behind Regulation 28 and are fully committed to continuous improvement. We have taken this case extremely seriously and have acted swiftly to strengthen staff awareness, review risk protocols, and optimise supervision strategies. We are always open to further dialogue or review, and we remain focused on delivering safe, person-centred, and dignified care to all residents at Ashton Lodge.

6. Action Plan in Response to the Regulation 28 Report

In direct response to the concern raised regarding staff supervision in communal areas, Ashton Lodge has developed the following action plan to enhance clinical oversight and minimise the risk of future incidents:

Action	Description	Responsible	Timeframe	Status
1. Install Nurses' Stations in Lounges	Introduce fixed Nurses stations in main communal lounges to enhance clinical presence and oversight. This will allow nurses to carry out administrative or clinical documentation while maintaining continuous visual supervision of residents.	Registered Manager / Operations Manager/ Director	By 30 October 2025	Under Implementation
2. Lounge Supervision Protocol	Develop and implement a formal protocol for staff working in communal areas to ensure visibility is prioritised during all tasks, including brief diversions (e.g.,	Clinical Lead / Clinical Head of Care	Effective from 1 August 2025	Implemented

Action	Description	Responsible	Timeframe	Status
	preparing drinks). Protocol will include "eyes-up" guidance, strategic positioning, and handover awareness.			
3. Enhanced Supervision During Peak Times	Introduce a structured rota to assign an additional staff member to lounges during peak activity times (e.g., after meals, afternoon activities), when distraction risk is higher.	Clinical Lead / Clinical Head of Care	Effective from 1 August 2025	Implemented
4. Staff Training Refresher	Provide targeted refresher training on falls prevention and shared-space supervision. This will emphasise balancing multiple residents' needs while maintaining safe monitoring practices.	Registered Manager/ Clinical Lead / Clinical Head of Care	Effective from 9, 12, 13, 15 of May 2025	Implemented
5. Daily Supervision Briefings	Introduce short daily team briefings, during staff handover to reinforce awareness of high-risk residents and key monitoring expectations in	Clinical Lead / Clinical Head of Care/ Shift Leaders	Effective from 9 of May 2025	Implemented

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Action	Description	Responsible	Timeframe	Status
	communal areas.			
6. Environmental Risk Review	Conduct a full review of communal area layouts to reduce blind spots, improve sightlines, and support supervision strategies.	H&S Lead / Registered Manager/ Clinical Lead/ Clinical Head of Care	By 30 September 2025	Under Implementation

Monitoring and Audit

We will monitor the effectiveness of the above actions through:

- Weekly clinical walkarounds by the management team
- Monthly supervision audits in communal areas
- Monthly falls governance meetings to analyse incident trends and adapt protocols accordingly

This action plan will be reviewed internally every three months and shared with external professionals upon request, to ensure accountability and transparency.

Thank you once again for the opportunity to respond.

Yours sincerely,

[redacted]

[redacted]
Registered Manager
Ashton Lodge Nursing Home