# **REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)**

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
	THIS REPORT IS BEING SENT TO:
	1. Ashton Lodge Care Home
1	CORONER
	I am Mr Andrew Walker, senior coroner for the coroner area of Northern 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 10 <sup>th</sup> October 2024 I commenced an investigation into the death of, Evelyn Chancellor, aged 91. The investigation concluded at the end of the inquest on 3rd Jue 2025. The conclusion of the inquest was Consequences of a fall in a care. The medical cause of death was 1a Intracranial Haemorrhage.
4	CIRCUMSTANCES OF THE DEATH
	On the 4th of October 2025 Evelyn Veronica Chancellor was in a supervised lounge in a care home when, in a moment when the person supervising the lounge turned away to collect some cups, she fell from her chair and struck her head. Mrs Chancellor was taken to hospital where a decision to arrange a CT scan was considered and decided against and Mrs Chancellor was discharged back to the care home.  Mrs Chancellor started so show symptoms of serious head injury and was returned to hospital where she died from the consequences of the head injury the next day.

# 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. -

There should be sufficient staff present to ensure the safety of the residents when staff members are engaged in activities that may distract them from their view of the residents.

#### 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 Friday 19th 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 Persons:

Family Members.

I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it.

I may also send a copy of your response to any other person who I believe may find it useful or of interest.

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.

9 **DATE: 25<sup>th</sup> July 2025**