	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1. [redacted] Medical Director Queen Elizabeth Hospital (QEH) Queen Elizabeth Hospital, Stadium Road, London SE18 4QH
1	CORONER I am Andrew Harris, Senior Coroner, London Inner South jurisdiction
2	CORONER'S LEGAL POWERS I make this report under paragraph 7, Schedule 5, Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	INQUEST I opened an inquest into the death of Mr Adrian Ashford, who died on 15th December 2018 in Queen Elizabeth Hospital, Woolwich (03452-18 JB). An inquest was opened on 7th June 2019 and was concluded on 7th January 2020. The medical cause of death was: 1a Upper gastro-intestinal bleeding 1b Chronic Peptic Ulcer. The conclusion was Natural Causes.
4	CIRCUMSTANCES OF THE DEATH Mr Ashford suffered from psychotic depression with associated anorexia, weight loss and constipation, about which he was fixated. This was sufficiently severe to have a colonoscopy which was normal and to require admission to a mental health ward. On 11th December he was transferred to A&E with concern about the risk of a GI bleed. He was transferred back as he was stable, without referral to a gastroenterologist. He was admitted to a medical ward the following day, but the risk of bleeding on initial assessment that day was not communicated to the consultant reviewing him on 12th. He was rehydrated and his further drop in haemoglobin ascribed to dilution. His circulation was restored with fluids the following day when the haemoglobin and blood pressure further dropped. He died after a massive GI bleed at 15.52 on 15th, from which he could not be resuscitated. Even if the diagnosis of his asymptomatic chronic peptic ulcer had been made by endoscopy before death, it cannot be concluded it would have enabled his life to be saved.
5	MATTERS OF CONCERN The family have made a submission listing eleven concerns, which they say trigger my Regulation 28 duty. These have been carefully considered. Three general remarks are needed; Firstly, individual matters of clinical misjudgment, still less

	retrospective missed opportunities do not in themselves trigger my statutory duty. Secondly that Mr Ashford's death and the hearing of this inquest has raised awareness of risks and led to professionals reviewing their clinical practice. Thirdly service developments have addressed some risks such as the urgent cancer referral process and the unified connect care system, linking health care across organizations, which is being implemented. The court has received submissions from QEH, that a PFD report is not required.. CORONER'S MATTERS OF CONCERN are as follows. – 1. [redacted] GP and [redacted] Divisional Medical Director, both gave evidence of the value of having some system for regular weighing, and that it might save lives. This would enable reported weight loss to be verified and quantified and highlight triggers for investigation in a timely manner. But there appears to be no systematic process of recording weights. 2. The consultant in acute medicine, who was on call when Mr Ashford was admitted to A&E on 12th December 2018 by psychiatrists, concerned about the risk of GI bleeding, diagnosed constipation and returned him to a psychiatric bed. It appears he failed to identify the risks of GI bleed identified in A&E on 11th, nor the reasons for concern for urgent transfer (dehydration and drop in haemoglobin from 126 to 102g/l). On 14th he also failed to consider referral to a gastro-enterologist, after his blood pressure fell to 83/59 with a tachycardia of 112. He told the court "he was not thinking GI bleed". Asked about learning from this death, he said that there was no change in his practice, other than increased awareness.
6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths. I believe that the NHS Trust medical director would wish to learn of the evidence given in the inquest about the circumstances of this death and are in a position to mitigate or prevent future deaths and consider: a) Whether there is benefit is a systematic process of recording patients' weights b) Whether the consultant involved in this case would benefit from reporting this case to whoever conducts his appraisals, to consider if he would benefit from further support or professional development.
7	YOUR RESPONSE You are under a duty to respond to this report within 56 days of the date of this report, namely by 2nd April 2020. I, the coroner, may extend the period.

	If you require any further information or assistance about the case, please contact the case officer, Ms [redacted] and [redacted]
8	COPIES and PUBLICATION I have sent a copy of my report to the following Interested Persons: [redacted] sister Oxleas Mental Health Trust [redacted] Valentine Health 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.
9	[DATE] [SIGNED BY CORONER] 7th February 2020 **Andrew Harris, Senior Coroner**