

H M Senior Coroner for Gloucestershire Ms Katy Skerrett

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
	 THIS REPORT IS BEING SENT TO: 1. Ms Lee, Chief Executive of Gloucestershire Hospitals NHS Foundation Trust, Trust Headquarters, Alexandra House, Cheltenham General Hospital, Sandford Road, Cheltenham, Gloucestershire GL53 7AN
1	CORONER
	I am Katy Skerrett, Senior Coroner for Gloucestershire.
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 13 th November 2017 I commenced an investigation into the death of Andrea Franzosi. The investigation concluded at the end of the inquest on the 24 th October 2018. The conclusion of the inquest was a narrative conclusion. The medical cause of death was 1A Cardiac failure, 1B Necrotising Aortic Valve Endocarditis, 2 Chronic Obstructive Pulmonary Disease and Emphysema
4	CIRCUMSTANCES OF THE DEATH Mr Franzosi, was a 52 year old man who presented to the Emergency Department at hospital on the 8 th November 2017 with "flu-like" symptoms which he reported experiencing for two weeks. He had also suffered three episodes of central chest pain which was associated with shortness of breath. Mr Franzosi was diagnosed with pneumonia and discharged home on oral antibiotics. He was not admitted for further investigations. As a result his endocarditis was not diagnosed, and he did not receive treatment for this condition. This amounted to neglect which contributed to the cause of death. At approximately 11.21 hours on the 9 th November 2017 Mr Franzosi collapsed whilst out with a friend. Emergency services attended and despite extensive resuscitation efforts, Mr Franzosi was pronounced deceased at 13.55 hours.
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 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 – (1) The level of supervision of junior Doctors on the ward. In particular, when a patient is discharged without being examined by a more senior practitioner.
6	ACTION SHOULD BE TAKEN
	In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.

YOUR RESPONSE You are under a duty to respond to this report within 56 days of the date of this report, namely by 4pm 20th December 2018. 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 (1) Family Franzosi. (2) NHS England South, Sanger House, 5220 Valiant Court, Gloucester Business Park, Gloucester, GL3 4FE 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 Dated 25th October 2018 Signature Ms K Skerrett Senior Coroner for Gloucestershire