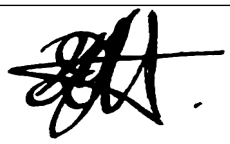
Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 [redacted], Secretary of State for Health and Social Care**
1	**CORONER** I am Darren STEWART OBE, HM Area Coroner for the coroner area of Suffolk
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 03 January 2023 I commenced an investigation into the death of Charlotte Louise ALDERSON aged 34. The investigation concluded at the end of the inquest on 02 May 2025 which I heard with a Jury. The conclusion of the Inquest Jury was that: Narrative Conclusion - Mrs Alderson reported feeling unwell from 17th December 2022. She attended the GP Surgery on 19th December 2022. Observations were taken which were considered to be within normal range. Centor score of 2 was generated which indicated no anti-biotics were required at this time. An outer ear infection was diagnosed and a prescription was given for a topical anti-biotic spray. Redness of the throat was observed and a throat swab was taken to be sent for analysis. It was recorded she was taking over-the-counter pain relief. It was advised she should return to the surgery if her symptoms worsened. Mrs Alderson reported feeling better on 20th December 2022 but then felt worse that evening. She then suffered bouts of sickness and diarrhoea throughout the night. On 21st December 2022 at 7am, Mrs Alderson reported this to her husband and went to bed. At 11am on the same day, her husband checked on her and upon observing a blue tinge to her lips, called 111. The 111 call handler triaged the symptoms using a computer-based system. Upon reporting a blue tinge to Mrs Alderson's lips in module 0, a category 2 ambulance response was triggered. The 111 call handler manually called 999 as the system did not automatically dispatch an ambulance. Mrs Alderson's condition worsened, and her husband made an additional call to 999. He was advised the ambulance was en route. The ambulance arrived at 11:57am and a Senior Emergency Medical Technician (EMT) made a clinical assessment of Mrs Alderson, including multiple observations. The Senior EMT did not observe blue-tinged lips. Observations were generally within normal range, other than a slightly elevated temperature and heart rate. At the scene, the Senior EMT called Mrs Alderson's GP surgery and discussed symptoms and observations with the duty doctor. This was standard practice at the time. With no requirement identified for immediate hospitalisation, the ambulance left at 13:15.

	Mrs Alderson's conditioned worsened further and her husband left to purchase pain relief. Upon his return, he found Mrs Alderson in a state of collapse. She was unconscious but breathing. He called 999 immediately (14:09). During this call, Mrs Alderson stopped breathing. Bystander CPR commenced and an ambulance was dispatched at 14:15. En route to the scene, further backup was requested due to the report that Mrs Alderson had stopped breathing. The ambulance arrived at 14:26 and the ambulance crew took control of resuscitation attempts. Leading Operations Manager Team arrived at 14:37, followed by the critical care team (HEMS) a minute later, who employed multiple methods of resuscitation. Resuscitation attempts were ceased at 15:29 and Record of Life Extinct was completed at 15:54. The post-mortem examination carried out on 30th December 2022 found that the cause of death was as a result of multi-organ failure due to septic shock, arising from the rapid progression of a bacterial infection into the bloodstream. This infection was identified as beta haemolytic streptococcus infection, the presence of which was confirmed by the results of the swab previously taken for testing on 19th of December 2022. The toxicology report was unremarkable. It is therefore concluded that Charlotte Louise Alderson died of natural causes. The jury would like to express their sincere personal condolences to the family. The medical cause of death was confirmed as: 1a Multi Organ Failure 1b Septic Shock 1c Beta Haemolytic Streptococcus Infection
4	**CIRCUMSTANCES OF THE DEATH** See Above Narrative
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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: (brief summary of matters of concern) **I have concerns in three areas which are as follows:** **a. There are two scoring systems used by clinicians to assess infection in patients presenting to them, namely; CENTOR and FEVERPAIN. Either may be used by clinicians. Both systems use similar parameters to diagnose and indicate treatment. However, in their application to a given set of circumstances they can produce different outcomes, specifically in relation to the prescription of antibiotics. It is possible in Mrs ALDERSON's case that the use of the FEVERPAIN scoring system (as opposed to CENTOR) may have made a difference by indicating a prescription for antibiotics, which if taken on the day she was assessed by her**

	GP, may have resulted in a different outcome. There is a need to review these scoring systems, drawing upon the most effective elements of each, with a view to providing guidance on a single scoring system that can consistently be applied by clinicians. **b. Evidence received during the Inquest indicated that a number of existing measures within the National Health Service are capable of modification to provide testing tools for the early identification of sepsis/risk of sepsis and which would better inform decisions to prescribe antibiotics. These include CRP, finger prick and lateral flow tests. The risks associated with sepsis and the speed with which a rapid deterioration can occur in patients without clear warning signs of sepsis being present, are well known. There is therefore a need for the expeditious development of measures which assist clinicians in the early identification and treatment of sepsis.** **c. During the course of the evidence presented at this Inquest, the Court heard that the Interoperability toolkit (ITK) used to handover information between 111 and 999 services will on occasions fail, requiring the manual backup of a telephone call. This was identified as a national issue which, although not frequent, when it occurs carries a significant risk of critical information not being passed due to human error. I am concerned that in such circumstances the manual backup is not adequate and there is a risk that significant information is not passed thereby increasing a risk to life.**
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or 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 August 13th, 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: **The Family of Charlotte ALDERSON** **[redacted], The Market Cross Surgery, Mildenhall** **[redacted], The Market Cross Surgery, Mildenhall** **East of England Ambulance Service NHS Trust** **NHS 111 (Practice Plus Group)** I have also sent it to: **The Royal College of General Practitioners** 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.
9	**Dated: 18/06/2025**

	 **Darren STEWART OBE** **HM Area Coroner for** **Suffolk**