



Regulation 28: REPORT TO PREVENT FUTURE DEATHS

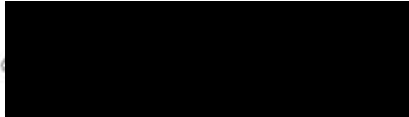
NOTE: This form is to be used **after** an inquest.

	<p>REGULATION 28 REPORT TO PREVENT DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <p>1 NHS ENGLAND</p>
1	<p>CORONER</p> <p>I am Sophie LOMAS, Assistant Coroner for the coroner area of Northamptonshire</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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.</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On 22 November 2024 I commenced an investigation into the death of Luke John ABRAHAMS aged 20. The investigation concluded at the end of the inquest on 23 January 2026. The conclusion of the inquest was a narrative conclusion:</p> <p>Luke Abrahams died due to a rare condition called Lemierre syndrome which presented as a sore throat and, over the course of a week, progressed to a septic emboli which travelled through his blood stream to his soft tissue and muscles and developed into necrotising fasciitis. At the point of diagnosis he was in septic shock. He underwent emergency surgical debridement and limb amputation which was necessary surgery but placed further pressure on an already overwhelmed system and further tested his physical reserves. He died following a cardiac arrest due to septic shock.</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>On 15th January 2023 Luke Abrahams developed a sore throat. He was diagnosed with tonsillitis and was prescribed antibiotics. He remained unwell and spent time in bed resting. On 18th January 2023 Luke reported pain in his leg which became progressively worse. He had an out of hours GP consultation in the early hours of 20th January 2023 where he was diagnosed with sciatica and was prescribed pain relief. Later the same day paramedics attended Luke's home address. At this point Luke had a high pain score and an abnormal blood sugar reading. The paramedics helped him to mobilise and decided to discharge him at home rather than convey him to hospital. Luke remained at home and on 22nd January 2023 the ambulance service was contacted again as his condition had further deteriorated. He was taken to hospital where tests showed that he had an infection and a CT scan raised a suspicion that he had necrotising fasciitis. Whilst in hospital he continued to deteriorate and was showing signs of septic shock. In the early hours of 23rd January Luke underwent emergency surgical debridement. During surgery the necrotising fasciitis was confirmed and was found to be extensive; it was deemed necessary for Luke's lower leg to be amputated. Post-surgery Luke was transferred to critical care where, despite treatment, he remained unstable and critically unwell. Due to septic shock he had a cardiac arrest and despite extensive resuscitation efforts he could not be revived. He sadly died on 23d January 2023 at Northampton General Hospital.</p> <p>A post-mortem examination determined that Luke had died due to sepsis from necrotising fasciitis which had been caused by a rare condition known as Lemierre syndrome. This syndrome had caused a clot of infection to enter his blood stream and settle in the soft tissue of his psoas muscle where it had developed into necrotising fasciitis. At the point</p>



	<p>when Luke experienced leg pain the clot had settled and the infective process had then developed over the following days leading to sepsis. The court heard evidence that Lemierre syndrome is a rare complication of a bacteria commonly found in the throat and that for this to settle in the soft-tissue is extremely rare. The court further heard that necrotising fasciitis is difficult to diagnose, particularly in the earlier stages of the infective process and that it carries a high mortality rate. The treatment for the condition is urgent surgical debridement but surgery places additional physiological pressure on the body. The surgery in Luke's case was necessary as the only chance to potentially save Luke but this likely tested his physical reserves further.</p>
<p>5</p>	<p>CORONER'S CONCERNS</p> <p>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.</p> <p>The MATTERS OF CONCERN are as follows: (brief summary of matters of concern)</p> <p>During the inquest the court heard evidence regarding the difficulties in diagnosing necrotising fasciitis by medical practitioners and a general lack of awareness amongst the public about the condition and how it can present. The court was directed to the NHS website which sets out that "Necrotising fasciitis...can happen if a wound get infected". The symptoms listed all relate to a cut or wound. In Luke's case there was no wound and the website entry does not make it clear that the condition can present as intense / disproportionate pain without any noticeable skin changes or wound. This gives rise to a concern as the website is frequently used by member of the public and is often shared by healthcare professionals when providing advice to patients.</p>
<p>6</p>	<p>ACTION SHOULD BE TAKEN</p> <p>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.</p>
<p>7</p>	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by April 05, 2026. I, the coroner, may extend the period.</p> <p>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.</p>
<p>8</p>	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons</p> <p>The family of Luke Abrahams East Midlands Ambulance Service Northampton General Hospital DHU 111</p> <p>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.</p> <p>I may also send a copy of your response to any person who I believe may find it useful or of interest.</p> <p>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</p>



	<p>interest.</p> <p>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.</p>
9	<p>Dated: 08/02/2026</p> <p></p> <p>Sophie LOMAS Assistant Coroner for Northamptonshire</p>