

[REDACTED]
Chief Executive
Stockport NHS Trust
Poplar Grove
Stockport
Cheshire
SK2 7JE

[REDACTED]
15 October 2025

Private and Confidential

Mr. B Myers,
HM Assistant Coroner,
1 Mount Tabor Street,
Stockport,
Greater Manchester,
SK1 3AG

Re: [REDACTED] Inquest into the death of Mr Kenneth Edwards

Inquest date: 01 August 2025

Dear Mr Myers,

I am writing to you further to the conclusion of the inquest into the death of Mr Kenneth Edwards on 01 August 2025, and in response to your request for assurance regarding the circumstances surrounding his care, specifically in relation to radiological reporting, anticoagulation, and governance processes.

We would like to begin by expressing our sincere condolences to Mr Edwards's family. We recognise the distress caused by the events leading to his death and are committed to learning from this case to improve patient safety and care.

- **A subdural haematoma was not identified in the report on the first CT scan 18:51 hours on 22nd March 2025, reported at 19:30 hours.**

Mr Kenneth Edwards underwent a CT brain scan at 18:51 hours on 22 March 2025 ('scan #1') following an out-of-hospital fall. As this imaging was conducted outside routine hours, it was reported at 19:30 by Medica, the Trust's contracted out-of-hours radiology service.

The report on scan #1 was: *"Negative for intracranial haemorrhage. Age-related involutional changes as described."*

A further scan was performed the following day i.e., 23 March 2025 ('scan #2') at 12:28. This was reported as showing an acute shallow extra-axial collection overlying the right cerebral convexity with a maximum depth of approximately 4.5 mm. No significant associated mass-effect. Possibly some subarachnoid blood overlying the right posterior temporal lobe. Post-traumatic soft tissue swelling/haematoma overlying the right parietal bone.

A further scan was performed on 23 March 2025 ('scan #3') at 17:42. This showed a significant increase in size of the right frontoparietal and temporal subdural bleed causing

effacement of the lateral ventricles and midline shift. Urgent neurosurgical review was advised.

Following Mr Edwards's death, a rapid review was conducted by the Trust's medicine team. A radiology review was undertaken of the CT scans by one of our in-house radiologists (Dr [REDACTED]) who identified that the report regarding scan #1 noted a right occipital scalp haematoma but did not identify a thin right-sided subdural haematoma, which was present on the scan. No skull fracture was reported. This review was, of course, undertaken with the added benefit of hindsight.

Medica were invited to comment on the discrepancy following Dr [REDACTED] review and concluded that the subdural haematoma was not appreciable on the initial scan and therefore did not amend their report. As Medica retains responsibility for their reports, any further concerns regarding content or conclusions are appropriately directed to them via the Trust's legal team.

This finding was subsequently reviewed at our REALM (Radiology Education and Learning Meeting) in August 2025, where radiological discrepancies are anonymously reviewed alongside examples of excellence. This engages the radiologist cohort to discuss and create learning points from difficult cases.

The consensus was that this was a difficult case as the subdural haematoma on initial CT is small and subtle and a number of colleagues would not have appreciated this. Several consultant radiologists confirmed that they would not have identified the subdural haematoma at the time of the initial report.

Medica were invited to comment on the discrepancy following Dr [REDACTED] review and concluded that the haematoma was not appreciable on the initial scan and therefore did not amend their report. As Medica retains responsibility for their reports, any further concerns regarding content or conclusions are appropriately directed to them via the Trust's legal team.

- **Evidence was given that this was not the first time that detail had been missed on a scan reported upon by Medica.**

We acknowledge that during the inquest, reference was made to previous occasions where details may have been missed in scans reported by Medica. While we are unable to retract this statement, we recognise that it may have reflected a subjective observation rather than a comprehensive or representative assessment of the reporting standards and governance processes currently in place.

Stockport NHS Foundation Trust maintains a longstanding contractual relationship with Medica for out-of-hours radiology reporting, governed by a Service Level Agreement that includes defined Key Performance Indicators. Medica undertakes regular audits of its reporting output and contributes to shared learning through participation in governance meetings, including REALM (Radiology Education and Learning Meetings).

Any concerns or discrepancies identified in Medica reports are formally escalated via the Insight portal, with responses incorporated into the Trust's incident management system (Datix). This process ensures transparency, accountability, and continuous quality

improvement. At present, there are no outstanding concerns regarding the quality of Medica's reporting service, and their overall accuracy remains within acceptable thresholds consistent with national standards and patient safety expectations.

At Stockport it should be noted that it is already normal practice that a clinician will review scans with a radiologist with subspecialist interest when the clinical picture does not match the CT findings. This allows for review with any additional clinical information that may change or refine the opinion of the scan report.

- **The administration of blood-thinning medication whilst awaiting the results of the second CT scan of the head to identify bleeding should not have happened. Whilst the treating clinician/s could not have known about the bleed that had not been identified on the first scan, they should have known that such medications were contra-indicated where the results of the second scan to identify brain bleeding were awaited.**

The initial CT brain scan, performed at 18:51 on 22nd March 2025 and reported at 19:30 did not identify a thin right sided subdural haematoma. Blood thinning medication was prescribed at 08:53 hours on 23rd March 2025, appropriately given negative for intracranial haemorrhage on the radiology report.

Shortly after this was prescribed, Mr Edwards had a fall in the Emergency Department, at 09:00 hours. He had a medical review and a CT head and neck scan was requested. Mr Edwards had the CT scan at 11:19 hours.

The enoxaparin and clopidogrel were administered to Mr Edwards at 12:23 hours, when he had returned from CT scan. The result of the CT head scan was reported at 12:28 hours which showed an increase in the right subdural haematoma.

Although the initial scan did not report the subdural haematoma, which was attributable to the initial fall, the Trust acknowledges that greater clinical caution should have been exercised in the administration of anticoagulant therapy while awaiting further neuroimaging. In Mr Edwards's case, there was a missed opportunity at the point of the medical review post fall to cease the prescription for enoxaparin and clopidogrel, and a missed opportunity by the nurse to hold administration of the medication until the CT head and neck scan had been reported and reviewed. The inherent risks associated with anticoagulation in the context of potential intracranial injury are well recognised, and clinical judgement must be carefully applied in such scenarios.

This aspect of care has been subject to internal review and will be addressed through targeted education and training for emergency department and acute care staff. Specific emphasis will be placed on risk stratification, clinical vigilance, and the importance of deferring anticoagulation when intracranial pathology remains a possibility pending imaging confirmation.

We hope the information provided above offers assurance that Stockport NHS Foundation Trust has taken the findings of the inquest into Mr Kenneth Edwards's care extremely seriously. We are committed to learning from this case and have implemented the following measures to strengthen our processes:

- Reinforced standards for consent, handover, and clinical documentation across all patient-facing teams.
- Continued close collaboration with Medica to support shared learning and ensure their participation in relevant governance meetings.
- Ongoing engagement in REALM (Radiology Education and Learning Meetings) to review complex cases and promote diagnostic excellence.
- Maintenance of a robust incident review and escalation framework for radiology discrepancies, including those involving external providers.

We remain dedicated to continuous improvement in patient safety and care quality. Should you require any further information, please do not hesitate to contact me.

Yours sincerely,



Chief Executive

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