

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <p>1. Chief Executive Stockport NHS Foundation Trust</p>
1	<p>CORONER</p> <p>I am Benjamin Myers KC, Assistant Coroner for the coroner area of Greater Manchester South</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 the 16th April 2025, an inquest was opened concerning the death of Kenneth Edwards, aged 85 years at the time of death. The inquest concluded on the 1st August 2025.</p> <p>The medical cause of death was: 1a) Acute Traumatic Subdural and Subarachnoid Haemorrhage</p> <p>The conclusion of the inquest was as follows [narrative]: Kenneth Edwards died as a consequence of bleeding to the brain caused by two falls, which was contributed to by blood-thinning medication administered to him whilst in hospital.</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>On the 22nd March 2025, Kenneth Edwards fell whilst walking in the street. He was taken to Stepping Hill Hospital where at 18:51 hours he underwent a CT scan. The CT scan was reported as showing no intracranial haemorrhage. On the morning of the 23rd March 2025, Kenneth Edwards fell again whilst at the hospital. At 11:30 hours he underwent a second CT scan of his head to assess whether this second fall had caused bleeding. At 12:23 hours, whilst awaiting the results of that scan, he was administered medication including the blood thinning medications clopidogrel and enoxaparin. The administration of these medications whilst awaiting the results of a CT scan to rule out brain bleeding is not best practice; they are contra-indicated in such circumstances. The scan results were read at 12:28 hours: the scan indicated a subdural haemorrhage and a subarachnoid haemorrhage. Kenneth Edwards died on the 23rd March 2025.</p> <p>The rapid review conducted after the death of Kenneth Edwards included amongst its findings a review of the first CT scan. On that review it was found that there was a thin subdural haematoma that had not been reported.</p>
5	<p><u>CORONER'S CONCERNS</u></p> <p>During the course of the inquest the evidence 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:</p> <p>1. 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). The inquest heard that since this scan took place out of hours [i.e. between 17:00 and 09:00] hours it was dealt</p>

	<p>with by an out of hours service provided by a company called Medica. The rapid review which identified the haematoma after Kenneth Edwards's death was conducted by one of the hospital's own radiologists. Had the haematoma properly been identified at the time the first scan was reported, appropriate steps could have been taken to deal with it at a relatively early stage. Furthermore, this would have identified circumstances at an early stage of Kenneth Edwards's treatment that militated against the administration of blood-thinning medication.</p> <p>2. Evidence was given that this was not the first time that detail had been missed on a scan reported upon by Medica.</p> <p>3. 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.</p>
6	<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 organization] have the power to take such action.</p>
7	<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 2nd October 2025. 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>
8	<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>1. Son of Kenneth Edwards, on behalf of the family.</p> <p>I have also sent it to:</p> <p>2. The Department of Health and Social Care 3. NHS England 4. Northern Care Alliance</p> <p>who may find it useful or of interest.</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 other 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 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.</p>
9	<p>7th August 2025</p>

A handwritten signature in black ink, appearing to read "Benjamin Myers". The signature is written in a cursive style with a horizontal line underneath.

**Benjamin Myers KC
HM Assistant Coroner
Greater Manchester South**