REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Greater Manchester Integrated Care
1	CORONER I am Alison Mutch, senior coroner, for the coroner area of Manchester South
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 I commenced an investigation into the death of Margaret Crooks. The investigation concluded at the end of the inquest on 10th November 2025. The conclusion of the inquest was narrative: **Died of the complications of medical treatment. The medical cause of death was 1a) Intracerebral haemorrhage 1b) Intravenous thrombolysis.**
4	CIRCUMSTANCES OF THE DEATH Margaret Crooks attended Stepping Hill Hospital and was diagnosed as having a stroke. She was given intravenous thrombolysis as she met the criteria to be offered it. She subsequently developed complications from the thrombolysis. A CT scan reported at 00:28 confirmed a large bleed caused by the thrombolysis medication. Advice was sought from Salford Royal Hospital as the out of hours support is to be provided by that trust after11:30pm in accordance with the Greater Manchester protocol. The doctors at Stepping Hill Hospital were not advised to give medication to try and prevent further bleeding. They should have been. She was transferred to Salford Royal Hospital where the treatment was given. However, she continued to deteriorate and died at Salford Royal Hospital on 20th February 2025.

5	<u>CORONER'S CONCERNS</u> 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. The MATTERS OF CONCERN are as follows. – The Inquest was told that Greater Manchester has a stroke network. In essence there are 3 hospitals that are stroke centres, and that Stepping Hill is one of them. However, under the system overnight (after 11.30pm) Salford Royal provides all expert stroke input into the other 2 centres. This is because the assessment of need has identified that the presence of stroke provision overnight at the other 2 centres is not justified by the demand. During the course of the inquest there appeared to be some confusion amongst some of the stroke clinicians who support the work as to the level of support that was to be provided by Salford Royal overnight to Stepping Hill. This creates a risk that expert and complex advice is not given as quickly as necessary. The evidence was that many of the decisions in relation to how to deal with complications arising from thrombolysis in a stroke patient need to be made by a stroke consultant and are time critical. In Mrs Crooks case the evidence of the stroke team was that they would have expected the overnight team based at Salford to have advised the Stepping Hill medical team to start giving treatment before the transfer to Salford Royal. The advice whilst Mrs Crooks was at Stepping Hill appears to have been given by the stroke Registrar at Salford rather than with input from the stroke consultant. In Mrs Cooks' case it could not be confirmed that the outcome would have been different if she had received earlier treatment or there had been input earlier from a stroke consultant but in other cases a delay could change the outcome.
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 **9th January 2026**. 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 namely the family of Mrs Crooks, Stepping Hill Hospital and Salford Royal Hospital 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. They may send a copy of this report to any person who they believe 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	**Alison Mutch OBE** **Senior Coroner** [redacted] **14/11/2025**