REPORT TO PREVENT FUTURE DEATHS
REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's PFD Publication Policy (2026).

CORONER

I am Alison Mutch, Senior Coroner, for the coroner area of Greater Manchester (South).

DATE OF REPORT

4th August 2026

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.

THIS REPORT IS BEING SENT TO:

1) Chief Executive of The Football Association
2) Secretary of State for Education

You are under a duty to respond to this report within 56 days of the date of this report, namely by **29th September 2026**. I, the coroner, may extend the period if an appropriate application is made.

YOUR RESPONSE

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.

I have a duty to send a copy of your response to the Chief Coroner.

In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision.

Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online.

The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.

SUMMARY OF CORONER'S CONCERN

See below

ACTION SHOULD BE TAKEN

In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.

INVESTIGATION AND INQUEST

On 31st January 2024, I commenced an investigation into the death of Norbert Stiles, date of birth 18/5/42.

The medical cause of death was:

1a) Alzheimer's Disease
II) High Stage Chronic Traumatic Encephalopathy (CTE), Stage 3 Limbic-predominant Age-related TDP-43 Encephalopathy (LATE) and Small Vessel Cerebrovascular Disease.

Norbert Peter Stiles was a professional footballer who during the course of his career was required to repeatedly head the ball both in training and in games. On 30th October 2020 he died at Manorhey Care Centre. His health had significantly deteriorated in the years prior to his death. He had become immobile and bed bound prior to his death due to his profound neurological disability. Examination of his brain following his death confirmed an in life diagnosis of Alzheimer's disease. In addition, he was found to have high stage chronic traumatic encephalopathy (CTE), stage 3 Limbic-predominant age related TPD-43 encephalopathy (LATE) and small vessel cerebrovascular disease. All of which contributed to his death. The CTE was caused by the requirement to repeatedly head a football throughout his time playing football.

Conclusion
Died from natural causes in combination with chronic traumatic encephalopathy which was caused by repeated heading of the ball during his football career.

CIRCUMSTANCES OF DEATH

Norbert Peter Stiles was a professional footballer who during the course of his career was required to repeatedly head the ball both in training and in games. On 30th October 2020 he died at Manorhey Care Centre. His health had significantly deteriorated in the years prior to his death. He had become immobile and bed bound prior to his death due to his profound neurological disability. Examination of his brain following his death confirmed an in-life diagnosis of Alzheimer's disease. In addition, he was found to have high stage chronic traumatic encephalopathy (CTE), stage 3 Limbic-predominant age related TPD-43 encephalopathy (LATE) and small vessel cerebrovascular disease. All of which contributed to his death. The CTE was caused by the requirement to repeatedly head a football throughout his time playing football.

CORONER'S CONCERNS

During the course of the inquest I heard evidence 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 heard evidence that repeated heading of the football caused CTE in Mr Stiles. The evidence was that anyone who repeatedly headed a football was at risk of developing CTE as a consequence. The evidence given was that footballers whether amateur or professional adults and children are still repeatedly heading footballs in training and in matches creating a risk of them developing CTE in the future.

COPIES AND PUBLICATION OF THIS REPORT

I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it.

I also may send a copy of the report to any other person who I believe may find it useful or of interest.

I can confirm I have sent the report to:

1. The family of Mr Stiles

I also have a duty to send a copy of the report to the Chief Coroner.

You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.

SIGNATURE

