REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: The Secretary of State for Health and Social Care

CORONER

I am Chris Morris, Area Coroner for Manchester South.

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.
http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7
http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

INVESTIGATION and INQUEST

On 18th October 2024, Christopher Murray, HM Assistant Coroner for Manchester South, opened an inquest into the death of Robert John McGowan who died on 13th August 2024 at Stepping Hill Hospital, Stockport, aged 53 years. The investigation concluded with the inquest which I heard on 6th January 2025.

The inquest determined Mr McGowan died as a consequence of:

1) a) Cardiorenal failure;

1) b) Acute myocardial infarction;

1) c) Spontaneous bacterial endocarditis.

II. Autism

At the end of the inquest, I recorded the following Narrative Conclusion: -

'Mr McGowan died as a consequence of complications arising from partially treated spontaneous bacterial endocarditis against a background of barriers to accessing treatment connected with autism and complex mental health needs.'

CIRCUMSTANCES OF THE DEATH

Mr McGowan died on 13th August 2024 at Stepping Hill Hospital, Stockport as a consequence of complications arising from spontaneous bacterial endocarditis against a background of Autism.

CORONER'S CONCERNS

During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you.

I am concerned that, as a consequence of living with Autism and complex mental health needs, Mr McGowan encountered cultural, structural and systemic barriers to receiving treatment for his

physical health needs, the result of which was that the bacterial endocarditis which led to his death had only been partially treated. The court heard evidence that these barriers continued to exist notwithstanding advocacy provided by a charity which supported Mr McGowan, a range of individual adjustments healthcare professionals sought to make to facilitate his access to care and treatment, and the fact he had a Health Passport.

ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by **12th March 2025**. 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.

COPIES and PUBLICATION

I have sent a copy of my report to Mr McGowan's family and to the Chief Coroner.

I have also sent a copy to Stockport NHS Foundation Trust, Disability Stockport, Stockport Metropolitan Borough Council and NHS Greater Manchester ICB 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. He may send a copy of this report to any person who he believes 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.

Dated: 15th January 2025

Signature: Chris Morris HM Area Coroner, Manchester South.