

## REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: [REDACTED], Managing Director, Caring UK Ltd

CORONER

I am Chris Morris, Area Coroner for Greater 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/ukxi/2013/1629/part/7/made>

### INVESTIGATION and INQUEST

On 3 September 2025, an inquest was opened by Alison Mutch OBE, Senior Coroner for Greater Manchester (South) into the death of Patrick Griffin who died at the Stamford Unit, Tameside Hospital on 17 August 2025, aged 82 years. The investigation concluded with an inquest which I heard on 30 January 2026.

The inquest heard medical evidence that Mr Griffin died as a consequence of:

#### **1a) Bronchopneumonia**

#### **2) Alzheimer's Disease**

At the end of the inquest, I recorded a narrative conclusion, finding that Mr Griffin died in hospital from Bronchopneumonia having been admitted from a care home as a result of a number of his basic care needs not being met.

### CIRCUMSTANCES OF THE DEATH

Mr Griffin died on 17 August 2025 at the Stamford Unit, Tameside General Hospital, Ashton-under-Lyne as a consequence of Bronchopneumonia against a background of Alzheimer's Disease. Mr Griffin was admitted to Tameside General Hospital from Moss Cottage where he was receiving residential care on a temporary basis.

### 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.

The **MATTERS OF CONCERN** are as follows. –

Mr Griffin lived with advanced dementia and moved into Moss Cottage on temporary basis on 18 July 2025 to afford his wife and main carer a period of respite. I am concerned that, despite it being recognised that Mr Griffin needed support with dietary and fluid intake, and full

assistance with hygiene and personal care, when admitted to hospital on 6 August 2025, he was noted:

- 1) To be dehydrated; and
- 2) Not to have opened his bowels for 7 days.

#### 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 **21<sup>st</sup> April 2026** I, the coroner, may extend the period.

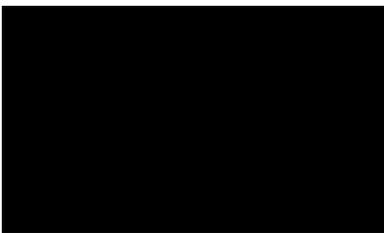
Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise, you must explain why no action is proposed.

#### COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner, together with Mr Griffin's daughter, Tameside Metropolitan Borough Council, and the Care Quality Commission who may find it useful or of interest.

The Chief Coroner may publish either or both in a complete or redacted or summary form. She 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: **24<sup>th</sup> February 2026**



Signature: Chris Morris, Area Coroner, Manchester South.