

REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

1. CORONER

I am James Thompson, Assistant Coroner, for the coroner area of Gateshead & South Tyneside.

2. DATE OF REPORT

17th June 2026.

3. 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.

4. THIS REPORT IS BEING SENT TO -

Secretary of State for Health & Social Care

You are under a duty to respond to this report within 56 days of the date of this report, namely by 12th August 2026. I, the coroner, may extend the period if an appropriate application is made.

5. 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](#).

6. SUMMARY OF CORONER'S CONCERNS

1. Recording of a patient's 'fire' risk on medical records.
2. Allocation of a named social worker or equivalent to provide long term oversight of a service user.
3. Equal consideration of other hospital discharge outcomes in addition to the 'Home First' principle.

7. 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.

8. INVESTIGATION AND INQUEST

On 15th January 2023, I commenced an investigation into the death of Malcolm Campbell, aged 84 years.

My investigation concluded at the end of his inquest hearing on 12th June 2026.

The medical cause of death was -

1a The effects of smoke inhalation

2 Interstitial lung disease & coronary artery atheroma

Malcolm Campbell died on 15th January 2023 at South Tyneside District General Hospital from the effects of smoke inhalation. This was caused by a fire in his home, 68 Shaw Avenue, South Shields on the 14th January 2023.

A narrative conclusion was recorded.

9. CIRCUMSTANCES OF DEATH

Mr Campbell lived alone in his home. He was diagnosed with dementia in May 2022. He was seen to decline in his physical and mental health from this time until his death. He received carer visits 4 times a day. He regularly smoked in bed and this was seen as risk by his carers, his GP and other visiting professionals. A fire service assessment in November 2022 considered him at high risk due to fire and considered him unable to self rescue with 5 minutes in the event of a fire. He was also seen as a high risk for falls.

The local authority installed monitored smoke/fire alarms as well as a fall alarm. He was supplied with fire retardant bedding.

He was admitted to hospital twice in December 2022 on both occasions he was seen to lack capacity in terms of care and treatment decision making and DOLS authorisations were put in place.

He was discharged home on both occasions no capacity assessments were undertaken during his time at home during the period November 2022 to his death or upon discharge from hospital to his home.

His risk laden activities continued at home and concerns were raised. He was seen as effectively bed bound and with increasing frailty as well as progression of his dementia. On 14th January 2023 a fire started in his home and the local authority monitoring service noticed alarm activations and attempted to speak with Mr Campbell. His responses were confused and as a result the emergency services were alerted. They arrived promptly and rescued Mr Campbell, who was resuscitated and taken to hospital with the effects of smoke inhalation.

Despite treatment he died on 15th January 2023.

10. 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:

1. Mr Campbell was prescribed an emollient cream which carers would apply to his legs. This cream had a paraffin base. A fire investigator opines the cream may have over time soaked into bedding and the carpet near his bed as, well as its presence in its container, once the fire started allowed the fire to spread. Mr Campbell's GP was aware when prescribers select an item which contains a product with paraffin in it an warning is displayed. However, there was no ability to place on a patient's medical records a 'Fire' flag to show that person has been classed as a fire risk due to smoking in bed etc. The medical professional would need to read the patient's medical records to identify any fire risk issues and make the connection between this and the potential risk of issuing a paraffin based product. I have a concern that NHS patient records do not have the ability to overtly warn medical professionals where a person is seen to be a risk of injury/death due to fire to assist them in tasks such a prescribing medication, home visits etc. This appears to be a concern which is not confined to a individual surgery, but to medical records systems generally.
2. Mr Campbell was seen by different social workers on several occasions during the last few months of his life. There was evidence that they and other professionals saw him for a limited period of time and their assessments were based on a 'snap shot' of his presentation at that particular time. Evidence was heard that the use of a named social worker or other social care professional who could be allocated to a person for the duration of their care. This could enable better monitoring of a service user and to enable better intelligence to be gathered to allow better decision making. The inability to undertake this allocation of named social work professionals was seen as due to the significant increase in workload since the Covid pandemic. My concern is the allocation of a social worker or equivalent who can 'supervise' a service user over a long period may be more adept at identifying changes in their condition and presentation.
3. Social workers gave evidence about the strategy of Improving Hospital Discharge (<https://www.england.nhs.uk/urgent-emergency-care/improving-hospital-discharge/reducing-long-term-stays/>) which contains the principle (5) of 'Home First'. The expectation that upon discharge from hospitals most persons should return to their home. I was told that the management of risk is paramount in that assessment of them

returning home. However, I have heard evidence that other options such as Mr Campbell going to a residential/nursing home on a trial basis on discharge were not considered on an equal footing as the option of returning home. My concern is whilst the aim of the policy is understandable, those involved in the discharge process should actively consider the risk of a return to their home and consider other options on equal basis as a return home.

11. 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 Malcolm Campbell
2. South Tyneside Council
3. South Tyneside & Sunderland NHS Foundation Trust
4. Cumbria, Northumberland and Tyne & Wear NHS Foundation Trust
5. Dale Care Limited

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.

12. SIGNATURE

