

[REDACTED]

Thursday, 04 June 2026

PRIVATE AND CONFIDENTIAL

Robert Cohen HM Assistant Coroner for Cumbria
HM Coroner's Courts
Allerdale House
Workington
Cumbria
CA14 3YJ

[REDACTED]

Dear Mr Cohen

**Re: North Cumbria Integrated Care's Regulation 28 Response and Action Plan
Concerning the Inquest into the death of James Patrick Stewart**

I write following the inquest held on 13 and 14 April 2026 into the death of Mr James Stewart.

You concluded that Mr Stewart died on 27 December 2024 at the Cumberland Infirmary, Carlisle, Cumbria. The medical cause of death was recorded as:

- 1a Multiorgan Failure
- 1b Cardiac Arrest
- 1c Hanging

You further concluded that Mr Stewart died due to suicide, contributed to by neglect, specifically the premature decision to discharge him and the failure to intervene when concerns were raised regarding his safety prior to discharge.

During the inquest, you identified matters of concern which give rise to a risk of future deaths unless action is taken. In accordance with your statutory duty, you issued a Regulation 28 Report to the Trust.

On behalf of the Trust, I would like to reiterate our sincere condolences to Mr Stewart's family. We recognise the profound impact of his death.

For completeness, I would note that the Trust's learning response completed in January 2025 was based on the contemporaneous evidence available at the time, including accounts from staff directly involved in Mr Stewart's care. These accounts did not indicate that an explicit expression of intent to end his life by hanging had been escalated immediately prior to discharge. Notwithstanding this, I acknowledge your careful consideration of the evidence and accept the seriousness of your findings. The Trust has undertaken extensive reflection on the circumstances of Mr Stewart's care, and is fully committed to ensuring that the learning identified is embedded into clinical practice and operational delivery.

Pillars Building, Cumberland Infirmary, Infirmary Street, Carlisle, Cumbria, CA2 7HY

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Safe, high quality care **every time**

Matters of Concern and Trust Response - Information available to Flow Coordinators

You raised concern regarding the adequacy of information provided to Flow Coordinators in relation to patient vulnerability, and the associated risk of inappropriate discharge arrangements.

I recognise that Flow Coordinators fulfil a non-clinical coordination role once a patient has been deemed medically fit by registered clinical professionals for discharge. However, I accept that this function requires sufficient awareness of relevant risks, particularly where patients present with vulnerability, mental health needs, or safeguarding concerns.

Actions Taken and Planned

1. Flow Coordinator Role and Discharge Processes

I have commissioned a review of the Band 4 Flow Coordinator role and associated discharge processes. This includes:

- Clarification of role scope, responsibilities, and accountability
- Strengthening the flow of relevant clinical and risk information during discharge coordination
- Clear escalation expectations where vulnerabilities or risks are identified
- Reinforcement that discharge decisions remain clinically led and have a multidisciplinary approach

2. Transport and Discharge Arrangements

I have commissioned a review of discharge transport and planning processes, with particular focus on vulnerable patients. This includes:

- Clarification of roles and responsibilities for transport decisions
- Strengthened escalation pathways where transport arrangements present risk
- Enhanced documentation of agreed arrangements and contingency planning

This work is intended to ensure that discharge coordination is supported by appropriate risk awareness and system oversight.

While I recognise that the following was not identified by you as a matter of concern within your Regulation 28 report, I note your findings that Mr Stewart's discharge was premature, as he was still suffering from the symptoms of alcohol withdrawal. We have therefore identified the following actions to address this and to reduce the risk of recurrence:

3. Alcohol Withdrawal and Detoxification Guidance

A full review of Trust guidance relating to alcohol withdrawal and detoxification has been initiated. This includes:

- Clear expectations for discharge decision making during detoxification
- Defined escalation requirements where Clinical Institute Withdrawal Assessment for Alcohol (CIWA-Ar) scores remain elevated or fluctuate
- Guidance on involvement of specialist mental health or liaison services

4. Assurance of CIWA-Ar Scoring and Clinical Response

We are strengthening audit and assurance processes relating to CIWA-Ar scoring, including:

- Accuracy and consistency of scoring and documentation
- Timeliness of reassessment
- Clinical response and escalation to elevated scores
- Oversight of discharge decisions where withdrawal symptoms persist

Learning from this work is being embedded through governance and clinical education structures.

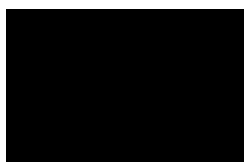
Learning from this case will continue to be shared across the organisation through governance and leadership forums. Key areas of focus include:

- Early recognition and escalation of patient safety concerns
- Strengthening multidisciplinary challenge and professional curiosity
- Communication and coordination at the point of discharge
- Management of co-existing physical health, alcohol dependence, and mental health risks
- Standards of documentation and escalation recording

I want to assure you that the Trust has given careful and thorough consideration to the concerns raised within your Regulation 28 Report. We are taking forward a programme of work designed to deliver sustainable improvement and reduce the risk of future harm.

I will continue to oversee this work through our governance framework and ensure that patient safety remains central to our organisational priorities.


I hope this response provides assurance that the matters identified have been taken seriously and that meaningful action is being undertaken.



Yours sincerely,



Deputy Chief Executive, Executive Medical Director and Responsible Officer
North Cumbria Integrated Care NHS Foundation Trust

Ref	Action	Lead	Timescale	Evidence of Completion	Assurance / Monitoring
1	Implement process for sharing clinical risk information during discharge coordination and ensure MDT-led discharge for all patients. This includes mental health services.	Collaborative Lead Nurse Emergency Care	31/08/2026	Update discharge documentation to include: <ul style="list-style-type: none"> - Mental health section. Has the patient had any involvement in mental health services during their admission or inpatient stay. - If patient has been involved in mental health services – consider a referral to PLT prior to discharge. 	Emergency Care Collaborative Workforce Group
2	Strengthen incident reporting and management process in relation to mental health patients to allow triangulation of information and escalation of risk	Patient Safety System Manager	31/10/2026	Incident reporting and management floor walk and engagement training. Training record.	Delivering Quality and Safety Group
3	Trust wide shared learning	Corporate Risk Manager	31/05/2026		Patient Safety Group