Miss K J Gomersal LLB | Senior Coroner | Cumbria

HM Coroner's Courts, Allerdale House, Workington, Cumbria CA14 3YJ

[redacted] **Web:** hmcoronercumbria.org.uk

Case Ref: [redacted]

14 April 2026

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: North Cumbria Integrated Care NHS Foundation Trust

1) CORONER

I am Mr Robert Cohen, HM Assistant Coroner for Cumbria

2) 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

3) INVESTIGATION and INQUEST

On 3 January 2025 an investigation was commenced into the death of James Patrick. The conclusion of the inquest was:

Suicide.

Mr Stewart's death was contributed to by neglect, being the decision to prematurely discharge him and the failure to intervene when concerns were raised as to his safety prior to his discharge.

I found that the medical cause of death was:

1a Multiorgan Failure

1b Cardiac Arrest

1c Hanging

II

4) CIRCUMSTANCES OF THE DEATH

My conclusions as to the circumstances of Mr Stewart's death were as follows:

James Stewart was 52 years old. He had a past medical history of mental illness and drug and alcohol abuse. On 21st December 2024 he came to the notice of Cumbria Police and made threats to harm himself. He was detained under the Mental Health Act. It was identified that Mr Stewart was also in alcohol withdrawal and he was admitted to the Cumberland Infirmary. His initial period of detention under the Mental Health Act expired. Thereafter, Mr Stewart continued to express a settled intention to harm himself. He was detained under section 5 of the Mental Health Act but it was then determined that detention was not required and that he would remain in hospital voluntarily for alcohol detoxification. A decision was made to discharge Mr Stewart on 26th December 2025. This was premature: Mr Stewart was still suffering from the symptoms of alcohol withdrawal, had not been reassessed by the Psychiatric Liaison Team, and required ongoing treatment. Mr Stewart had understood that transport would be provided to return him to his home in Wales, but the hospital did not consider that this was necessary or appropriate. Mr Stewart went to leave the hospital. As he did so he made a gesture indicating an intention to hang himself. Despite a Health Care Assistant raising concerns, the discharge continued. Mr Stewart went to a nearby hotel where he placed a ligature around his neck and rendered himself unconscious. He was found and returned to the hospital, but had sustained catastrophic injuries which were incompatible with life. Mr Stewart's death was confirmed at 2:10 on 27th December 2024.

5) 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. –

(1) I heard evidence from a Flow Coordinator who was responsible for taking the practical steps to arrange a patient's discharge after the treating clinicians had determined that the patient was medically fit. I understand that the Flow Coordinator is to make the necessary logistical arrangements for discharge, not to decide whether discharge is appropriate. However, the evidence was that the Flow Coordinator would not necessarily be briefed on any particular vulnerabilities that a patient had. For instance, in this instance Mr Stewart had made repeated threats to harm himself, including on the railway, which the Flow Coordinator did not know of. She considered making arrangements for him to travel home by train, which might have been especially risky. Whilst these matters did not eventuate in this inquest, I consider that not giving Flow Coordinators information about patient vulnerability risks them making unsuitable arrangements.

6) ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you North Cumbria Integrated Care NHS Foundation Trust have the power to take such action.

7) YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 10th June 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.

8) COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the Interested Persons. 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.

14 April 2026

Signature

Robert Cohen HM Assistant Coroner for Cumbria