Miss K J Gomersal LLB | Senior Coroner | Cumbria

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

[redacted]

[redacted]

17 August 2026

REPORT TO PREVENT FUTURE DEATHS

REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's PFD Publication Policy (2026)

1.	**CORONER** I **am Margaret Taylor, Area Coroner for Cumbria**
2.	**DATE OF REPORT** 17 August 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** **1. Recovery Steps Cumbria** You are under a duty to respond to this report within 56 days of the date of this report, namely by 14 October 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 CONCERN** see below
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 27 October 2025 I commenced an investigation into the death of Graeme John Wear ELLIOTT. The investigation concluded at the end of the inquest. The conclusion of the inquest was: Suicide 1a Hanging
9.	**CIRCUMSTANCES OF DEATH:** Graeme Elliott, who was known to mental health and drug misuse services, was found deceased in a hotel room on 17 October 2025. The evening prior to his death he had been in Carlisle with a group of people and had consumed alcohol and [redacted], both of which had been identified as leading to a deterioration in his mental health. Those sharing the hotel room where Graeme was found left at approximately 09.30 hours following Graeme's indication that he would hand the key into reception when he left. At 11.04 hours police were called to the hotel as Graeme had been found [redacted]. Paramedics attempted cardio respiratory resuscitation. Their attempts were unsucessful and Graeme was pronounced deceased at the scene. On the balance of probabilities Graeme who was possibly suffering from low mood after the primary stimulant effects of the [redacted] he had consumed had worn off intended that his actions would lead to his death. Graeme had been known to mental health services since January 2023 and had been placed on the Early Intervention psychosis 3 year pathway having been diagnosed with anxiety, depression and possible psychosis. He remained under the Early intervention psychosis Team until his death in October 2025. Between 26 August and 9 October he was noted to be working with the team's senior psychologist and was engaging well. The team had referred him to Recovery Steps Cumbria for assistance with alcohol and substance use on 20 August 2025. On 10 October Graeme attended an appointment with his recovery co-ordinator. During the meeting he disclosed that he suffered from anxiety and depression and although feeling well at that time he had a suicide plan in place, that he would hang himself [redacted]. This information was not shared with Graeme's family or his mental health team.

10. 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:

Whilst it is not possible to determine that Graeme's death by hanging on 17 October was preventable the failure to share this information led to a missed opportunity for other agencies to review Graeme's risk to himself.

1. I am concerned that upon receiving information which could possibly inform formulation of the risk of self harm and plans to mitigate the risk this was not automatically shared with a partner agency who was actively involved in the care and treatment of a client.

2. Family, one of whom worked within mental health, were supportive of Graeme yet there appears to have been no discussion about sharing this information with them.

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.Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

2.The family of Graeme Elliott

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.

SIGNATURE



[redacted], HM Area Coroner for Cumbria