Miss K J Gomersal LLB | Senior Coroner | Cumbria

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

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17 April 2026

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: Lancashire and South Cumbria 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 19 May 2025 an investigation commenced into the death of Julie Ley. The investigation concluded at the end of the inquest.

The conclusion of the inquest was the following narrative:

Julie Ley was 71 years old. She had a substantial history of mental illness. In December 2024 Mrs Ley's condition deteriorated and she became progressively more anxious and had depressive symptoms. On several occasions Mrs Ley was admitted to hospital before being discharged to different supportive environments. However on each occasion Mrs Ley's symptoms made it impossible for her to care for herself and she was readmitted to hospital. On 16th January 2025 Mrs Ley was admitted to the Kentmere Ward at Westmorland General Hospital. Mrs Ley's condition worsened over time and she was detained under the Mental Health Act 1983 from 7th April 2025.

The care received by Mrs Ley on the Kentmere Ward was inadequate. From mid April 2025

Mrs Ley became increasingly withdrawn and unkempt. Insufficient support was provided to her. In May 2025 Mrs Ley stopped accepting medication, food or drink. Monitoring of Mrs Ley's nutrition was not undertaken with appropriate diligence and she was not referred for treatment at a more appropriate hospital where IV therapy could be administered. The powers available under the Mental Health Act to give treatment without Mrs Ley's consent were also not used.

Mrs Ley's physical condition deteriorated. Her risk of embolus was not properly monitored. On 15th May 2025 Mrs Ley died, on the Kentmere Ward, as a result of a deep vein thrombi. Her death was confirmed at 15:42.

Lancashire and South Cumbria NHS Foundation Trust have accepted that there were failures in respect of Mrs Ley's nutrition, physical health monitoring, and use of legal frameworks and that Mrs Ley would not have died but for these failings.

Mrs Ley's death was contributed to by neglect, being the failure to monitor her nutrition, the failure to transfer her to a hospital able to treat her worsening condition and the failure to use available powers to administer medication to her.

The medical cause of Mrs Ley's death was:

1a Myocardial fibrosis and pulmonary thrombo-emboli due to deep vein thrombi

1b

1c

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4) CIRCUMSTANCES OF THE DEATH

In addition to the matters recorded in the above narrative, I heard evidence that when CPR was delivered to Mrs Lay it took place on her bed, a soft surface.

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) The consultant who was involved in performing CPR on Mrs Ley agreed that she had been in bed at the time. When asked why he had not moved her to a solid surface he replied that he had attended many advanced life support training sessions and had never been told this was necessary. In their article "The impact of compliant surfaces on in-hospital chest compressions: Effects of common mattresses and a backboard" in the journal Resucitation (Vol 80, Issue 5, May 2009) the authors notes that carrying out CPR in a hospital bed may be 50% less effective. I am concerned that despite receiving training a senior clinician was unaware of this and consider that it gives rise to a risk of future deaths.

6) ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you Lancashire and South Cumbria 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 12th 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.

17 April 2026

Signature 

Robert Cohen

HM Assistant Coroner for Cumbria