



**Miss K J Gomersal LLB | Senior Coroner | Cumbria**

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

[REDACTED]

[REDACTED]

23 July 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 Robert Cohen HM Assistant Coroner for Cumbria

2.

#### **DATE OF REPORT**

24 July 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. North Cumbria Integrated Care NHS Foundation Trust
2. Cumberland Council
3. Cumberland Safeguarding Children Partnership

You are under a duty to respond to this report within 56 days of the date of this report, namely by 18th September 2026. 1, 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**

In summary, I consider that there is evidence that:

- Clinicians are insufficiently clear on the dangers of codeine addiction.
- Clinicians demonstrated a lack of professional curiosity in respect of codeine addiction.
- The threshold for involving local authority social care is too high in practice.

**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 2 August 2024 I commenced an investigation into the death of Isla Alma McVeigh. The investigation concluded at the end of the inquest . The conclusion of the inquest was:

Isla McVeigh was born on 19th June 2024 and died just over a month later, on 25th July 2024. At birth Isla was found to be dependent on opiates and was admitted to hospital to be treated with morphine to mitigate opiate withdrawal. She was discharged, against medical advice, on 2nd July 2024. She was found deceased at home ( [REDACTED] ) on the morning of 25th July 2024. Her death was confirmed at 7:22. It is more likely than not that Isla died of asphyxiation as a result of an unsafe sleeping environment. It is possible that the sedating effects of opiate use were a contributory factor.

The medical cause of death was:

1a Asphyxia

1b

1c

II

## **9. CIRCUMSTANCES OF DEATH**

Isla McVeigh was born with Neonatal Abstinence Syndrome. In other words, she had become dependent on opiates in utero and required medical care to mitigate the symptoms of opiate withdrawal. Isla had been exposed to opiates because her mother was taking codeine. Whilst in hospital staff raised concerns on several occasions when Isla was found being held by a person who was asleep. Significant guidance was given as to safe sleeping.

Isla was found dead at home in circumstances that make it more likely than not that she asphyxiated as a result of an unsafe sleeping environment. It is not possible to determine whether or not the individual who had been feeding Isla had used opiates, but it is possible.

Isla was not referred to local authority children services during her life.

## 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:

- 1) The evidence I heard indicated that clinicians did not always understand the extent to which codeine addiction might translate into the misuse of other opiates. It appeared to be the view of many that because codeine had been prescribed to Isla's mother, Isla's dependence upon it was not concerning. But this ignored the frequently encountered situation in which opiates are legitimately prescribed but still come to be abused.
- 2) Witnesses agreed that they had not sought to probe the nature of opiate use. Whilst Isla was in SCBU there were limited records of discussion of the use of opiates. The BadgerNet notes also show that this was the subject of only very limited discussion during pregnancy before Isla was delivered. I am concerned that there is a lack of professional curiosity on this subject.
- 3) Safeguarding professionals' gave evidence that even if they had felt that Isla's mother was addicted to opiates they would not have considered that this met the threshold for escalation to Local Authority Children's Services because Cumberland Safeguarding Children Partnership's document 'Understanding the Level of Need and the Practice Response' provided that such a referral should only be made where a child is "at risk of significant harm or the needs are such that without intervention the child's health or development would be seriously impaired". They interpreted this to mean that in practice a referral would not have been accepted. They observed that, in their experience, the threshold for a successful referral was high. I am concerned that this overstates and elevates the threshold of risk necessary to refer a child to children's services. I am concerned that this gives rise to a risk of future death.

## 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. All interested persons.
- 2.
- 3.

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**

A solid black rectangular box used to redact the signature of Robert Cohen.

Robert Cohen, HM Assistant Coroner for Cumbria