

Chief Medical officer's office
Royal Cornwall Hospital
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Date: 2 February 2026



Private and Confidential

Mr. Andrew Cox
H.M Senior Coroner for Cornwall and the Isles of Scilly
Pydar House
Pydar Street
Truro
Cornwall
TR1 1XU

Dear Mr Cox,

Re: The Late Izzah Fatima Ali – Regulation 28 PFD Report and Response

I write in response to the Regulation 28 Report to Prevent Future Deaths, dated 09 December 2025 and received on the 10 December 2025. This was issued following the inquest into the death of Izzah Ali which was heard over 17-18 November 2025 and concluded on 09 December 2025.

I would like to take this opportunity to express my sincerest condolences to the family of Izzah Ali for their tragic loss.

During the inquest, the evidence revealed matters giving rise to concern. Which are as follows:

- 1. There was a failure to recognise that 'bottle fed' is an incomplete description and requires an additional question of 'what is in the bottle?' – there was a lack of professional curiosity*
- 2. During ante-natal and post-natal visits with a woman who did not speak English, no interpreter was involved, contrary to guidance.*

Please find below the response from the Trust and details of the actions taken in relation to the above concerns.



Response:

1. Izzah's case has been widely shared across the organisation and has increased professional awareness, knowledge and confidence in asking the appropriate question on feeding in infants.

The Emergency Department are to change their language when asking parents about how babies are fed from 'bottle' to 'formula' – e.g. 'is your baby formula or breast fed?' In addition, ED documentation in terms of proformas for paediatric clerking in the ED by both medical and nursing staff will reflect this change.

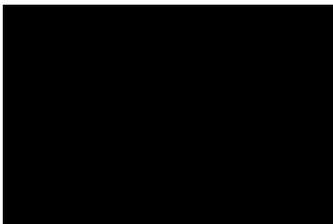
In relation to our paediatric team, completion of routine enquiry will be embedded into the admission proforma use for our inpatient children's ward. "What is in the bottle?" has become a standard enquiry for us all in paediatrics and will be included in their admission documentation. Support can then be provided for families if indicated.

Maternity services use routine enquiry about the exact nature of bottle feeding as a mandatory question at every safe opportunity making the identification of need or risk earlier.

2. I reiterate the contents of paragraphs 9 – 11 from [REDACTED] statement dated 3 September 2025 (Interim Director of Midwifery at time of signing, now Director of Midwifery) which was produced into evidence at the hearing on 17 November 2025. Since Izzah's tragic death, the Trust has already undertaken and has in place the following:
 - a. Enhanced Continuity Pathway developed and implemented
 - b. Pregnancy Circles implemented with face-to-face translators
 - c. Strengthened interpreter and language support in maternal care
 - d. Audits of interpreter and language support will be reported to the Clinical Audit Assurance software (AMaT) and through Perinatal Safety Trust Board report. This commenced in January 2025 and will continue to be audited every 3 months.

I hope that this letter provides both you and Izzah's family with assurance that the Trust has taken seriously the concerns raised in your report and that the Trust has taken the appropriate action to prevent future deaths.

Yours Sincerely



**Chief Medical Officer
Royal Cornwall Hospitals NHS Trust**