NOTE: This form is to be used after an inquest.

# **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**

### THIS REPORT IS BEING SENT TO:

1. Community Health

#### 1 CORONER

I am Andrew Cox, the Senior Coroner for the coroner area of Cornwall and the Isles of Scilly.

### 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.

## 3 INVESTIGATION and INQUEST

On 9/12/25, I concluded the inquest into the death of Izzah Fatima Ali who died on 7/9/24 at the age of 9 months.

I recorded the cause of death as:

1a Acute on chronic decompensated heart failure

1b Cardiomyopathy

1c Iron deficiency anaemia (treated with a blood transfusion)

I recorded a conclusion that Izzah died from complications caused by her treatment for profound iron-deficiency anaemia in turn due to her consumption of cow's milk. A copy of my full judgment is available upon request.

## 4 CIRCUMSTANCES OF THE DEATH

Izzah was a nine-month-old female infant who had been born fit and well. Both of her parents came from Pakistan and her mother had only been in England for a couple of months before her daughter was born. She did not speak English.

An interpreter was not used at ante-natal interactions contrary to guidance. A guide to feeding your baby was produced in English only and it did not set out that providing cow's milk to an infant under the age of one was contra-indicated because it ran the risk of causing iron-deficiency anaemia. I was told the Guide had been withdrawn and was being re-written. A UNICEF guide that was available in Urdu and which explained this was not provided.

There were two health visitor attendances again without an interpreter present. At the time of the second attendance, Izzah was still breast-fed only.

Unaware of the risks of using cow's milk, Izzah's parents provided this to their daughter believing it would be beneficial to her.

There were multiple interactions with a wide variety of different healthcare professionals when it was noted Izzah was being breast and bottle fed. No inquiry was made to check that bottle fed meant formula fed or otherwise to establish what was in the bottles being given to Izzah. It was not identified that she was receiving cow's milk until her last admission to hospital.

On 6 August 2024, Izzah was seen in a Minor Injuries Unit and then referred to paediatric colleagues in Royal Cornwall Hospital. At that time it is more likely than not that she had developed anaemia and this was the cause of her pallor and distended abdomen. A urine dipstick confirmed a urinary tract infection and antibiotics were prescribed. The anaemia was not diagnosed.

On 6 September 2024, Izzah was re-admitted into Royal Cornwall Hospital. It was established that she was profoundly anaemic. She needed to be treated by transfusion and this was undertaken. Izzah had a collapse and suffered cardiac arrests. She could not be resuscitated and was verified deceased on 7 September 2024.

# 5 CORONER'S CONCERNS

During the course of these inquests, the evidence has 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.

I wanted to ensure that the authors of the Essential Guide to feeding your Baby that I was told was being re-produced were aware of the facts of this case. I wanted them to reflect on whether the revised Guide needed to state that giving cow's milk to an infant under the age of one was not advised because it ran the risk of preventing the absorption of iron from other sources and causing anaemia.

## 6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] 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 8/2/2026. 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 following Interested Persons:

- Next of kin
- Royal Cornwall Hospital
- Cornwall Partnership Foundation Trust
- Cornwall Council

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I am also under a duty to send the Chief Coroner a copy of your responses.

The Chief Coroner may publish either or both in a complete or redacted or summary form. She may send a copy of this report to any person who she 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.

9 **[DATE]** 

**ISIGNED BY CORONER1** 

10/12/25