IN THE WEST YORKSHIRE (WESTERN) CORONER'S COURT
IN THE MATTER OF:

The Inquest Touching the Death of Maya ZAB
A Regulation Report – Action to Prevent Future Deaths

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

1. **Department of Health……**
2. **NHS England……**
3. **……**

1 CORONER

I am Ian PEARS, HM Assistant Coroner for the area of West Yorkshire Western Coroner Area

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 Thirteenth August 2020 I commenced an investigation into the death of Maya ZAB aged 11 Months. The investigation concluded at the end of the inquest the conclusion of the inquest was natural causes. The medical cause of death was:

I a Multiorgan Failure
I b Chronic Severe Microcytic Hypochromic Anaemia with Severe Iron Deficiency
I c
II

4 CIRCUMSTANCES OF THE DEATH

Maya Zab was born on 28th August 2019 to non-English speaking parents. Due to the language barrier there were a number of missed opportunities for primary carers to see Maya. This was compounded by the Covid pandemic. Maya had severe iron deficiency which led to chronic severe microcytic hypochromic anaemia, which in turn lead to her dying from multi organ failure on 6th August 2020 at Calderdale Royal Hospital

5 CORONER'S CONCERNS

The MATTERS OF CONCERNS are as follows:
During the course of the evidence it became clear that in the Yorkshire & Humber region there has been an increased incidence of severe nutritional anaemia in 2020 in a paediatric setting, resulting in 2 deaths, Maya's death being one of the two. The witness had not seen any deaths previously in her career.
The witness had consulted 9 colleagues over the data. They surmise that a number of factors arising indirectly from the pandemic may explain the findings:

- The "stay at home" message resulted in less 1 to 1 consultations, so health professionals were not able to spot the signs of anaemia
- Limitation of social contact meant other professionals and friends and family were not able to report concerns about a child's health
- Widening of socio-economic inequalities (including unemployment and reduced household earning capacities) means that certain members of society are not able to purchase a

balanced,good quality nutrition for their children
I accept that these are not factors that have been scientifically tested, but nevertheless the increase in the incidents of anaemia and the deaths that are now arising are a matter of concern

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 11 November 2021. 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

- [redacted]
- Dr [redacted]
- Locala Community Partnerships CIC

and to the Local Safeguarding Board (where the deceased was under 18). I have also sent it to:

- Dr [redacted]
- DC [redacted]

who may find it useful or of interest.

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.

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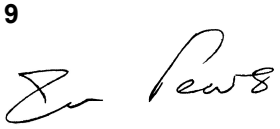

Ian PEARS
HM Assistant Coroner for
West Yorkshire Western Coroner Area
Dated: 16 September 2021