MR G IRVINE
SENIOR CORONER
EAST LONDON
Walthamstow Coroner's Court, Queens Road Walthamstow, E17 8QP
[redacted]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

[redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted] Head of Operations, The Partnership of East London Cooperatives Ltd** **2. [redacted] Maylands Healthcare Surgery Sent via email: [redacted]** **3. [redacted] Chief Executive Office, Barts Health NHS Trust** **4. [redacted] Secretary of State for Dept. Health & Social Care** [redacted]
1	**CORONER** I am Graeme Irvine, senior coroner, for the coroner area of East London
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 04/12/2023 this Court commenced an investigation into the death of Urielle Mayila Kuyenga aged 4-years. The investigation concluded at the end of the inquest on 30/09/2025. The Court returned a short-form conclusion of "Natural causes contributed to by neglect". Urielle's medical cause of death was determined as; 1a Streptococcus Pneumoniae Sepsis 1b Sickle Cell Disease (HbSS)
4	**CIRCUMSTANCES OF THE DEATH** Urielle Mayila Kuyenga was a 4-yr old girl who died in hospital on 4th December 2023. Urielle's death was caused by sepsis resulting from bacterial pneumonia. Urielle was predisposed to fatal consequences of respiratory infections as she suffered from sickle-cell disease. Contributary factors in her death were; • The failure to ensure that prophylactic penicillin prescribed to Urielle was administered, and, • Failures by doctors to identify that she had been diagnosed with sickle cell disease when she presented with symptoms of an upper respiratory tract infection on three separate occasions in the weeks before her death.
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could 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. As a patient with Sickle Cell Disease, Urielle was prescribed prophylactic penicillin to mitigate the risk of her developing fatal symptoms arising from typical respiratory infections. Urielle's mother chose not to collect those prescriptions and administer penicillin to Urielle. Urielle's specialist doctors believed that her GP was monitoring the prescription and dispensation of the penicillin, whilst Urielle's GP was misled by Urielle's mother that the hospital were dispensing the medication directly. The breakdown of communication means that Urielle was left unprotected from opportunist infection which caused this avoidable death. 2. In the weeks prior to her death Urielle's mother presented her daughter to three separate GPs about a respiratory infection. On each of these three attendances the attending clinician was ignorant of Urielle's Sickle Cell diagnosis. The reasons for these lapses were, firstly Urielle's mother did not inform the doctor of the fact and, second, that the doctors did not adequately read the clinical records available to them.
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 12 February 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 Urielle's family, the Care Quality Commission, the GMC, NHS England, CDOP (deceased was under 18)]. I have also sent it to the local Director of Public Health who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**[DATE] 9th December 2025 [SIGNED BY CORONER]** [redacted]