## **Regulation 28: Prevention of Future Deaths report**

## Shyama Vadwatee RAMPADARUTH (died 17.04.20)

	THIS REPORT IS BEING SENT TO:
	1. Medical Director Whipps Cross Hospital Whipps Cross Road Leytonstone London E11 1NR
1	CORONER
	I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	CORONER'S LEGAL POWERS
	I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	INVESTIGATION and INQUEST
	On 3 July 2020, I commenced an investigation into the death of Shyama Rampadaruth, aged 86 years. The investigation concluded at the end of the inquest earlier today. I made a determination at inquest of death by natural causes.
4	CIRCUMSTANCES OF THE DEATH
	Ms Rampadaruth had a number of co-morbidities, including renal failure, diabetes, hypertension, heart failure, asthma and cervical spondylosis.
	When she attended Whipps Cross Hospital for her routine renal dialysis on 13 April 2020, she was found to have a raised temperature and so was moved to a separate waiting area and dialysed with other patients suspected of having contracted COVID19.

	She was discharged home as usual, but deteriorated that night and was admitted as an emergency in the early hours of the following morning. COVID19 was diagnosed, she continued to deteriorate and died three days later.
5	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.
	When COVID19 was suspected at her routine dialysis appointment on 13 April, precautions were taken to separate Ms Rampadaruth from other patients to reduce the risk of transmission. She was re-allocated to the evening dialysis clinic with other potentially infectious patients, so that the unit could be thoroughly cleaned overnight to make it safer for patients at the next clinic the following day.
	However, this meant that Ms Rampadaruth had to wait for approximately six hours on a hard chair in a hospital waiting area. This is clearly sub optimal for the health of a frail, elderly lady with multiple co-morbidities.
	The patient transfer service is likely to have been busy, but Ms Rampadaruth and her husband lived nearby. Her niece, who was very involved with her care, works locally. A quick call to a family member would have resulted in immediate arrangements being made to collect Ms Rampadaruth, bring her home to sit in comfort with familiar company and her usual food and drink, and then to return her when hospital staff were ready to begin her dialysis. Her general well being could have been so enhanced by just a small change to administrative arrangements.
6	ACTION SHOULD BE TAKEN
	In my opinion, action should be taken to prevent future deaths and I believe that you 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 February 2020. 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 following.
	<ul> <li>HHJ Mark Lucraft QC, the Chief Coroner of England &amp; Wales</li> <li>methods and the constraint of the constraint</li></ul>
	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 SIGNED BY SENIOR CORONER
	11.12.20