King's College Hospital
NHS Foundation Trust

HM Senior Coroner Andrew Harris
London Inner South District
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London SE1 1YD

BY EMAIL ONLY

Chief Executive
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23 September 2022

Dear Sir,

Inquest into the death of Mr Locksley Burton

We write in relation to the Regulation 28 Report to Prevent Future Deaths dated 29th July 2022 in connection with the inquest of Mr Locksley Burton.

We are very sorry that Mr Burton died in these circumstances at King's College Hospital during the Covid-19 pandemic. We have apologised to his family for the care he received at King's and offer our heartfelt condolences.

In your report you have identified concerns which we set out below (in bold) and respond to each in turn in as far as they relate to King's College Hospital Trust:

Mr Burton did not receive adequate inspections of his wound and changes of dressings when the attendance at the diabetic foot clinic ceased to be weekly or fortnightly.

Following the beginning of the first lockdown, on the 23rd March 2020, there was a reduction of patients seen by the Diabetic Foot Clinic from fifty to approximately twenty-five per day. However, there is no evidence from Silhouette (which is the Diabetic Foot Clinic's records system) that Mr Burton was seen less frequently than clinically indicated. Mr Burton was seen, as planned on the 26th March 2020, in the Diabetic Foot Clinic. His right and left feet were treated with a plan to review in three to four weeks' time. The review timescale was based on clinical history, observations and clinical judgement taken on the day. There is no evidence that this decision was made due to the impacts of the Covid-19 pandemic. The decision was made based on the clinical judgement of an experienced podiatrist who knew the patient well.

The Diabetic Foot Clinic continued to operate throughout the Pandemic offering face-to-face appointments. Patients were prioritised on the basis of clinical need and continued to be seen in-person at the frequency that was required.

There was no evidence at inquest that alternative arrangements and revised care plan was made.

As described above, there was no need for a new care plan or alternative arrangements to be made by the Trust, as Mr Burton's diabetic feet were stable and he was given a further follow-up appointment to be seen in the Diabetic Foot Clinic.

The GP did not know of the reduction in clinic attendance or reduction in changes of dressing and assumed others were inspecting the wound and prescribed antibiotics without an examination being done.

There would only be communication to the GP from the Diabetic Foot Clinic if there had been significant change to the ulcers or the management plan, neither of which was the case. An increase in the time between outpatient appointments would not necessarily result in the GP being written to. There was no change in the frequency of the dressings and so the GP did not need to be informed.

No witness was able to demonstrate any process of managing a patient who declined necessary potentially life threatening care and probably lacked capacity to make the decision.

Mr Burton was well known to the King's College Hospital Diabetic Foot service, having been treated since 2016. During this time he had continually expressed a strong wish not to undergo a major amputation of his left foot despite this being recommended at that time and on several occasions afterwards.

When Mr Burton presented to the Trust on 16th April 2020, his foot was found to be unsalvageable and therefore an amputation may have been an appropriate clinical course of action. Mr Burton continued to express wishes not to have a major amputation. However, at that time Mr Burton was not considered a fit surgical candidate for a major amputation, and this was the reason why surgery was not progressed. Mr Burton's clinical notes do show that he was, at times, confused during this final admission. If Mr Burton's clinical condition had improved and surgical intervention (i.e. amputation) was considered in his best interests, then a formal capacity assessment would have been indicated here. It may also have been appropriate to involve an Independent Mental Capacity Advocate (IMCA).

We do recognise that documentation in relation to a mental capacity assessment could have been clearer in Mr Burton's medical records. All clinical staff at the Trust currently take a Mental Capacity Act (MCA) and Consent training module at induction, and the Trust's "Mental Capacity Act Policy" clearly lays out expectations for all staff in relation to capacity assessments.

In the last three months, we have increased the range of learning and training available for our clinicians in relation to consent and the MCA through our internal and external legal partners. The Trust has already held three consent seminars with clinicians.

In conjunction with the Corporate Medical Director for Quality and Governance, we have established a working group for improving consent and MCA assessments. We are working alongside the Director of Nursing for Vulnerable People and the Associate Director of Nursing for Mental Health to establish an improvement plan. This will include evaluation of the consent and MCA training programmes to ensure that these are effectively supporting staff in delivering best practice.

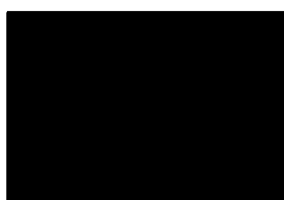
The Trust's consent policy has been reviewed and updated to make it easier for clinicians to follow, and seek additional support as appropriate. In September 2022, we also initiated a Trust-wide consent audit through our Clinical Governance Leads forum; the results of which will be reviewed through the Patient Safety Committee which is chaired by the Chief Medical Officer.

To examine the current collaborative multi-disciplinary arrangements and ensure they are appropriate and safe.

Communication with the GP would have taken place if there had been a significant change in the condition or management of Mr Burton's diabetic foot. Had there been a deterioration identified at his Diabetic Foot Clinic appointment, the GP would have been written to and any requirement for district nurse support or other primary care intervention would have been outlined in the clinic letter. It would then be for the GP to communicate to the relevant primary care team. As there was no significant change in Mr Burton's management, there was no necessity to communicate this to the GP as Mr Burton remained under the care of the Diabetic Foot Clinic and had a future appointment booked.

Thank you for raising these points and for giving us an opportunity to respond. I trust that this letter provides you with an assurance that we have seriously considered the points raised in your report.

Yours sincerely,



Chief Executive