

**FOA: Mr Andrew Harris, Senior Coroner, London Inner South jurisdiction**

Dear Sir

**Re: Regulation 28 Report to Prevent Future Deaths**

Further to the inquest touching the death of Mr Locksley Burton, as heard on 7 October 2022, and the corresponding Regulation 28 Report to Prevent Future Deaths of 29 July 2022, please find attached the response on behalf of Tower Bridge Care Home, 1 Aberdour Street, London, SE1 4SH.

The Learned Coroner identified the following matters of concern:

- 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. The pandemic was a likely reason for this, but there might be other reasons in future for such changes.
- There was no evidence at inquest that alternative arrangements and revised care plan was made.
- 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.
- 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.

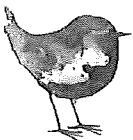
The Learned Coroner requested that Kings College Hospital, QHS GP Care Home Service and Tower Bridge Care Home provide a response to enable him to understand the current collaborative multi-disciplinary arrangements. As Home Manager for Tower Bridge Care Home (the Home), I am providing the following response:

The Diabetic Foot Clinic (DFC) is run by Kings College Hospital, with 8am to 5pm clinic hours. The DFC will send the Home a letter for clinic attendance and advise the Home on clinic appointments. The Home will then book transport, and either a carer or a family member attends with the resident. In the circumstances of Mr Burton's care, his daughter preferred to be in attendance at the appointments. Where she was not available, staff would attend with Mr Burton instead.

Due to their clinical expertise and knowledge of the individual, the DFC decides the frequency of appointments dependent on presentation. However, if the Home considers that an appointment needs to be made, staff from the Home would go through the GP and the GP would make the contact.

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The relevant GP from QHS GP Care Home Service attends the service three times a week (Tuesdays, residents on the Ground and First floors; Thursday, residents on the Second and Third Floors; Friday, for any additional urgent enquiries). When the GP attends the service, they are provided with the relevant list of which individuals require review. One of the Home's nurses will accompany the GP throughout their visit and the GP provides their instructions after review of each patient. Any prescriptions are then emailed to Boots Pharmacy, which delivers the relevant prescriptions to the Home. This continued throughout the pandemic.

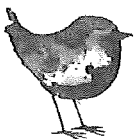
As the Coroner has correctly concluded, the pandemic was the reason that the DFC reduced its attendance. The GP was made aware of this during his attendances at the Home during the relevant period. We do note however that it was a period of unprecedented uncertainty and many services, the DFC included, were running a reduced service and attempting to adapt to the changing status of contact with individuals requiring care during this period.

Although Mr Burton had made it clear throughout his time in the Home that he only wanted the DFC to change his dressings, there is evidence within Mr Burton's notes of the Home's staff working with his behaviours and there is record of staff changing his dressing, taking photographs, updating his Wound Care Plan, the @hometeam changing his dressings and confirming that there were noted deteriorations. In addition, Mr Burton was still engaging with dermatology and Tissue Viability Nurse appointments during this period and attended the Hospital to have a blood transfusion. He and the Home were therefore continuing to engage with his care needs. At this time, the GP had been informed of the deterioration of Mr Burton's wound and Mr Burton was on antibiotics. We are unable to comment on whether the GP made contact with the DFC as a result of receiving this information.

The first formal confirmation of a reduced DFC service was received by the Home on 7 April 2020. Attempts were made to contact the DFC once the wound was noted to be deteriorating.

In April, Mr Burton was identified as having deterioration to his wound, continued to be on antibiotics for potential infection and was subsequently identified as Covid positive. This information was recorded in his notes and Mr Burton's care was adapted accordingly.

It is important to note that Mr Burton was deemed to have capacity on admission and throughout his time at the Home. Mr Burton had been diagnosed with a personality disorder, but this did not affect any decision on his capacity. Mr Burton had no formal diagnosis of dementia and he was regularly reviewed by staff at the Home and external professionals. Mr Burton was also under the care of the South London and Maudsley Trust's Care Home Intervention Team (CHIT). His presentations in relation to non-compliance with personal care and assessment of his cognition were assessed by the CHIT, initially in December 2019 and as relevant after this date. The CHIT consulted with staff at the Home and with Mr Burton's daughter. Mr Burton's daughter is recorded as advising that Mr Burton's significant behavioural issues were not reflective of a diagnosis of dementia.



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In general terms, in circumstances where a resident declined necessary potentially life-threatening care and where there were concerns in relation to whether the resident lacked capacity, the process would be to refer the resident back to their GP, involve social services and other professionals and record that this has happened. All these steps were taken in relation to Mr Burton, including (as above) the involvement of CHIT. Residents who have capacity have the right to decline treatment even if it is life threatening.

The principles of Mental Capacity Act apply to residents in Care Homes. We would note that, during his hospital stay, Mr Burton made it clear that he did not want another amputation and that the decision was for him to be comfortable. The Consultants upheld his wishes not to have another surgery.

#### Current collaborative multi-disciplinary arrangements

Throughout the pandemic 'lockdowns' and since, the Home has continued to engage with the regular Monthly Multi-Disciplinary Meetings. During the pandemic, these were a blend of virtual and in-person meetings. As the Home Manager for the Home, I review the Clinical Risks of each resident through our monthly Key Clinical Indicators exception reports. These include wounds and the escalation process. Mr Burton's wound deterioration and his presentations were discussed at these meetings.

Monthly Multi-Disciplinary Meetings have continued. Attendance comprises the Home's Home Manager, Deputy Home Manager, Clinical Lead and Unit Manager of the unit, in conjunction with the Consultant Geriatrician, GP, Advanced Nurse Practitioner, and Dietician (in-person), and the social worker, CHIT Team, palliative team, and pharmacist (joining online).


In September 2022, through agreement with the Consultant Geriatrician from Guys and St Thomas' Hospital, the Home also introduced a weekly review of high-risk residents which takes place outside of the monthly Multi-Disciplinary Meetings. The Home identifies residents with high needs and reports to the Consultant Geriatrician who then visits to have a face-to-face review with the residents and the staff in the Home. Actions needed to be taken are then escalated by people assigned for the particular action.

We hope that the above addressed the coroner's concerns, as raised Regulation 28 Report to Prevent Future Deaths of 29 July 2022.

We would like to reiterate our condolences to Mr Burton's family for their loss.

Yours sincerely,

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