	REGULATION 28 REPORTS TO PREVENT FUTURE DEATHS
1.	**CORONER** I am Andrew Harris, Senior Coroner, London Inner South jurisdiction
2.	**CORONER'S LEGAL POWERS** I make these reports under paragraph 7, Schedule 5, Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3.	**INQUEST** On 7th October 2020 an inquest into the death of Mr Locksley Burton was opened. He died on 24th April 2020 in King's College Hospital, London. (case ref: 4160929) The inquest was concluded on 29th July 2022, heard before me with a narrative conclusion delivered.
4.	**CIRCUMSTANCES OF THE DEATH** The medical cause of death was: 1a Systemic sepsis 1b Covid-19 (coronavirus) pneumonia and osteomyelitis of the left heel (joint causes) 1c II Type 2 diabetes mellitus, peripheral vascular disease, dementia, multiple myeloma The circumstances of death were: Mr Burton was an 80 year old disabled right leg amputee with dementia, bipolar disorder, diabetes and other conditions, who received nursing care and support in a residential home from May 2019. He was seen weekly or fortnightly in the hospital diabetic foot clinic until 2020 when, in the pandemic, visits became monthly, unknown to the GP. He developed an infection on his left foot. The podiatrist stressed the importance of changing dressings and of keeping the wound dry, but Mr [redacted] was not always compliant with its being inspected and dressed in the nursing home. The staff tried, but could not find ways to keep the wound clean and dry. When

	he became lethargic, blood tests were done which identified that he was anaemic and had an infection. It was assumed that this was non-specific, but his wound was not inspected by the visiting GP on 2nd April. He was given antibiotics, and tested positive for Covid (for which he had high risk) on 11th, despite precautions taken by the nursing home. He was admitted to hospital on 15th April where his wound was found to be necrotic and gangrenous. It was locally debrided but he was unfit for surgery and died at 20.00 hours on 24th April 2020. The conclusion as to the death was: He died of mixed natural causes. It cannot be determined, had it been possible to provide better supervision and management of his wound, whether that would have led to a different outcome.

5.	**This REPORT IS BEING SENT TO:** 1. [redacted], Chief Executive, Kings College Hospital, Denmark Hill, London, SE5 9RS 2. Dr [redacted], General Practitioner, QHS GP Care Home Service, Spa Medical Centre, 50 Old Jamaica Road, London, SE16 4BL
6.	3. [redacted], Home Manager, Tower Bridge Care Home, 1 Aberdour Street, London, London, SE1 4SH **THE CORONER'S MATTER 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.

7.	**ACTION SHOULD BE TAKEN** The case is brought to the attention of the three organizations involved in care, to enable them to examine the current collaborative multi-disciplinary arrangements and ensure they are appropriate and safe.
8.	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by Monday 26th September 2022. I, the coroner, may extend the period. If you require any further information or assistance about the case, please contact the case officer [redacted]
9.	**COPIES and PUBLICATION** I have sent a copy of my report to the following interested persons: [redacted] (Daughter) Dr [redacted], Nursing Home General Practitioner [redacted] (for Nursing Home), Senior Associate, Lester Aldridge [redacted], Inquest Manager, Legal Service Department, Quality Improvement and Assurance Directorate, Guys and St Thomas' Hospital (GSTT) [redacted] (for KCH), Legal Director, Hill Dickson LLP I am also copying it to Royal College of General Practitioners and The Care Quality Commission, who may have interest in the matter. I am also under a duty to send the Chief Coroner a copy of your response. He 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.
10.	**[DATE]** **[SIGNED BY CORONER]** **29th July 2022** **A N G Harris, Senior Coroner**