Sussex
NHS Commissioners

NHS

Sussex NHS Commissioners
Hove Town Hall
Norton Road
Hove
BN3 3BQ

Ms Veronica Hamilton-Deeley
The Coroner's Office Woodvale
Lewes Road
Brighton
BN2 3QB

8th September 2021

Dear Ms Hamilton-Deeley

The late Kevin John Fitton - Prevention of Future Deaths Report

On 24th May, Brighton and Hove Clinical Commissioning Group, part of Sussex NHS Commissioners, received the above report in accordance with the Coroners (Investigations) Regulations 2013.

Sussex NHS commissioners have considered the report and discussed your concerns both internally and with other Health and Social Care partners in Brighton and Hove via the Safeguarding Adults Board.

As you will be aware, the Safeguarding Adults Board held a Safeguarding Adults Review following the death of Mr Fitton. This review resulted in a number of recommendations which were reflected in the Prevention of Future Deaths Report. Having considered these actions the Safeguarding Adults Board has created an action plan to ensure that those recommendations will be achieved. This plan will be regularly monitored by the Safeguarding Adults Board to ensure progression at a reasonable pace.

Within the plan the Clinical Commissioning Group is required to share the report with commissioners so as to give consideration to how long term service delivery can be improved for people with acquired brain injuries. The report has been shared with commissioners who are reviewing how acquired brain injuries can be specifically considered within the services that are commissioned.

The Clinical Commissioning Group will continue to engage with partner organisations in the Safeguarding Adults Board to support service improvement for people with acquired brain injuries.

Yours sincerely,

Chief Nursing Officer

On behalf of Sussex NHS Commissioners

Brighton & Hove City Council

Health and Adult Social Care
Brighton & Hove City Council
Second Floor, Hove Town Hall
Norton Road
HOVE
BN3 3BQ

Private and Confidential

Date: 14th July 2021

Ref::

Veronica Hamilton-Deeley DL, L.L.B,
Her Majesty's Senior Coroner for the
City of Brighton & Hove

[redacted] [redacted]
[redacted] [redacted]

Dear Ms Hamilton-Deeley

Re: **Inquest into the death of Kevin John Fitton on 04 May 2021**

With respect to the above inquest thank you for sharing your formal Report to Prevent Future Deaths made under Regulation 28 that I have read carefully and has been given full consideration by myself and colleagues within the Health and Adult Social Care directorate at Brighton and Hove City Council. Please find enclosed our formal response in which we have fully acknowledged the areas you have raised with us. To support and develop good practice we have progressed on a number of key actions as detailed within our response.

Kind regards

[redacted]
Executive Director Health and Adult Social Care

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Private and Confidential

Veronica Hamilton-Deeley DL, L.L.B,
Her Majesty's Senior Coroner for the City of Brighton & Hove

Dear Ms Hamilton-Deeley

Response to Report to Prevent Future Deaths made under Regulation 28 and 29 of the Coroners (Investigations) Regulations 2013 concerning Kevin John Fitton

Thank you for your correspondence of 20th May, Regulation 28 report to prevent future deaths, noting your concerns raised during the course of the inquest regarding Kevin John Fitton.

We would like to acknowledge the areas you have noted and thank you for feeding back to our organisation regarding these.

As you know a Safeguarding Adults Review (SAR) under S.44 of the Care Act 2014 has been undertaken following concerns regarding whether agencies could have worked more effectively to with Kevin Fitton.

With regard to the concerns you have raised with us at the Local Authority we provide the following response. This response is based on meetings and conversations that have taken place in the Local Authority since receiving your s28 regulation notice, involving key internal stakeholders leaders and practitioners in our directorate, in order that we ensure we are responding proactively and working together to address the concerns you raise.

We have fully considered each of your concerns, namely:

- There was an almost complete reliance on the assumption of capacity. The lack of capacity assessments resulted in failure to identify the area and support needed by Mr Fitton and a failure to use best interests policy appropriately
- There was a failure to seek specialist support regarding Acquired Brain Injury (ABI)
- There was a failure to understand the way Mr Fitton's ABI impacted on his abilities
- There was a failure to understand how ABI impacted on Mr Fitton's substance use and vice versa.
- Communication between the various teams and individuals was poor.
- Lead and Co-ordination were lacking
- There was a failure to react to the deterioration in Mr Fitton's living conditions, his being cuckoo'd, the downward slide in his physical health and the increase in his drug use.
- Staff received no adequate training in dealing with ABI. There was no training on the codes of practice for the Mental Capacity Act or the Care Act.

- There was a reasonable Care Act assessment in 2017 however it was poorly/inadequately implemented. It should have been repeated annually, it was not.
- There was failure to deal with Mr Fitton's situation robustly.

In response we update you on the following which we are taking forward to support and develop good practice in these areas:

- While there is existing training on trauma available within the Local Authority we are actively considering the implementation of further specialised training on trauma, namely the PIE model (psychologically informed environments) which other areas of the Local Authority have found useful in terms of enhancing their systems and processes to better enable access and understanding.
- We will take forward the area of Social Work practitioner access to specialists when undertaking capacity assessments with people with new or historic ABI and/or when the specific brain impairment necessitates a specialist. We will explore a joint commissioning arrangement with health to agree a pathway for our health and adult social care practitioners to access.
- We will review our existing Mental Capacity Act (In Practice) training which includes the Code of Practice, and guidance on use of the Best Interests process and refresh the message on ensuring good practice of this. We will monitor practitioner take up of the training, percentage attended and those who have refreshed, and communicate with front line teams to ensure practitioners attend these and refresh regularly.
- We will review our Care Act training on offer and make any adjustments necessary to ensure that the key aspect of co-ordination in multi-agency work, and consideration of review, are refreshed features.
- We will ensure that our Safeguarding training contains additional focus on non-engagement in safeguarding adults responses to cover where this needs to be provided creatively between partner agencies (for example, as was the case with Mr Fitton, the person will not engage with the Local Authority Social Worker).
- We have designed and implemented a non-engagement policy within the directorate which is now live.
- We will ensure that the SAR action plan and your concerns are included in our Safeguarding Adults Governance, Quality Assurance and Performance groups
- We will develop a stand-alone training course on Mental Capacity Assessments and executive functioning/capacity
- We will continue to provide standalone training courses on Acquired Brain Injury and will encourage practitioner engagement in this training course as well as extending the content depth and duration.
- We will continue to provide training on self-neglect which references SAR outcomes and decision making

- We will continue to attend the police led multi agency cuckooing meeting and encourage increased awareness of this within our directorate and we will seek opportunities for wider learning from this meeting.
- We acknowledge the value of a specific expertise to support substance misuse casework in Health and Adult Social Care and will continue to encourage awareness and understanding of the importance of consulting relevant expert staff where appropriate.
- We will share these responses with our health partners in commissioning of services and specialist accommodation.
- We will provide monitoring and governance of these responses and actions through our Practice Development and Assurance Board within the directorate.
- We will work with our partners to finalise the Sussex wide SAB escalation and resolution policy which is being developed.
- We will review our internal risk management protocols for casework to strengthen our organisational oversight.
- We will request that all Learning and Development consultants are enabled within our Workforce Development Team to read SARs and ensure that lessons are incorporated into relevant training