VERONICA HAMILTON-DEELEY DL,
LL.B.
Her Majesty's Senior Coroner
for the City of Brighton & Hove

THE CORONER'S OFFICE
WOODVALE, LEWES ROAD
BRIGHTON
BN2 3QB

[redacted]

CORONERS SOCIETY OF ENGLAND AND WALES

ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	THIS REPORT IS BEING SENT TO: 1. **Brighton & Hove Health and Adult Social Care** [redacted] 2. **Brighton and Hove CCG/Sussex NHS Commissioner's** [redacted] 3. **Brighton & Hove Director of Housing** [redacted] 4. **Brighton & Hove Safer Communities Team** [redacted] 5. **Sussex Police – Care of** [redacted]
1	**CORONER** I am Veronica HAMILTON-DEELEY, Senior Coroner, for the City of Brighton & Hove
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 17th September 2019 I commenced an investigation into the death of KEVIN JOHN FITTON. The investigation concluded at the end of the inquest on 5th May 2021.The conclusion of the inquest was Drug related death/misadventure being myocardial infarction directly related to Spice use in circumstances where a failure to obtain an urgent echocardiogram on 12th July 2019 represented a missed opportunity to diagnose left ventricular hypertrophy and treat Mr Fitton in the High Dependency Unit. If the correct diagnosis had been made and if fluids had been administered in a more controlled way the outcome may have been different. The ongoing use of spice arose against a background of several years of ineffective care and support for stroke induced acquired brain injury causing self-neglect.

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4	**CIRCUMSTANCES OF THE DEATH** Kevin Fitton suffered a catastrophic stroke at the age of 33 in 2010. Prior to that he was a successful fit man enjoying his life in all respects. Following the stroke, although properly assessed by the leading neuropsychologist so that the damage was fully recognised, his ongoing care never reflected his needs. It was clear from the evidence that none of those providing that care understood the effects on him of his acquired brain injury. In particular during the nine plus years between the stroke and his death, Kevin's mental capacity was only assessed on three occasions, the last being in 2013 at the insistence of one of his sisters. His last Care Act Assessment in 2017 was incomplete and not followed through. His care was branded ineffective by the Independent Safeguarding Adult Reviewer. The main problems were his self-neglect, his almost daily use, latterly, of Spice and his vulnerability which meant he was taken advantage of by some members of the street homeless community. His Spice use took him to Accident and Emergency on several occasions in the last two to three years of his life. The final admission was on 12th July 2019. Kevin required fluid support, however, the precarious state of his heart was not identified (a requested echocardiogram was not carried out). He became fluid overloaded, had a cardiac arrest and died some 27 hours after being brought into Hospital by ambulance.
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: – (1) There was an almost complete reliance of 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. (2) There was a failure to seek specialist support regarding Acquired Brain Injury (ABI). (3) There was a failure to understand the way Mr Fitton's ABI impacted on his abilities. (4) There was a failure to understand how ABI impacted on Mr Fitton's substance use and vice versa. (5) Communication between the various teams and individuals were poor. (6) Lead and Co-ordination were lacking. (7) There was a failure to react to the deterioration in Mr Fitton's living conditions, his being cuckooed, the downward slide in his physical health and the increase in his drug use. (8) 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. (9) There was a reasonable Care Act Assessment in 2017 however it was

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	poorly/inadequately implemented. It should have been repeated annually – it was not. (10) There was a failure to deal with Mr Fitton's situation robustly.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you AND your organisation 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 19th July 2021. 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 Chief Coroner and to the following Interested Persons 1. Chief Coroner 2. Family of Mr Fitton 3. University Hospitals Sussex NHS Foundation Trust 4. Secretary of State for Health, Department of Health 5. [redacted] Chief Executive, NHS England 6. [redacted] 7. [redacted] at Brighton & Hove City Council 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 by the Chief Coroner.

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9	**Date:** 28th May 2021	**SIGNED BY:** V Hamilton Deeley **Senior Coroner Brighton and Hove**