CORONER'S OFFICE
DISTRICT OF HERTFORDSHIRE

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MR EDWARD G. THOMAS Senior Coroner
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25th July 2014

INTERNAL POST

John Wood
Chief Executive
Hertfordshire County Council
Peg Lane
Hertford
Hertforshire
SG13 3DY

Your Ref: t.b.a.
Our Ref: 00229-2014

Dear Mr Wood,

Re: Stephen Mark AMER, deceased

I am writing to you under the provisions of Schedule 5 (paragraph 7) of the Coroners & Justice Act 2009 which came into force in July 2013. This re-enacted the provisions of the old Rule 43 of the Coroners Rules 1984. Attached to this letter is information concerning the new rules and regulations from which you will see requires a written response. Copies of this letter and the response received from you will be forwarded to the other interested persons identified at the inquest in accordance with the list attached. I am also sending a copy of this letter to my contact at the Care Quality Commission and the University Hertfordshire Partnership NHS Trust who carried out a seven day review in connection to their previous contact with Stephen and with whom there had been discussions over this tragic incident.

On the 23rd July 2014, I concluded an inquest into the tragic death of Stephen Mark Amer who was born on the 4th January 1954 and had therefore reached 60yrs just before he died. Please find attached a copy of the Record of Inquest. Stephen had in fact been born at his home address; [redacted] and was the sole carer of his mother, retiring from him employment as a lorry driver some time previously. In January 2014 his mother was admitted to hospital and Stephen was taken by his family to the Accident & Emergency Department at the Lister Hospital where he was found to be malnourished and reported hearing a noise in his head. He was assessed both physically and mentally and was felt to be objectively and subjectively depressed. He was prescribed mirtazapine and to be seen by his doctor and for his family members to oversee his mother's care. Stephen was seen by his General Practitioner Dr Turner and saw him subsequently on the 16th January 2014 where he self reported as being very much better and well supported by his family and that the

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responsibility of caring for his 88yr old mother had been too much for him. There had been no previous reports of self-harm and he denied any ideation or intention of self-harm. Stephen's blood pressure was normal and it was the general opinion of all that he was making good progress.

A multi-disciplinary case conference had taken place at the Lister Hospital at which it was concluded that it was in [redacted] best interest to be cared for by residential assessment initially for respite. However the Social Worker reported subsequently that when [redacted] was seen on her own that she very much expressed the wish and desire to return home and to the Social Worker on her own expressed the view that she was not happy about going into residential care not withstanding that it appeared that she had accepted going into residential care when seen with the family. The assessment of the Social Worker was that [redacted] had capacity and therefore the provisions of the Mental Capacity Act and Deprivation of Liberty was not applicable. [redacted] and her son had never requested a full package of care but the Team Manager felt that [redacted] should be returned home with a full package of care to support [redacted] in her perceived wish to be at home and to support her carer, Stephen.

This decision was communicated to Stephen by telephone and shortly thereafterwards he took his own life. His body was discovered some two days after contact had been made.

A helpful investigation was carried out by [redacted] who gave evidence at the Inquest. I also was in receipt of a seven day report from the Hertfordshire University Partnership NHS Trust who had recommended that there should be liaison with Social Care concerning a protocol to share information concerning service users presenting with significant carer fatigue.

[redacted] informed that this protocol was underway and we discussed the issues of consent and how these matters should be communicated. At the Inquest it was debated as to whether it might be helpful:-

- To try and ensure that appropriate consents are always given from service users to enable those responsible for providing care to have full information to ensure the most appropriate care is provided. i.e. it would have been helpful for the Adult Care Team to have had Mr Amer's consent for them to have received the information from his General Practitioner and also the Hertfordshire University Partnership NHS Trust as to their assessment carried out at the Lister Hospital.

- If as in this case there is a change of plan that the full details of the plan should at least be in embryo form before the change of plan is given to the relevant person, in particular the carer.

- The manner of communication should be considered carefully. I would suspect that a face to face communication if possible would be more appropriate as it gives the ability for questions to be answered and full explanations given. It also enables those informing the decision to be able to gauge the reaction of the recipient of that information.

It would have been useful if the Adult Care Team had known the content of the Hertfordshire University Partnership NHS Trust assessment and the contact with the GP made on the 16th January 2014.

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I discussed the above with [redacted] and he indicated that he would be communicating some of these issues outside Hertfordshire and that is why I felt it appropriate

to write more formally as this letter is then made public through the helpful register kept by the Chief Coroner.

I hope therefore that my drawing your attention to this case and to some of the comments made during the Inquest will be helpful for you.

The schedule requires a response from you within 56 days of receipt which I calculate is the Friday 19th September 2014. Please let me know if there are difficulties in complying with this timescale or whether there is anything you wish to discuss. I am willing to extend the deadline if there is good reason to do so.

I look forward to receiving your views in due course.

Yours sincerely

Edward G Thomas
Senior Coroner