Kent and Medway NHS
Strategic Health Authority

REPORT INTO THE CARE AND TREATMENT OF

DARREN ROGERS

MAY 2003

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1. INTRODUCTION

1.1 On 8th October 1999 Darren Rogers fatally stabbed his girlfriend, Avril Hollens at her home in Tonbridge.

1.2 Darren Rogers was arrested at the scene, initially charged with murder and subsequently convicted at the Old Bailey of manslaughter. He was sentenced to 7 years imprisonment. Darren Rogers was 24 years old at the time of the incident and Avril Hollens was aged 22 years.

1.3 Darren Rogers' contact with the mental health services was limited to an assessment visit by a Community Psychiatric Nurse, accompanied by a colleague on 21st July 1999. This followed a referral of the Community Mental Health Team from Darren Rogers' General Practitioner who had been treating him for depression.

1.4 There had, however, been two visits to the Accident and Emergency Department at the Kent and Sussex Hospital following an overdose of paracetamol in July and in August 1999 after an incident when he made superficial self-inflicted cuts to his wrist.

1.5 Our inquiry has aimed to track and review Darren Rogers' care and treatment over that relatively short period of time. We have looked in particular at the linkage between services, the appropriateness of interventions and the service options available to meet Darren Rogers' needs. We have tried to identify any lessons that can be learned for the benefit of service users, their families, carers and staff in the future. The inquiry has also examined potential options for services for people at risk of suicide and of harming others.

1.6 We are grateful for the way in which most of the professionals involved in Darren Rogers' care and treatment have worked with us. Their candour, openness and commitment to providing the best possible service to local people was commendable. However, we were disappointed that key potential witnesses who have since left the NHS were not willing to talk to us.

1.7 The families of Darren Rogers and Avril Hollens were offered the opportunity to talk to the Inquiry Team or to submit their views in writing. They did not respond to our request.

1.8 We were though, able to gain an insight and perspective from Darren Rogers himself when we visited him in prison. This was most useful to the work of the Inquiry Team.

1.9 Last, but not least, we wish to thank Melanie Bloomfield for her considerable help, support and expertise in managing the process of the Inquiry.

1.10 Why an Inquiry was needed

1.10.1 In May 1994, National Health Service Guidelines were issued which require an "Independent Inquiry" to be held when a person in contact with mental health services commits homicide. In these circumstances the Acting Chief Executive of West Kent Health Authority and the Regional Office of the National Health Service agreed that a "small time limited" independent inquiry should be commissioned.

1.11 Terms of Reference

1. To provide a joint Health and Social Services overview of this case in relation to the Care Programme Approach.

2. To review the work of the Internal Inquiry from Invicta Community Care NHS Trust.

3. To look at the process of Mr Rogers' presenting at Accident and Emergency following suicide attempts and referral to the Deliberate Self Harm Team.

4. To understand the process of referral from Accident and Emergency staff to psychiatric services and make recommendations accordingly.

5. To look at the eligibility criteria in relation tot his case as the Internal Inquiry stated that he did not meet the criteria for Social Services.

6. To make any comments and recommendations in the light of the findings of the Inquiry.

1.12 Who Conducted the Inquiry?

The inquiry was undertaken by:

Malcolm Barnard (Chairman)	Former Area Director of Social Services and Senior NHS Manager.
Sarah Donlan	Social Worker and former Senior Social Services Manager.
Dr John Basson	Consultant Psychiatrist.

1.13 How the Inquiry was Conducted

1.13.1 Darren Rogers' permission for the release of his health and social services records was sought and given. All records relating to Darren Rogers were requested and received from the General Practitioner, Invicta Community Care NHS Trust, Maidstone and Tunbridge Wells NHS Trust and Kent County Council Social Services Directorate.

1.13.2 The Panel members reviewed records and documents including the Report of the Invicta Community Care NHS Trust Internal Inquiry, and drew up a list of key witnesses. A letter was sent to all potential witnesses (please see Appendix A) inviting them to attend a hearing and give verbal evidence. Witnesses were offered the opportunity to submit a written statement in addition to giving verbal evidence. A separate letter (please see Appendix B) was sent to the parents of Darren Rogers and Avril Hollens inviting them to give evidence if they wished. A list of witnesses is included as Appendix C.

2. DARREN ROGERS' CARE AND TREATMENT

2.1 History

2.1.1 Neither the Invicta Community Care NHS Trust Internal Inquiry Report nor Darren Rogers' medical records reveal any history of mental ill health. There were, however, some indicators in the past to suggest some vulnerability.

2.1.2 On 6th January 1993 a General Practitioner from the Tunbridge Wells and Tonbridge Doctors On-Call Services visited Darren and noted: "Can't control his anger and almost hit his mother with a knife and also hurled abuse at father and threatened him with a knife. Had a fight with brother and girlfriend did not give him Xmas presents. Episode of hyperventilation during Xmas. Smokes cannabis 1 year 2-3 times a week. Drinks once or twice a week lager? An evening. Tired needs to sleep? Needs to see a psychiatrist." Darren was advised to visit his General Practitioner at the surgery. The General

Practitioner notes on 7th January 1993 refer to the TTDOC slip and note "chat re cannabis". There is, however, no record of a discussion about cannabis or the events on 6th January at any subsequent consultations with his General Practitioner.

2.1.3 Darren saw his General Practitioner on 27 July 1993. He had attended with tension headache, but further questioning from the General Practitioner revealed "many poorly compensated stresses". Darren's parents had also contacted the General Practitioner on 2 August 1993, anxious about his behaviour at home. On several occasions he had become "verbally violent" and on one occasion physically violent towards his mother when he got "stressed out". The General Practitioner also noted Darren's concern that when stressed out he might lose control and seriously hurt someone.

2.1.4 The General Practitioner notes record an attendance at the Accident and Emergency Department on 3rd August 1993 when Darren was aged 17 years. The Accident and Emergency notes at the time indicate that he had attended as a result of an overdose of Anadin self poisoning. The Accident and Emergency doctor had a twenty-minute chat with Darren and his mother. The notes refer to a girlfriend two-timing him. He was referred back to his General Practitioner for follow-up.

2.1.5 On 4th August 1993, Dr Roger A Marson-Smith, then a General Practitioner trainee in the practice, referred Darren to Mrs J Bore, Senior Social Worker at Kent County Council Social Services Department. The General Practitioner sought advice from Mrs Bore for counselling and advice. Dr Marson-Smith comments in the referral letter: "if he is not redirected I should think he is going to pose a threat to the community". Dr Marson-Smith's referral letter was dictated the day before Darren's overdose.

2.1.6 Mrs Bore's response to the referral was swift. She saw Darren for an hour on 6th August 1993. In her letter to Dr Marson-Smith on 9th August 1993, Mrs Bore describes Darren's difficulties in finding effective ways of channelling his frustrations in any areas of his life, referring to tensions within the family, a "dead-end" job he disliked and a girlfriend now with another young man. The session was described as "fairly promising". Further appointments were made for 16th and 31st August 1993 to consider breaking down the problems into manageable steps for him to regain some control".

2.1.7 Darren was unable to stay for his appointment on 16th August and did not keep his appointment on 31st August 1993. A further appointment was offered for 23rd September 1993, but again he did not attend. Mrs Bore saw Darren at a re-arranged appointment

on 1st October when he claimed to have no problems as described in the referral. Mrs Bore noted that there was no way he was motivated to work with her and closed the case.

2.1.8 Further attendances at Accident and Emergency are noted on 8th July 1994 having taken alcohol and ecstasy when Darren did not wait for treatment, and on 15th June 1995, as a result of an alleged assault. On this occasion Darren was examined and discharged home with advice but no treatment.

2.1.9 The General Practitioner on-call service notes record telephone advice given on 14th January 1997 concerning a cut eye with advice to attend Accident and Emergency and wait for treatment. Darren had in fact attended Accident and Emergency, but had not waited for treatment.

2.1.10 On 24th January 1998, Darren attended Accident and Emergency having been assaulted. He had been hit on the jaw with a heavy object. He received further treatment at the Queen Victoria Hospital, East Grinstead having sustained a fractured mandible.

Comment

2.1.11 The history from 1993 provides a picture of a vulnerable young man. Concerns until his visits to Accident and Emergency in 1999 had been intermittent, but the events of 6th January 1993 when Darren threatened his parents with a knife do now appear with hindsight to be significant. It is unfortunate that there was no follow up by his General Practitioner to the suggestions by the On-Call Service doctor that he might need to see a psychiatrist. It is, however, not at all certain that Darren would have agreed to such a referral.

2.1.12 Dr Marson-Smith's referral of Darren to Mrs Bore in August 1993 appears to us to have been entirely appropriate. His reference to Darren as potentially posing a threat to the community can now be seen as prophetic. Mrs Bore's response was swift and appropriate and, given Darren's unwillingness to work with her, it seems she could do little else than close the case.

2.2 Accident and Emergency

2.2.1 Darren Rogers attended the Accident and Emergency Department twice in 1999, on 19th July and 21st August.

2.2.2 We had the benefit of a comprehensive report prepared for us by Dr Julian Webb, Consultant at the Accident and Emergency Department, Kent & Sussex Hospital, covering Darren's attendances in 1997, 1998 and 1999. The report also dealt with the identification of the patient as Darren Rogers (there were some differences in the hospital numbers, date of birth, address, and name of General Practitioner between some of the attendances). In addition Dr Webb's report outlined the Accident and Emergency Department's policy regarding patients presenting with Deliberate Self Harm, medical education with respect to deliberate self-harm, nursing education and computer records.

2.2.3 In verbal evidence to the Inquiry Dr Webb commented that both members of the Deliberate Self Harm Team, David Foster-Smith and Mary Stewart-Smith were well respected, experienced and very good at their jobs. They had a good relationship with the Accident and Emergency Team.

2.2.4 Dr Webb outlined the key aspects of Darren Rogers' attendance on 19th July 1999. Darren told the Triage nurse that he had taken 19 distalgesic tablets, together with 8 paracetamol tablets. He was seen by the duty Senior House Office who filled in a SAD person's score form in accordance with normal procedures. He was transferred to the Observation Ward and initially started on parvolex infusion due to the amount of paracetamol he had taken. However, this was discontinued when the levels were found to be satisfactory. Darren took his own discharge the next day, having signed a "discharge form against medical advice". Dr Webb told us that the notes clearly found their way to the Deliberate Self Harm Team via the set procedure because the notes indicate on 20th July 1999 "DSH 'Hello' letter sent" and David Foster-Smith had signed this. Dr Webb was also able to explain to us the communication system by which the Deliberate Self Harm Team were notified of patients in need of their support. This is explored in more detail in paragraphs 2.4.2 and 2.4.5 below.

2.2.5 On 21st August 1999, Darren Rogers presented at the Accident and Emergency Department with a laceration to the right wrist. Dr Webb explained that Darren had given a history of being depressed and having cut his wrist twice with a Stanley knife. He had disagreed with his partner and wanted to "escape". On this occasion Darren was not keen to enter the Accident and Emergency Department although he did

eventually agree to have the wound dressed. At this stage, Darren is recorded to have said "not to bother because it will not be worth it". He further explained that he had two children, whom his partner would not let him see. The Triage nurse asked Darren whether he felt suicidal and did he want to kill himself. Darren replied "no" but he wanted to get away from Tonbridge for a "break". He took his discharge from the Department against the advice of the Senior Sister who subsequently informed the police. Darren's father also rang the Accident and Emergency Department to find out what happened. On this occasion, Deliberate Self Harm Team were not informed, but Dr Webb believed that David Foster-Smith had later spotted that Darren had been in the Department during a trawl of the computer log. This is explored further in paragraph 2.4.5 below.

2.2.6 Dr Webb agreed with the Inquiry Panel that the Deliberate Self Harm Team should have been told about Darren's visit to Accident and Emergency on 21st August. He added that the Accident and Emergency nurse involved was very experienced and, from what she had written in the notes, she was concerned enough to ask Darren whether he was feeling suicidal. Dr Webb suspected that the nurse had been interrupted before she could put the card into the Deliberate Self Harm Team's basket, adding that it was fortunate that the attendance had been picked up shortly after via the trawl of records.

2.2.7 Dr Webb confirmed that General Practitioners are routinely informed if one of their patients attends Accident and Emergency. A letter would be automatically generated on discharge. However, this was difficult in respect of Darren's attendance on 19th July 1999 when the records indicate the General Practitioner as "Etkin, Ticehurst House". (This is not the name of a General Practitioner and neither Dr Webb, nor Darren Rogers were able to explain why this name was shown. Enquiries at Ticehurst House, a relatively local private Psychiatric Unit, confirmed that Darren Rogers was not known to them.) We have to assume, therefore, that this name was included in error. For the attendance on 21st August 1999, the General Practitioner's name is recorded as "unknown".

2.2.8 We noted that the Accident and Emergency records gave a more complete picture of Darren's history than his General Practitioner records. Dr Webb confirmed that the Accident and Emergency Department was rarely contacted, for example, by mental health services for a patient's previous history. He added that the Deliberate Self Harm Team did have access to Accident and Emergency records, which was one of the advantages of them being based in Accident and Emergency.

2.2.9 Dr Webb concluded by saying that he believed that there was nothing in the records that would have made him feel that Darren Rogers' case should have been followed up more vigorously than anyone else with a similar presentation.

Comment

2.2.10 We were concerned about the failure to inform the Deliberate Self Harm Team of Darren's attendance in August 1999 and return to this question in the Sub Section 2.4 "Deliberate Self Harm Team" – below.

2.2.11 Whilst understanding the considerable pressure under which staff in Accident and Emergency are working we are also concerned that, as Darren's General Practitioner's name was not recorded, details of his attendances were not passed to his General Practitioner and an opportunity for possible intervention was therefore lost. Darren saw his General Practitioner on 20th July 1999, but the General Practitioner was unaware of the visit to Accident and Emergency.

2.2.12 In other respects, however, Darren Rogers' treatment at the Accident and Emergency Department appears to have been efficient, effective and appropriate.

Recommendation

2.2.13 The Accident and Emergency Department should remind staff of the need to elicit whenever possible accurate information on the name and address of the patient's General Practitioner so that follow up letters can be generated.

2.3 An Overview of Involvement with the Community Mental Health Services

2.3.1 Darren Rogers' first and only direct contact with the specialist mental health services was on 21st July 1999 when he was visited at home by Anna Adams, Community Psychiatric Nurse with her colleague Sita Sui, also a Community Psychiatric Nurse. Both were members of Tonbridge Community Mental Health Team.

2.3.2 He had been referred to the Community Mental Health Team by telephone by his General Practitioner, Dr Goozee, on 20th July 1999. Darren Rogers had visited Dr

Goozee on 20th July 1999 and the consultation notes describe Darren as "distressed". The notes referred to a recent split from his girlfriend and concerns that he won't see his children. Worries over housing were mentioned. Darren was noted to be very upset and crying. Dr Goozee recorded a long discussion with Darren and his parents and notes that Darren had "some suicidal ideas". Fluoxalite 20 mg was prescribed. No mention is made in the notes of Darren Rogers having taken an overdose of paracetamol and co-proximal the previous day, nor of his attendance at the Accident and Emergency Department on 19th July 1999 at the Kent and Sussex Hospital, his overnight stay for observation and his self discharge at 09:10 hours on 20th July 1999.

2.3.3 At the home visit on 21st July 1999, Anna Adams found that Darren related a history of untreated depression, worsening over the previous month. He felt he had been depressed for the past five years on and off. He had anger management problems with more frequent verbal outbursts, but denied any physical violence towards his girlfriend or children. Darren and his girlfriend, Avril, had argued on Friday 18th July and the following day he returned to an empty house and a letter from Avril saying she had left him. He impulsively overdosed on tablets he found in the house and rang his mother to say "good bye". Darren denied any current suicidal thoughts at the time of the visit. Anna Adams advised Darren to continue with his medication; find out his rights regarding his housing tenancy at the Citizens' Advice Bureau and to sort out access to the children with his girlfriend.

2.3.4 On 22nd July 1999 Darren was discussed at a meeting of the Tonbridge Community Mental Health Team. Anna Adams requested a Social Work Assessment but this was not felt appropriate by the Senior Practitioner (from Social Services), as Darren did not meet the Care Management eligibility criteria. It was, however, suggested that Darren could be advised to contact the Bridge Trust Advice Centre concerning his housing problem.

2.3.5 Mrs Adams contacted Darren by telephone on 23rd July 1999 with this advice, but later that day received what was recorded as an "abusive" telephone call from Darren's father complaining that the Bridge Centre were unhelpful. This was followed by a further abusive call from Darren fifteen minutes later. Anna Adams left Darren Rogers' file open, although recording doubt about whether he would engage with the service.

2.3.6 On 10th September 1999, there having been no further contact for Darren, his case was closed.

2.4 Deliberate Self Harm Team (DSHT)

2.4.1 We were particularly interested in the actual and potential role of the Deliberate Self Harm Team in Darren Rogers' care and treatment. We were therefore pleased to receive both written statements and verbal evidence from the two members of the Deliberate Self Harm Team based at the Accident and Emergency Department at Kent and Sussex Hospital, Mary Stewart-Smith and David Foster-Smith.

2.4.2 The Invicta Community Care NHS Trust Internal Inquiry Report indicated that the Deliberate Self Harm Team had no record of being contacted by Accident and Emergency after Darren's two self-harm attempts in 1999. However, both Dr Webb and Mr Foster-Smith were able to confirm that the agreed procedure had been followed in Accident and Emergency in respect of Darren's first attendance. That is the Accident and Emergency card had been placed in the Deliberate Self Harm Team basket and this had been followed up with a "hello" letter sent to Darren on 20th July 1999.

A copy of the "hello" letter is included as Appendix D.

This letter invites patients attending Accident and Emergency who are not seen by the Deliberate Self Harm Team or duty psychiatrist to make contact with the Deliberate Self Harm Team. It was not usual practice to follow up every "hello" letter although Mary Stewart-Smith told us that if they were particularly worried about someone, they would follow up with a telephone call.

2.4.3 The second attendance at Accident and Emergency with cuts to the wrist was not followed with a referral to the Deliberate Self Harm Team. On this occasion the procedure to put the Accident and Emergency card in the Deliberate Self Harm Team basket was not followed. We return to issues of resourcing, support and organisation of Deliberate Self Harm Teams in paragraphs [numbers] below.

Comment

2.4.4 This was an unfortunate lapse because a second "self harm" attendance within such a short time would, as Mary Stewart-Smith told us, have been the cause of

more concern and perhaps triggered contact with the Community Mental Health Team and Darren.

2.4.5 However, Darren's attendance on 21st August 1999 was picked up when David Foster-Smith did a trawl of Accident and Emergency records on 23rd August. (Such trawls were ideally carried out weekly, but in practice could only be managed fortnightly.) He remembered telephoning Tonbridge Community Mental Health Team as a result of this, indicating to us that this would have been a routine call sometime during the week of 23rd August to ask whether the Community Mental Health Team knew Darren Rogers. Unfortunately, Mr Foster-Smith could not remember to whom he spoke and this contact is not noted in the Community Mental Health Team records.

2.4.6 David Foster-Smith told us that he would not have realised that Darren had attended Accident and Emergency before, until he came to file his copy of the Accident and Emergency record.

Comment

2.4.7 *It is commendable that such a "double-check" process was in place but of concern that support for the Deliberate Self Harm Team was not adequate for weekly trawls of records. Concerns about adequacy of policy and procedures, communications with Community Mental Health Teams and difficulty in tying together information on different Accident and Emergency attendance episodes are also addressed in Section 4 below.*

2.4.8 *Issues identified concerning the strategic context and framework for services for people who self harm or attempt suicide are considered further in Section 4 of this report. That section also discusses the resourcing, organisation and administrative systems support for Deliberate Self Harm Teams.*

2.5 The Community Mental Health Team

2.5.1 It is unfortunate that Anna Adams, the Community Psychiatric Nurse who visited Darren Rogers at home on 21st July 1999 was not willing to meet us or to provide written evidence to the Inquiry. Ms Adams has left the employment of the Invicta Community Care NHS Trust. Ms Adams' immediate manager at the time, Mr Nand Seeboruth, Service Manager, has also left the Trust and was not willing to provide evidence. We

were reliant on the Community Mental Health Team records, General Practitioner and Accident and Emergency records and the Invicta Community Care NHS Trust's Internal Inquiry Report to review the role of the Community Mental Health Team in Darren Rogers' care and treatment.

2.5.2 However, we did have the benefit of hearing from Sita Sui, the Community Psychiatric Nurse who accompanied Ms Adams on the home visit. Dr Rosalind Oliver, the Consultant Psychiatrist in the Community Mental Health Team at the time, provided us with useful information about how the Team operated. Tim Arnold, Senior Practitioner from Kent County Council Social Services was able to give us his perspective, particularly relating to communications and eligibility criteria for care management and the Care Programme Approach.

2.5.3 Darren's General Practitioner, Dr Goozee made an urgent telephone referral to the Tonbridge Community Mental Health Team (CMHT) on 20th July 1999. The referral is incorrectly described as non-urgent in the Internal Inquiry Report. It is marked as "Telephone Referral (urgent)" in the notes. The referral was taken by Mr Nand Seeboruth, Service Manager, who contacted Darren by telephone and ascertained that he had no further suicide intentions, had support from his friends and family and had the Community Mental Health Team contact number. Mr Seeboruth formed the view that there was no need for a visit that day, but that contact would be made with a view to assessment.

2.5.4 Anna Adams agreed to undertake the assessment. She contacted the Deliberate Self Harm Team and was advised by Mary Stewart-Smith not to visit Darren alone at home due to the risk of violence. Ms Adams' notes of the telephone call to the Deliberate Self Harm Team indicates indicates "high risk – Mary said parents sitting on him. She thought GP should admit to hospital. Called parents from his flat – semi comatose and very concerned". This implies some early knowledge of Darren's attendance at Accident and Emergency by Mary Stewart-Smith, but she told us she had little recollection of Darren at this stage but may well have given general advice on potential violence and safety.

2.5.5 Ms Adams contacted Darren by telephone on the morning of 21st July 1999 and ascertained that he was unable to come to the unit for an appointment as he would not leave the house, fearing that his girlfriend would come and take his belongings.

Arrangements were therefore made for Anna Adams and Sita Sui to visit Darren at home later that morning.

2.5.6 A full assessment of the presenting problems was made. These included having too many commitments at such a young age, working long hours – six days a week, drifting apart from his girlfriend who had recently left him, poor anger management for years, depression and mounting debts.

2.5.7 The assessment summary indicated that Darren was depressed, but not currently suicidal and recommended "crisis intervention" and "direct to housing/CAB for advice re accommodation". The Action Plan was to "re-contact this week" and "refer to Social Services for Care Management Assessment/advice re housing/CAB".

Comment

2.5.8 The assessment undertaken by Anna Adams appears to have been a timely, comprehensive and well recorded.

2.5.9 Sita Sui accompanied Anna Adams. She had attended as an observer, principally because of advice received for Mrs Stewart-Smith not to undertaken the visit alone. The two Community Psychiatric Nurses had informed their manager of the time and location of the visit. Sita Sui was able to tell us how the assessment had gone. She had observed Darren to be polite and show self-control and described for us the process of taking assessments back to the multi-disciplinary Community Mental Health Team for further discussion. Sita Sui told us that, at the time, there was no formal risk assessment process or documentation. Dr Oliver and Mr Arnold also confirmed this. It was, however, normal practice for risk to be assessed at initial assessment and Ms Sui confirmed that this had happened on 21st July 1999.

2.5.10 On the afternoon of 21st July 1999. Darren telephoned concerning housing and was advised by Anna Adams to contact the Citizens' Advice Bureau.

2.5.11 On 22nd July 1999, the case was discussed at a meeting of the Community Mental Health Team. A Social Work assessment was requested but denied according to Anna Adams' notes, because Darren did not meet care management criteria. It was, however, agreed that Ms Adams should refer Darren to the Bridge Trust (a local voluntary organisation) for housing advice and support. Dr Oliver had not been present at the

Community Mental Health Team meeting that day, but explained for us the process of discussing initial assessments, confirming that the Team did not always accept decisions or recommendations made by the staff carrying out the initial assessments. Dr Oliver also confirmed that if a Community Psychiatric Nurse needed a psychiatrist's involvement, they would ask. She was also able to inform us that whilst she would not take responsibility as Responsible Medical Officer (RMO) for anyone she had not seen, she would see all patients who had been referred to her by name by General Practitioners.

2.5.12 Anna Adams telephoned Darren on 23rd July 1999 and advised him to go to the Bridge Trust that day. She also advised contact with the Citizens' Advice Bureau. Later the same day, telephone calls described in the notes as "abusive" were received from Darren's father and Darren. Both had been angry about the response from the Bridge Trust. Darren indicated that there was no point in seeing Anna Adams again. Ms Adams left it open for Darren to contact her again if needed. She notes that she discussed the position with Tim Arnold, Social Worker.

2.5.13 The final entry in the Community Mental Health Team notes, again signed by Ms Adams, indicates no further contact and discharge.

2.5.14 We asked Tim Arnold, Senior Practitioner Kent County Council Social Services Department, about the concerns raised by the Invicta Community Care NHS Trust Internal Inquiry regarding eligibility for care management. Mr Arnold told us he was not present at the Community Mental Health Team meeting on 22nd July 1999. The referral to Social Services had taken the form of Anna Adams talking to one of Mr Arnold's colleagues who completed a form SS1 (the Social Services referral form). Mr Arnold decided to speak to Ms Adams and he recalled that they discussed whether a social work assessment was needed. After their discussions, Anna Adams agreed that she would look into the accommodation and debt issues. Mr Arnold advised her about the local housing association and homeless trust, and the Citizens' Advice Bureau for the debt problems. Mr Arnold's view was that these actions could be pursued on the basis of Ms Adams comprehensive assessment without the need for an additional Social Work Assessment. He added that the decision not to do a social work assessment was based on the Community Mental Health Team assessment already undertaken by the Community Psychiatric Nurse who had formed a view about the applicability of the Care Programme Approach and therefore about care management. We return to issues concerning the Care Programme Approach in paragraphs 5.3 and 5.10 below. Mr

Arnold saw nothing remarkable or exceptional in the way this case was handled. It was quite normal for two professionals to have such discussions and reach such conclusions.

2.5.15 The Invicta Community Care NHS Trust Internal Inquiry Report in its conclusions states:

"We are extremely concerned about the carrying out of the Social Services assessment as the responses from Sita Sui and Anna Adams indicate that the decision of whether DR would receive support from the Social Services staff at Dry Hill Road appears to have been decided without an assessment. We would suggest that West Kent Health Authority raise this matter with the appropriate Social Services Department as a matter of urgency."

2.5.16 Mr Arnold had not been invited to talk to the Internal Inquiry Panel. Mr Arnold's manager at the time, Paul Fisher, Service Manager, told us that he had heard indirectly about criticisms of social services in the Internal Inquiry report and had written to the Kent County Council Operational Manager, James Sinclair, complaining about the lack of an opportunity to offer the social services perspective.

Comment

2.5.17 We were somewhat surprised that in a service where operational integration of health and social care had made substantial progress, the Trust chose to restrict the Internal Inquiry to "health" staff only. The opportunity to hear, as we did, the basis on which the decision not to undertake a social work assessment should have eased the concern of the Internal Inquiry Panel. Our view is that Anna Adams' assessment was very thorough. The decision not to arrange a separate social services assessment was made properly s a result of a discussion between two professionals and within the structures of eligibility criteria in place at the time. Paper work to support the decision was satisfactorily completed.

3. DARREN ROGERS' PERSPECTIVE

3.1 In giving permission for the release of his medical and social services records to the Inquiry Team, Darren Rogers indicated that he wished to speak to us. We were grateful to the Prison Service for agreeing to our request to visit Darren.

3.2 Darren told us that he felt let down by his General Practitioner who had prescribed Prozac when he had really wanted someone to talk to. He felt that the Prozac made him feel worse and might have contributed to his violent outburst. He commented that it was a shame there was no counsellor for him to see at the time when he visited his General Practitioner's surgery.

3.3 He described the reaction of one of the nurses at Accident and Emergency on his second visit (on 21st August 1999, when he cut himself with a Stanley knife) as "negative". In addition, Darren felt that a "diplomatic approach" offering the opportunity to talk to someone in Accident and Emergency or the ward at the time of the incident, would have been more appropriate.

3.4 He could not explain how Dr Etkin had appeared as his General Practitioner on the Accident and Emergency record. He had not heard of Dr Etkin and did not know where Ticehurst House was.

3.5 Darren described Anna Adams' visit on 21st July 1999 as "not good". He felt that there was not a good rapport, and told us that Anna Adams was abrupt and so was he! He had not felt comfortable enough to tell Anna Adams that he needed someone to talk to. Darren's recollection was that he described his main problem as housing and the Community Psychiatric Nurse said he could go to a hostel. He had also discussed his many troubles. He recalled telling Anna Adams that he was working seven days a week with lots of travelling and he needed a break.

3.6 Darren did not think the Community Mental Health Team were the appropriate people to provide support or to meet his needs. He knew he had problems, but told us that his reaction when visited by "mental health workers" was, at the time, "I'm not mental, bye bye, close the door".

3.7 In prison, Darren now talks to the Chaplain, a Psychologist, a bereavement counsellor and friends. He described to us how he used to feel as if in a pressure cooker, but now understands the valves needed to turn the pressure off.

3.8 When asked what sort of services he may have felt able to respond to, Darren replied:

- A diplomatic approach from the Deliberate Self Harm Team (we had explained their role to him. He had no recollection of their "hello letter".)

- Awareness by professionals of the side effects of Prozac (referring to the risk of violence).

- Being able to talk to someone.

He saw the main need as for Primary Care based counselling and for counselling in Accident and Emergency or the hospital ward at the time. He also identified (in the light of his experiences of talking in prison) the need for continuity and trust. He told us "people have got to be trained properly to take the right approach."

Comment

3.9 *It was most helpful to have a perspective from Darren. His view of his General Practitioner's support, whilst understandable, is not backed up by the evidence. Dr Goozee, who did not know Darren well, had in fact not only prescribed Prozac, but had also talked to Darren and his parents for some time on 20th July 1999. In addition, he had made a thorough record of Darren's visit to the surgery and made an urgent telephone referral to the Community Mental Health Team. In the circumstances, this seemed an appropriate response from Dr Goozee.*

3.10 *We return to the issues around the timeliness of response (someone to talk to) in Accident and Emergency or on hospital wards in Section 4 below.*

3.11 *Darren's view of the intervention by the Community Mental Health Team was of particular interest. It appears that in July and August 1999, Darren may well have been unwilling or unready to talk to anyone about his feelings. Nevertheless, the reaction of a young man experiencing difficulties as Darren was, to an offer of help from "mental health" services, was not untypical. This says much about the remaining stigma in society around mental illness, but also raises questions about the appropriateness of the involvement of specialist mental health services in responding to the needs of people like Darren who self harm (and are potentially a risk to others), but who do not have a severe or enduring mental illness. These issues are dealt with further in Section 4 below.*

4. MEETING THE NEEDS – A STRATEGIC AND CO-ORDINATED APPROACH

4.1 Overview

4.1.1 At the time of Darren's attendance at Accident and Emergency in 1999, the Deliberate Self Harm Team at the Kent and Sussex Hospital was able to offer follow up appointments. The effectiveness of follow up is supported by research and evidence (please see paragraph 4.5.2). Liaison psychiatry arrangements at the Kent and Sussex were in place but lacked any guaranteed sessional availability (except for an hour each fortnight to meet with the Deliberate Self Harm Team). The availability of the liaison psychiatrist was also affected by the need for the Registrar to cover for his Consultant and by pressures of other psychiatric work.

4.1.2 We are concerned that the service response to Darren Rogers' needs was not in the context of a well-defined strategy within West Kent for services to support people who present at Accident and Emergency Departments or at their General Practitioner's surgery in distress, self-harming or as a potential risk to other people. Such a strategy does not exist. This position is not confined to West Kent. We would have found the same lack of strategy in many parts of the country.

4.1.3 Any strategy should clearly define the respective roles of Deliberate Self Harm Teams, Counselling in Primary Health Care and Specialist Mental Health Services, particularly Community Mental Health Teams.

4.1.4 The opportunity now exists to develop a Kent-wide Strategy, building on the work already well underway to operate an agreed Model of Care for Adult Secondary Mental Health Services. In its present draft form the model describes links to Primary Care level services, but does not specifically deal with services for people who self harm. (Except for a reference to Accident and Emergency liaison and/or Deliberate Self Harm work and a recognition that "more work is needed to refine the model of care in this respect").

4.1.5 Such a strategy would also be informed or guided by the Mental Health National Service Framework, the NHS Plan and the National "Confidential Inquiry into Suicide and Homicide by People with Mental Illness".

Recommendation

4.1.6 **We recommend that the new Kent Strategic Health Authority, lead Primary Care Trust(s) for commissioning Mental Health Services and the new Health and Social Care Trusts for Mental Health Services in Kent should jointly commission work as soon as possible to develop a Kent-wide strategy for the provision of consistent services for people who self harm and/or attempt suicide.**

4.2 Strategic Framework for Service Response

4.2.1 It is important that all the components of a comprehensive service for people who self-harm or attempt suicide are identified. Not all people will need all services, but General Practitioners, Counsellors, mental health professionals, social services staff and voluntary organisations, including service users and carers should all have access to a clear picture of the services and resources available within the locality and how to contact them.

4.2.2 All the component parts of the service should link together when they need to. Care pathways for people who self-harm and/or attempt suicide should be identified. This will require good communications between Hospitals (mainly via Accident and Emergency Departments), General Practitioner practices and the Specialist Mental Services in the locality.

4.2.3 The development of a strategy for services for people who self-harm and/or attempt suicide should be seen as a subset of a Kent Strategy for the Prevention of Suicide. Such a prevention strategy would be based on the helpful advice and references included with the Mental Health National Service Framework specifically on preventing suicide.

4.2.4 The NSF states "it is essential that people who have self harmed receive a specialist psychosocial assessment before discharge, preferably performed by a mental health nurse or other professional who knows local services and can arrange speedy follow up and appropriate support".

Comment

4.2.5 *We would strongly endorse that statement. However, services in West Kent and most of the rest of the country remain some way short of that standard at present. There are significant variations in the organisation of such assessments in different hospitals in West Kent. It is clearly not possible for the two professionals in the Deliberate Self Harm Team at the Kent and Sussex Hospital to provide a twenty four hour, seven days a week assessment service and liaison psychiatry arrangement appear to be patchy.*

Recommendation

4.2.6 **The strategy should include a requirement for clear standards for the pre-discharge (from Accident and Emergency or acute hospital inpatient wards) psychosocial assessment of people who self harm.**

4.2.7 **The strategy should provide for a directory of resources to be produced and disseminated to all relevant professionals, agencies, user and carer groups and voluntary organisations in each locality.**

4.3 Referral Procedures

4.3.1 The criteria for referral to the Deliberate Self Harm Team by Accident and Emergency staff at the Kent and Sussex Hospital appear to be well established and understood. The service may nonetheless benefit from re-documenting these criteria, re-issuing them to all staff and keeping them easily accessible within the Department for staff to refer to.

4.3.2 The means of communicating such referrals within Accident and Emergency needs to be reviewed. The present system relies on the Accident and Emergency card (referring to the patient's attendance) being placed in the Deliberate Self Harm in-tray by a member of the Accident and Emergency staff. The system is simple, but not always reliable. On 21st August 1999, Darren Rogers' Accident and Emergency card was not placed in the Deliberate Self Harm Team in-tray. It appears that the nurse responsible may have been busy and distracted at the time. On this occasion, the "safety net" system of trawling the computer records did work when Darren's attendance was identified on 23rd August. The fact that the trawl happened only two days after the attendance was, however, a matter of luck as Deliberate Self Harm Team resources only allow such trawls to happen fortnightly.

Recommendation

4.3.3 **We recommend that the Kent and Sussex Hospital Accident and Emergency Department and the NHS Trust responsible for the Deliberate Self Harm Team jointly review the means of communicating referrals from Accident and Emergency to the Deliberate Self Harm Team and pay particular attention to the administrative support to the Deliberate Self Harm Team. This would enable more effective use of the computer system to track attendance of patients who self harm.**

4.3.4 **Subject to appropriate protocols concerning confidentiality, systems to enable crosschecking of records between Accident and Emergency, Deliberate Self Harm Teams, Community Mental Health Teams, and General Practitioners should be developed.**

4.4 Assessment

4.4.1 Assessment of Darren's needs by the Deliberate Self Harm Team was not possible at the time of his attendances at Accident and Emergency in July and August 1999. This was because the Deliberate Self Harm Team can only operate during "office hours" and both attendances were in the evening. There is no way of knowing whether the offer of such an assessment would have been accepted by Darren at the time anyway.

4.4.2 As we have already indicated, the assessment carried out by Anna Adams, Community Psychiatric Nurse, on 21st July 1999 was thorough and professional. However, we have also commented on Darren's reluctance to be involved with "mental health services". This raises questions about whether an assessment by the Community Mental Health Team was the most appropriate intervention for Darren.

4.4.3 Our view is that if the Deliberate Self Harm Team had adequate resources and was appropriately organised and supported, then assessment by a member of that team might well have been more appropriate and acceptable. Knowledge by the Deliberate Self Harm Team of other local resources (including the Community Mental Health Team if severe and enduring mental illness is suspected) could place them at the centre of a local assessment service for people who self harm. Incorporating hospital liaison

psychiatrists with Deliberate Self Harm Teams in each Accident and Emergency Department would also help to facilitate timely assessment. An average of 24 people a week presented at the Accident and Emergency Department at the Kent and Sussex Hospital following deliberate self harm from April 2000 to March 2001.

Recommendation

4.4.4 **We recommend that adequately resourced Deliberate Self Harm Teams based in each Accident and Emergency Department should be at the centre of future assessment arrangements.**

4.5 Options for Follow-up Intervention

4.5.1 Timely appropriate and acceptable assessment alone is unlikely to be sufficient for many people who self-harm. Adequate arrangements for follow-up will also be needed. We heard from Mary Stewart-Smith and David Foster-Smith that the Deliberate Self Harm Team at Kent and Sussex Hospital had, in the past, been able to offer 6-8 sessions per patient follow-up, including home visits if appropriate. They were, however, now unable to offer this follow-up service because of the workload for just two team members. People who need follow-up are now referred to the Community Mental Health Team. Visits and follow ups have been re-instituted from January 2002 but at a reduced rate from previously. David Foster-Smith was also concerned that referral to the Community Mental Health Team of people who do not have a severe and enduring mental illness leads only to an initial assessment with no follow-up on offer as was the case with Darren Rogers.

4.5.2 Recent evidence from the School of Psychiatry and Behavioural Sciences, University of Manchester (BMJ 325 21.7.01) shows that compared with the usual treatment, four sessions of psychodynamic interpersonal therapy reduced suicidal ideation and self reported attempts of self harm. The study, a randomised controlled trial conducted at the Accident and Emergency Department of the Manchester Royal Infirmary and with the actual involvement of members of the Deliberate Self Harm Team at the hospital This most recent study adds to a small body of evidence supporting the use of psychosocial and/or psychodynamic treatment, to prevent reoccurrence including Hawton K et al (Oxford) (BMJ 1998 317.441-7). A literature search, however, confirmed the need for more research nationally on the effectiveness of interventions for people who self harm.

A national survey of the hospital services for the management of adult deliberate self harm (Slinn et al, Psychiatric Bulletin (2001) 25:53-55) concludes that standards for deliberate self harm services in England fall substantially below existing national guidelines, particularly in the areas of planning and training.

Comment

4.5.3 *The options for follow-up intervention to help, support or treat people who attend Accident and Emergency Departments having harmed themselves, appear to be poorly defined. The Deliberate Self Harm Team at the Kent and Sussex Hospital provided the only follow-up resource specifically for people who self harm in West Kent. No other Accident and Emergency Department in West Kent provides such a service, although some may access services via liaison psychiatrists.*

4.5.4 *It is therefore often left to General Practitioners to identify the need for follow-up with their patients who have attended Accident and Emergency. This is a "hit and miss" approach. General Practitioners may not know about the attendance at Accident and Emergency if the patient has not given their General Practitioner's name (as with Darren Rogers) or does not have a General Practitioner. The patient may not see the General Practitioner after discharge from Accident and Emergency and many General Practitioners may not have the resources to pro-actively follow-up letters from Accident and Emergency regarding self harm with a request for an urgent visit by the patient to the General Practitioner's surgery.*

4.5.5 *When the General Practitioner does have the opportunity to follow-up, the response is likely to be "patchy". If the practice employs a counsellor, then it may be possible to refer the patient for urgent counselling. Many counsellors in primary care teams, however, have waiting lists of patients referred to see them.*

4.5.6 *The General Practitioner may refer patients to Community Mental Health Teams either because they suspect a severe and enduring mental illness or because there is no other alternative, e.g. primary care or other counselling service available.*

Recommendation

4.5.7 **A more strategic approach to the provision of an appropriate range of follow-up options is needed.**

4.5.8 **We recommend that the Strategic Health Authority/lead Primary Care Trust for mental health services/Mental Health and Social Care Trusts jointly commission further work to consider basing the co-ordination of assessment and initial follow-up services with adequately resourced Deliberate Self Harms based in each Accident and Emergency Department. Consideration should be given to the evaluation of follow up services when established.**

4.5.9 **The proposed Kent-wide strategy for services for people who self-harm should dovetail with the Kent model of care for adult secondary mental health services and with national initiatives to introduce primary care mental health workers.**

4.6 The Role of the Deliberate Self Harm Teams – Limitations and Potential

4.6.1 Dr Rosalind Oliver kindly shared with us a discussion document she submitted to the Thames Gateway NHS Trust in June 2001. This compared Deliberate Self Harm/Liaison Psychiatry arrangements at Kent and Sussex Hospital, Maidstone Hospital, Darenth Valley Hospital and Medway Hospital and outlined the advantages and disadvantages of each service. The paper confirmed our view that the current service across West Kent is patchy, inconsistent and poorly resourced.

4.6.2 Our view is that a dedicated Deliberate Self Harm Team along the lines of the Team at the Kent and Sussex Hospital would be the most appropriate basis of a service in each Accident and Emergency Department.

4.6.3 However, the Kent and Sussex Deliberate Self Harm Team is barely adequately resourced even for its Monday to Friday 9.00 am to 5.00 pm service. It seems likely that each Accident and Emergency Department would need, as David Foster-Smith suggested, around 6 WTE staff and full time secretarial support in order to operate on a seven days a week, twenty four hour basis and to operate follow-up co-ordination. He also said that liaison psychiatrists for each locality should be members of the Deliberate Self Harm Team.

Recommendation

4.6.4 **We recommend that work be commissioned to establish the staff numbers and skill mix need to operate Deliberate Self Harm Teams in each Accident and Emergency Department with seven days a week, twenty four hours a day access to the service and a co-ordination role for follow-up.**

4.7 Communications

4.7.1 We have already discussed problems of communication between the Accident and Emergency Department and the Deliberate Self Harm Team and between Accident and Emergency and the General Practitioner.

4.7.2 In addition, it has been difficult to track communications concerning Darren Rogers between the Deliberate Self Harm Team and the Community Mental Health Team. There is a diary record of Mary Stewart-Smith's telephone conversation with Anna Adams prior to the home visit on 21st July 1999. However, although the "safety net" Accident and Emergency trawl picked up Darren's second Accident and Emergency attendance on 21st August 1999, there is no record of David Foster-Smith having contacted the Community Mental Health Team once the attendance was known about. Mr Foster-Smith recalled telephoning Tonbridge Community Mental Health Team following the August 1999 attendance at Accident and Emergency, but there is no record either in the Deliberate Self Harm Team or at the Community Mental Health Team. Mr Foster-Smith also told us that as the police were aware of Darren's Accident and Emergency visit and of the reason for it, they would have contacted the Brocklehurst inpatient unit who would have passed on information to the Braeside Community Mental Health Centre, next door to Brocklehurst. This was, however, base to another Community Mental Health Team (not the Tonbridge Community Mental Health Team) and there was no direct access to databases between Community Mental Health Teams.

Comment

4.7.3 ***It is of concern that the Tonbridge Community Mental Health Team were not made aware (or did not deal with the message) of Darren's second attendance at Accident and Emergency on 21st August 1999. If they were aware of a second visit so soon after the assessment on 21st July 1999, it seems likely that a further***

attempt to offer support may have been made. Although we accept that Darren may have rejected such an offer, it was nonetheless a lost opportunity for further intervention.

Recommendation

4.7.4 **We recommend that an explicit and documented policy for communication is developed and disseminated. This should cover communication between Accident and Emergency Departments, Deliberate Self Harm Teams, General Practitioners and Community Mental Health Teams. It would be developed first for the Kent and Sussex Hospital Accident and Emergency Department catchment area and then be shared with other localities.**

4.7.5 **We recommend that, subject to appropriate protocols concerning confidentiality, a system should be developed for Community Mental Health Teams to access each other's records. Deliberate Self Harm Teams and Community Mental Health Teams should have similar interchange or access to records.**

5. THE MANAGEMENT PERSPECTIVE

5.1 We welcomed the opportunity to discuss the issues we had identified with managers of the Invicta Community Care NHS Trust, Kent County Council Social Services Directorate, West Kent Health Authority, and with Dr Webb, Accident and Emergency Consultant.

5.2 Dermot Monaghan, Inpatient and Community Services Manager for Invicta Community Care NHS Trust, was helpful in providing organisational background to the events we were considering. He was also able to outline the way the Trust's internal inquiry had undertaken its review.

5.3 In particular, Dermot Monaghan told us about progress made with the revision of the Care Programme Approach Policy and Procedures across Kent. Care Programme Approach and Social Services care management criteria, which were not integrated in the summer of 1999, are now fully integrated. He added that a system of Care Programme Approach compliance monitoring was now in place.

5.4 On the question of the most appropriate means of meeting the needs of someone like Darren Rogers, Mr Monaghan felt that the Deliberate Self Harm Team may have been best placed to offer a service, particularly as at the time they were able to offer follow-up sessions.

5.5 Peter Hasler, Service Development Lead – Mental Health at West Kent Health Authority, told us about work in Kent aimed at reducing suicides. Targets had been set, but only 30-40% of suicide cases were known to mental health services. West Kent Health Authority is taking the lead in a Kent-wide project looked at the total number of suicides. An audit is being undertaken to go through case notes and General Practitioner records. This has produced a retrospective audit of all suicide cases in Kent in the year 2000. An on-going audit of all 2001 cases was completed at the time of this Inquiry. This work, which will continue, will provide more information than that accessible from the National Confidential Inquiry into Suicide and Homicide, because it will include all cases rather than only those people who had a mental illness.

5.6 Mr Hasler also told us that the Health Authority had asked the NHS Trusts responsible for mental health services to implement the recommendation of the National Confidential Inquiry. The Health Authority will monitor progress through a Kent-wide group established for this purpose.

Comment

5.7 We commend these initiatives.

Recommendation

5.8 **We recommend that the audit of all suicide cases and the monitoring of progress on the implementation of the recommendations of the National Confidential Inquiry should inform and support the development of a Kent Strategy for the Prevention of Suicide and a Kent strategy for the provision of consistent services for people who self harm.**

5.9 Mr Hasler was able to give us an historical perspective to the development of Deliberate Self Harm Teams in West Kent. They had developed locally and without any central co-

ordination. The Invicta Trust had inherited two teams with different approaches. Both do good work and it will be important to preserve the best features of both for the future. In North Kent and Medway the liaison psychiatry elements were in place but follow-up is not developed as it is in Maidstone and Tunbridge Wells.

5.10 Commenting upon the issue of referrals between Community Psychiatric Nurses and Social Workers, Mr Hasler considered that such potential problems should no longer arise in the light of the further recent work on Care Programme Approach Policy and Procedures. The new integrated Mental Health and Social Care Trust and the new model of care for adult secondary mental health services should also ensure a more seamless service with fewer demarcations in the future.

5.11 Paul Fisher, Mental Health Service Manager for Kent County Council, was able to re-affirm the views of Mr Monaghan and Mr Hasler about progress and improvements in Care Programme Approach and integration at the local and countywide levels. This had lead to less difficulty in Community Mental Health Team allocation meetings and more clarity about who has managerial accountability. However, staffing remains an issue and more resources would be needed to deliver the new model of care.

5.12 In addition, Mr Fisher identified the need for robust primary care based services to help and support people with needs like those of Darren Rogers. Such people had tended in recent years to receive less attention as the focus within CMHTs had shifted towards those with severe and enduring mental illness.

5.13 Mr Fisher also supported the view that Deliberate Self Harm Services should be standardised "across the patch".

Comment

5.14 It was reassuring to hear such consistent messages independently from managers operating at different levels and employed by different agencies. They have served to confirm our views about the need for a strategic framework and consistency of service provision.

6. SUMMARY OF RECOMMENDATIONS

(A further summary grouped by the headings, Strategy; Referrals, Records and Communication; and Assessment, Co-ordination and Follow-up is included as Appendix E.

Recommendation 1

The Accident and Emergency Department should remind staff of the need to elicit whenever possible accurate information on the name and address of the patient's General Practitioner, so that follow-up letters can be generated. (Paragraph 2.2.13.)

Recommendation 2

The new Kent and Medway Strategic Health Authority, lead Primary Care Trusts and the new Mental Health and Social Care Trust should commission work as soon as possible to develop a Kent-wide strategy for the provision of consistent services for people who self harm. (Paragraph 4.1.6.)

Recommendation 3

The strategy should include a requirement for clear standards for the pre-discharge (from Accident and Emergency Departments or acute hospital inpatient wards) psychosocial assessment of people who self harm. (Paragraph 4.2.6.)

Recommendation 4

The strategy should provide for a directory of resources to be produced and disseminated to all relevant professionals, agencies, users and carer groups and voluntary organisations in each locality. (Paragraph 4.2.7.)

Recommendation 5

The Kent and Sussex Hospital Accident and Emergency Department and the NHS Trust responsible for the Deliberate Self Harm Team should jointly review the means of communicating referrals from Accident and Emergency to the Deliberate Self Harm Team. This should enable more effective use of the computer system to track attendance of patients who self harm. (Paragraph 4.3.3.)

Recommendation 6

Subject to appropriate protocols concerning confidentiality, systems to enable crosschecking of records between Accident and Emergency, Deliberate Self Harm Teams, Community Mental Health Teams and General Practitioners should be developed. (Paragraph 4.3.4.) (See also Recommendation 13 (Paragraph 4.7.5).)

Recommendation 7

Adequately resourced Deliberate Self Harm Teams based in each Accident and Emergency Department should be at the centre of future assessment arrangements. (Paragraph 4.4.4.)

Recommendation 8

A more strategic approach to the provision of an appropriate range of follow-up options is needed. (Paragraph 4.5.7.)

Recommendation 9

The Strategic Health Authority, lead Primary Care Trusts for mental health services and Mental Health and Social Care Trusts should commission further work to consider basing the co-ordination of assessment and initial follow-up services with adequately resourced Deliberate Self Harm Teams based in each Accident and Emergency Department. Consideration should be given to the evaluation of follow up services when established. (Paragraph 4.5.8.)

Recommendation 10

The proposed Kent-wide strategy for services for people who self-harm should dovetail with the Kent model of care for adult secondary mental health services and with national initiatives to introduce primary care mental health workers. (Paragraph 4.5.9.)

Recommendation 11

Work should be commissioned to establish the staff numbers and skill mix needed to operate Deliberate Self Harm Teams in each Accident and Emergency Department with

seven days a week, twenty four hours a day access to the service and a co-ordination role for follow-up. (Paragraph 4.6.4.)

Recommendation 12

An explicit and documented policy for communication should be developed and disseminated. This should cover communication between Accident and Emergency Departments, Deliberate Self Harm Teams, General Practitioners and Community Mental Health Teams. It could be developed first for the Kent and Sussex Hospital Accident and Emergency Department catchment area and then be shared with other localities. (Paragraph 4.7.4.)

Recommendation 13

Subject to appropriate protocols concerning confidentiality, a system should be developed for Community Mental Health Teams to access each other's records. Deliberate Self Harm Teams and Community Mental Health Teams should have similar interchange of access to records. (Paragraph 4.7.5.) (See also Recommendation 6 (Paragraph 4.3.4.))

Recommendation 14

The audit of all suicide cases and the monitoring of progress on the implementation of the National Confidential Inquiry into Suicide and Homicide should inform and support the development of a Kent strategy for the prevention of suicide and a Kent strategy for the provision of consistent services for people who self harm. (Paragraph 5.8.)

Appendix A

2 October 2001

Strictly Personal & Confidential

Dear

re: Inquiry into the Care and Treatment of Darren Rogers

West Kent Health Authority has set up this Inquiry after discussions with the National Health Service Executive. The members of the Inquiry Team are: Mr Malcolm Barnard, a former Area Director of Social Services, who will be the Chairman; Mrs Sarah Donlan, a retired Senior Social Services Manager and Dr John Basson, Consultant Forensic Psychiatrist. A copy of the Terms of Reference set for the Inquiry is enclosed for your information.

From our initial examination of records and documents relating to Mr Rogers' care and treatment, the Inquiry Team considers that you may have relevant evidence to give to the Inquiry. We would therefore request you to attend a Hearing in order to provide verbal evidence. We propose to hold Hearings on the following dates:

Wednesday 17 October 2001
Wednesday 24 October 2001 (afternoon only)
Tuesday 30 October 2001
Friday 2 November 2001
Tuesday 6 November 2001
Wednesday 7 November 2001
Friday 9 November 2001

Melanie Bloomfield, Administrator to the Inquiry Team will contact you during the week commencing 8 October 2001 to arrange a date and time for your attendance. Your reasonable travel expenses and subsistence costs arising from your attendance at the Inquiry will be re-imbursed.

The objectives of the Inquiry are to ensure that any lessons arising from aspects of Mr Rogers= care and treatment are learned, so that all the relevant agencies and their staff can be supported in their continuing efforts to improve services.

When giving evidence you may, if you wish, be accompanied by a friend or relative, trade union representative, lawyer or member of a defence organisation, or anyone else with the exception of another Inquiry witness. However, it is to you that questions will be directed and from whom replies will be sought. It is intended that the Inquiry Hearings, which will be in private will operate with the minimum of necessary formality. Therefore verbatim notes of the Hearings will not be recorded. However summary notes of hearings will be taken and copies will be sent to you if you wish.

In order to help to clarify issues before the Hearing we would ask you to consider providing us with a written statement, setting out and providing a commentary upon your involvement with Darren Rogers. If you do wish to provide such a statement, please let Melanie Bloomfield know when she contacts you about dates. Melanie will then be able to you know by when your statement should reach us.

If you need to review the records when completing your statement or prior to giving verbal evidence, please contact Melanie Bloomfield who will be able to advise you on how to access them. You will, of course, be expected to keep any such records and copies securely and confidentially, within the normal terms specified by your employing agency.

Yours sincerely

Malcolm Barnard
Panel Chairman

Appendix B

21 November 2001

Private and Confidential
Mr & Mrs Rogers

Dear Mr and Mrs Rogers

Re: Inquiry into the Care and Treatment of Darren Rogers

West Kent Health Authority has set up this Independent Inquiry after discussions with the Regional Office of the National Health Service. The Members of the Inquiry Team are: Malcolm Barnard, a former Area Director of Social Services, (Chairman), Mrs Sarah Donlan, former Senior Manager in Social Services and Dr John Basson, Consultant Forensic Psychiatrist. A copy of the Terms of Reference for the Inquiry is enclosed for your information.

We propose to hold hearings between 30 October and 21 December 2001.

The Objectives of the Inquiry are to ensure that any lessons arising from aspects of Darren Rogers' care and treatment by the health and social services are learned, so that all the relevant agencies and their staff can be supported in their continuing efforts to improve services. It is intended that the Inquiry Hearings, which will be held in private, will operate with the minimum necessary formality. Therefore verbatim notes of the hearings will not be recorded. However summary notes of hearings will be taken and copies will be sent to those giving evidence if they so wish.

We are keen to hear from all those who feel they are able to offer the Inquiry Team their perspective on Darren Rogers' care and treatment. If you wish to attend a hearing to give evidence please contact Melanie Bloomfield, Administrator to the Inquiry Team at the address or telephone number above. If you would prefer to put your views or observations to the Inquiry in writing, please send them to Melanie Bloomfield at the above address.

As we did not have information regarding your address, this letter has been forwarded to you on our behalf. If you do wish to make contact with the Inquiry Team it would be helpful if you could provide Melanie Bloomfield with an address and telephone number for future contact.

Yours sincerely

Malcolm Barnard
Panel Chairman

21 November 2001

Private and Confidential
Mr & Mrs Hollens

Dear Mr and Mrs Hollens

Re: Inquiry into the Care and Treatment of Darren Rogers

West Kent Health Authority has set up this Independent Inquiry after discussions with the Regional Office of the National Health Service. The Members of the Inquiry Team are: Malcolm Barnard, a former Area Director of Social Services, (Chairman), Mrs Sarah Donlan, former Senior Manager in Social Services and Dr John Basson, Consultant Forensic Psychiatrist. A copy of the Terms of Reference for the Inquiry is enclosed for your information.

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We are keen to hear from all those who feel they are able to offer the Inquiry Team their perspective on Darren Rogers' care and treatment. If you wish to attend a hearing to give evidence please contact Melanie Bloomfield, Administrator to the Inquiry Team at the address or telephone number above. If you would prefer to put your views or observations to the Inquiry in writing, please send them to Melanie Bloomfield at the above address.

As we did not have information regarding your address, this letter has been forwarded to you on our behalf. If you do wish to make contact with the Inquiry Team it would be helpful if you could provide Melanie Bloomfield with an address and telephone number for future contact.

Yours sincerely

Malcolm Barnard
Panel Chairman

Appendix C

LIST OF WITNESSES

Name	Position
Tim Arnold	Senior Practitioner KCC Social Services
Paul Fisher	Service Manager KCC Social Services
David Foster-Smith	Deliberate Self Harm Team – Kent and Sussex Hospital
Peter Hasler	Service Development Lead – Mental Health WKHA
Dermot Monaghan	Inpatient Services Manager, Invicta Community Care NHS Trust
Dr Rosalind Oliver	Consultant Psychiatrist
Darren Rogers	
Mary Stewart-Smith	Deliberate Self Harm Team – Kent and Sussex Hospital
Sita Sui	Community Psychiatric Nurse – Tonbridge Community Mental Health Team
Dr Julian Webb	Consultant, Accident and Emergency, Kent and Sussex Hospital

Kent County Council

DSH team
Kent & Sussex Hospital
Mount Ephraim
Tunbridge Wells
Kent, TN4 8AT
01892 526111 Ext 2405

Dear

Following your recent visit to Kent and Sussex Hospital, we would like to offer you the opportunity to talk about the circumstances which led up to your visit. We recognise that you may already have help from other people, or prefer not to discuss what happened, but should you wish to contact us, we are able to offer you short-term counselling. We are also able to give practical support and advice, where necessary.

We enclose a copy of our brochure which we hope that you will find useful. We are most willing to talk about the service we offer, and we can be contacted on **01892 526111 ext 2405.** We look forward to hearing from you shortly.

Yours sincerely

David Foster-Smith
Mary Stuart-Smith
Hesham Hassan

DSH Team

THEMATIC SUMMARY OF RECOMMENDATIONS

Strategy

Recommendation 2

The new Kent and Medway Strategic Health Authority, lead Primary Care Trusts and the new Mental Health and Social Care Trust should commission work as soon as possible to develop a Kent-wide strategy for the provision of consistent services for people who self harm. (Paragraph 4.1.6.)

Recommendation 3

The strategy should include a requirement for clear standards for the pre-discharge (from Accident and Emergency Departments or acute hospital inpatient wards) psychosocial assessment of people who self harm. (Paragraph 4.2.6.)

Recommendation 4

The strategy should provide for a directory of resources to be produced and disseminated to all relevant professionals, agencies, users and carer groups and voluntary organisations in each locality. (Paragraph 4.2.7.)

Recommendation 8

A more strategic approach to the provision of an appropriate range of follow-up options is needed. (Paragraph 4.5.6.)

Recommendation 10

The proposed Kent-wide strategy for services for people who self-harm should dovetail with the Kent model of care for adult secondary mental health services and with national initiatives to introduce primary care mental health workers. (Paragraph 4.5.9.)

Recommendation 14

The audit of all suicide cases and the monitoring of progress on the implementation of the National Confidential Inquiry into Suicide and Homicide should inform and support the development of a Kent strategy for the prevention of suicide and a Kent strategy for the provision of consistent services for people who self harm. (Paragraph 5.8.)

Referrals, Records and Communication

Recommendation 1

The Accident and Emergency Department should remind staff of the need to elicit whenever possible accurate information on the name and address of the patient's General Practitioner, so that follow-up letters can be generated. (Paragraph 2.2.13.)

Recommendation 4

The strategy should provide for a directory of resources to be produced and disseminated to all relevant professionals, agencies, users and carer groups and voluntary organisations in each locality. (Paragraph 4.2.7.)

Recommendation 5

The Kent and Sussex Hospital Accident and Emergency Department and the NHS Trust responsible for the Deliberate Self Harm Team should jointly review the means of communicating referrals from Accident and Emergency to the Deliberate Self Harm Team. This should enable more effective use of the computer system to track attendance of patients who self harm. (Paragraph 4.3.3.)

Recommendation 6

Subject to appropriate protocols concerning confidentiality, systems to enable crosschecking of records between Accident and Emergency, Deliberate Self Harm Teams, Community Mental Health Teams and General Practitioners should be developed. (Paragraph 4.3.4.) (See also Recommendation 13 (Paragraph 4.7.5).)

Recommendation 12

An explicit and documented policy for communication should be developed and disseminated. This should cover communication between Accident and Emergency Departments, Deliberate Self Harm Teams, General Practitioners and Community Mental Health Teams. It could be developed first for the Kent and Sussex Hospital Accident and Emergency Department catchment area and then be shared with other localities. (Paragraph 4.7.4.)

Recommendation 13

Subject to appropriate protocols concerning confidentiality, a system should be developed for Community Mental Health Teams to access each other's records. Deliberate Self Harm Teams and Community Mental Health Teams should have similar interchange of access to records. (Paragraph 4.7.5.) (See also Recommendation 6 (Paragraph 4.3.4.))

Assessment, Co-ordination and Follow-up

Recommendation 3

The strategy should include a requirement for clear standards for the pre-discharge (from Accident and Emergency Departments or acute hospital inpatient wards) psychosocial assessment of people who self harm. (Paragraph 4.2.6.)

Recommendation 7

Adequately resourced Deliberate Self Harm Teams based in each Accident and Emergency Department should be at the centre of future assessment arrangements. (Paragraph 4.4.4.)

Recommendation 8

A more strategic approach to the provision of an appropriate range of follow-up options is needed. (Paragraph 4.5.7.)

Recommendation 9

The Strategic Health Authority lead Primary Care Trusts for mental health services and Mental Health and Social Care Trusts should commission further work to consider basing the co-ordination of assessment and initial follow-up services with adequately resourced Deliberate Self Harm Teams based in each Accident and Emergency Department. (Paragraph 4.5.8.)

Recommendation 11

Work should be commissioned to establish the staff numbers and skill mix needed to operate Deliberate Self Harm Teams in each Accident and Emergency Department with seven days a week, twenty four hours a day access to the service and a co-ordination role for follow-up. (Paragraph 4.6.4.)

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