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REPORT OF THE INDEPENDENT INQUIRY INTO THE CARE AND TREATMENT OF ALAN KIPPAX

Commissioned by North West Lancashire Health Authority

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Ms. S. McKeever

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PREFACE

We were commissioned in May 2001 to undertake this Inquiry pursuant to Department of Health Guidance HSG (94) 27 into the care and treatment of Alan Kippax. We proceeded in accordance with that Guidance and within the process outlined by us to the agencies and persons involved.

The report deals with events leading up to the death of Gary Warburton and Alan Kippax's conviction for his murder. We have based our findings on the evidence of written records, and on the oral evidence and written submissions of individuals and agencies. There was a lapse of time between these events in 1998 and this Inquiry, which has made the task somewhat more difficult for all concerned: both in recollecting events as they occurred free of the overlay of subsequently acquired knowledge; and in evaluating professional responses against the standards and expectations of the time.

Within the intervening period there have been significant changes in the framework of regulation and guidance in mental health services. In the Trust concerned there have also been significant changes in patterns of service delivery and also structural changes. Where appropriate we have made reference to these changes.

During our deliberations the 2001 report of the five year study into homicides and suicide in mental health patients was published, and we have found some of the significant factors identified in that report to be evident also in this case.

INTRODUCTION

The Inquiry Team would wish to record their condolences to the family and friends of Gary Warburton whose untimely death has led to this Inquiry being set up. We would also like to record our gratitude to the family and professional witnesses who assisted us with their recollections of these events.

On the morning of Monday 30th November 1998 Alan Kippax had been visited by his next-door neighbour Gary Warburton for a drinking session in his flat. They proceeded to drink a bottle of vodka, were joined for a time by another friend who called round, and after his departure continued drinking from another bottle. Alan Kippax related that later that afternoon Gary Warburton began to make innuendos concerning little girls, and seeing a photo of a little girl in the flat, pointed to it. This photograph was of Alan Kippax's daughter. He later explained that he had felt at this time he had hit at a point he could not rationally deal with, which, coupled with the drink, led him to attack Gary Warburton, whom he killed with repeated blows to the head and neck with fists, feet or a blunt instrument and possibly also a knife.

Alan Kippax was divorced from Sharon Kippax, with whom their four-year-old daughter lived at this time. The marital breakdown had been stormy. There had been court proceedings concerning this and contact with the daughter. Some months previously, mother and daughter had moved out of the area, making contact with her father more difficult. His daughter was a pivotal figure for the emotional well-being of Alan Kippax.

Five months prior to the death of Gary Warburton, another friend of Alan Kippax, Matthew Brennan, had also died following a bout of substance abuse in Alan Kippax's company, which left the latter unconscious. Matthew Brennan had a known history of alcoholism and died of a non-dependent overdose of alcohol and heroin. Following this death Alan Kippax was subjected to persecution. It appeared that the family and friends of Matthew Brennan held him responsible for his death. In September someone daubed " Killer Kippax" on the wall facing the flats where he lived, and on the 17th of November Alan Kippax received a letter enclosing a photograph of him and his daughter, and threatening both his and his daughter's lives. Alan Kippax believed that these events were relevant to his mental state and the way he was feeling at the time of the murder.

On 16th November 1999 Alan Kippax was found guilty of the murder of Gary Warburton at Preston Crown Court and sentenced to life imprisonment. At his trial he had not attempted to defend the charge by reference to his mental health, but had initially pleaded guilty to manslaughter with a defence of provocation to the murder charge.

Following conviction, the Court heard of Alan Kippax's criminal record which included violent offences, and many past offences in which alcohol was a factor. During the time that he was under the care of mental health services in Blackpool he had had no further convictions for crimes of violence, although he had been found guilty of drunken and dangerous driving.

On 5th April 1982 Dr. A. A. Campbell of Prestwich hospital had described Alan Kippax in the metaphor of Henry Maudsley, discussing the problem of dealing with those who inhabit the borderland between insanity and crime, as "certainly a mentally abnormal offender, at times in need of psychiatric care, but one who does not need to be treated in hospital", and concluded that hospital detention as a disposal for his then offence would be mere containment for the prevention of future offences and not otherwise warranted as a response to his mental health needs.

Working within the Terms of Reference of this Inquiry, the central questions of public import to us could be distilled in terms with which this earlier perception resonated: "Did the mental illness of Alan Kippax contribute to the death of Gary Warburton? Could it, or something like it, have been predicted by those caring for him? Was he receiving appropriate care? If his care had been different could this death have been prevented?

The Terms of Reference as agreed by the Health Authority were

1 To examine all the circumstances surrounding the care and treatment of Mr. Alan Kippax, in particular:

- The quality and scope of his health and social care;
- The suitability of his treatment, care and supervision;
- The extent to which Mr. Alan Kippax's care corresponded with statutory obligations, the Mental Health Act 1983 and other relevant guidance from the Department of Health and local operational policies;
- The extent to which his prescribed care plans were:

effectively delivered; complied with and monitored by the relevant agency;

- the history of Mr. Alan Kippax's medication and compliance with that regime.
- The adequacy of risk assessment procedures.

2. To prepare an independent report and make recommendations.

INQUIRY PROCESS

1. Commissioning the Inquiry

North West Lancashire Health Authority were obliged under the provisions of Department of Health Guidance HSG 94/27 to commission an Inquiry. The killing in this case constituted a relevant incident following which an Inquiry was required to be set up to discover whether there were lessons to be learned, and to make recommendations for future delivery of services for mental health.

2. The Inquiry Team

Ms Claire Gilham (Chair), solicitor, lecturer in health and social care

Dr Ola Junaid, Consultant Psychiatrist

Ms Suzanne McKeever, Senior Nurse Practitioner

3. Procedure

- ❑ The Inquiry team met in private on a number of occasions to establish ways of working and to reflect on oral and written evidence and their terms of reference.
- ❑ Hearings were held in private to take evidence from persons and organisations involved in the care or control of Alan Kippax.
- ❑ Access to records was given in advance of hearings based on entitlement according to role.
- ❑ Witnesses were invited to bring any person (provided such persons were not themselves witnesses) with them to the hearing in the role of supporter rather then as an advocate.
- ❑ Witness contributions were electronically recorded and transcripts sent for verification and signature.
- ❑ Submissions were invited from any other interested party or organisation.

- Written responses were invited to potential criticisms of persons or that emerged through the process, but which could not be canvassed with the contributor.

- A report was prepared to include findings of fact and commentary based upon those findings; comment upon service delivery; key findings and recommendations

- The report was made public, records of evidence remained confidential.

Acknowledgements

The Inquiry team were very conscious that incidents of this nature affect a wide number of people significantly. The convening of an Inquiry revives these feelings and anxieties, especially so long after the event. The team were very well aware that such an Inquiry can be seen as an exercise to attribute blame, when it should better be seen as an opportunity to understand, and that this also leads to anxiety.

We were grateful to the Board and Managers of the Blackpool, Wyre and Fylde Community Health Services NHS Trust for their support throughout this Inquiry, and to the staff who attended to assist us in exploring these issues. We were also given invaluable support by Liz O' Neill and Carole Wilmer who gave us administrative assistance.

CHRONOLOGY

2.6.58	Born second eldest in family of three.
-.7.74	Left school with one GCE "O" Level. Joined army, during which period parents separated, suicide attempt, psychiatric involvement, discharged from army 1975
-.4.76	Criminal damage
-.5.76	Burglary, theft, and criminal damage – three months detention centre. Became hypomanic- transfer to Manchester prison hospital
20.8.76	Admission S. 26 Whittingham Hospital on release from Strangeways
2.6.77	Transfer to Burnley General Hospital, discharge to Richmond Fellowship hostel
21.4.78	Admission Prestwich Hospital following violent incident at hostel, discharge 24.4.78 to Risley Remand centre
7.6.78	Criminal damage, impersonating a police officer, assault on a police officer, theft. 2 years Probation with condition of psychiatric treatment
15.6.78	Admission Sharoe Green
-.6.78	Carrying an offensive weapon 12 months conditional discharge
2.7.78	Transfer to Langdale unit at Whittingham discharged 24.8.78
Jan '79	Out-patient attendance Sharoe Green
Feb 79	Criminal damage breaking window at mother's flat characterised in psychiatric report as mildly disturbed at the time but not requiring hospitalisation but therefore impulsive. Custodial sentence- six months

18.7.79	Three days after release from custody : theft of mother's property deferred sentence six months conditions of residence and psychiatric treatment
9.9.79	Impersonating a police officer and dishonesty
May '81	Working as a residential social worker Portal, Romford
May '81	Admissions to Warley hospital, Claybury hospital
23.5.81	Aggravated burglary psychiatric report : " he can be impetuous and violent. These last are facets of his personality and not symptoms of serious psychiatric illness."
14.9.81	Admission Sharoe Green Whittingham S. 136.
16.9.81	Discharge and arrest for forgery of prescription
21.11.81	Malicious wounding, possession of fire-arm, theft arrest and remand at Risley prison sentence
27.11.81	Projected marriage date to Linda Holmes
- . 4. 82	Section 20 wounding, possession of a firearm,theft
28.3.83	Release from custody
- . 3.84	Assault occasioning actual bodily harm
- .11.84	Burglary, theft
-. 1.84	Handling
-.11.85	Burglary
- . 8.86	Possessing an offensive weapon, criminal damage
- .7 .88	Assault occasioning grievous bodily harm, on his mother causing facial fracture18 month prison sentence
15.11.89	Section 2 admission following threats to mother to Burnley followed by one week at Langdale Unit
- . 3.90	Wounding with intent Section 18 on a police officer, theft two year prison sentence

- . 4.91	Assault occasioning grievous bodily harm on his mother three years imprisonment
June 94	Move to Blackpool, marriage to Sharon
31.7.94- 8.8.94	Admission ward 27 (Parkwood) marital violence
3.3.95-5.3.95	Admission (Parkwood)
18.3.95-15.5.95	S. 3 admission Ward 27 (Parkwood)
22.8.95	Marital breakdown
23.8.95-2.9.95	Admission ward 28 (Parkwood)
6.9.95-20.12.95	Section 3 admission ward 29 (Parkwood)
16.11.95.1.1	Matrimonial injunction
25.4.96-24.6.96	Admission ward 27 (Parkwood)
2.7.96-6.7.96	Admission ward 27 (Parkwood)
19.8.96	Dangerous and drunken driving
17.2.97-18.2.97	Admission ward 28 (Parkwood)
1.4.97-2.4.97	Admission PICU (Parkwood)
31.7.97-12.8.97	Admission (Parkwood)
1.3.98-9.4.98	Section 3 admission (Parkwood)
12.6.98	Death of Matthew Brennan
23.7.98-20.8.98	Admission (Parkwood)
30.11.98	Killing of Gary Warburton
16.11.99	Conviction for murder of Gary Warburton, life sentence

Chapter 1

Alan Kippax Significant Life Events 1958-1993

Alan Kippax was born in Burnley, the second eldest, and the only boy, in a family of four children. His elder sister had a learning disability. His mother suffered from clinical depression and required in-patient treatment from time to time. His parents' marriage was unhappy. Alan Kippax later reported that his father had been a bully, that he had been physically abused as a child, and that there had been an atmosphere of fear in the home.

Having left school at sixteen in 1974 with one GCSE "O" Level, Alan Kippax joined the army reportedly to get away from home. His parents then separated and Alan Kippax experienced guilt and paranoia, suffered an emotional breakdown in reaction as a result of which he attempted suicide. He attributed the onset of his depressive illness to these events, and when this was recognised became involved with psychiatric services, and was medically discharged from the army in 1975.

After his return to his community from hospital his father arranged for him to be taken on at the Building Society where he worked, Alan Kippax gave up this employment after six months and was then unemployed for a period.

In May 1976 Alan Kippax was convicted of burglary and criminal damage following an attack on his father's property for which he was sentenced to three months at detention centre.

Dr Kelly in a report dated 3 6 1977 stated:

He was admitted to Langdale unit on 20 08 1976 under section 25 of the mental health act.

"He had been serving a Detention Centre Sentence for crimes of breaking and entering and whilst there he had become acutely hypomanic and had been transferred to the hospital in Strangeways. His mental state had deteriorated and when I saw him there, together with a member of the nursing staff, he had poorly formed delusions of grandeur, accelerated thinking, mild paranoid ideas, and expressed feelings of ecstasy."

His condition however warranted transfer to Whittingham Hospital, where he was on occasion violent and threatening to staff. He was commenced on Lithium therapy and received ECT, and was transferred to Burnley General in the following June of 1977.

Alan Kippax describes the twelve-month detention in hospital at this stage as leaving him frustrated and angry and characterised the period of instability that followed as proceeding from this hospitalisation with offending the result of consequent heavy drinking.

After a short period in his local hospital Alan Kippax was discharged in September to a Richmond Fellowship hostel. His first offence of violence occurred here in April 1978, for which he was eventually sentenced to two years probation with a condition of psychiatric treatment. One week after sentencing and release from Risley remand centre, Alan Kippax was involved in a further incident, holding up a taxi-driver with an offensive weapon, and was admitted to Sharoe Green Hospital during which time his offence was dealt with by way of conditional discharge. He then spent a month at Whittingham in the Langdale Unit. Over the next year there were further offences of dishonesty, theft, impersonating a police officer and criminal damage, offending behaviours frequently targeting his family and with bizarre aspects that led to further sentences of immediate and deferred imprisonment and conditions of psychiatric treatment.

There then occurred the first apparently settled period in Alan Kippax's adult life-for eighteen months. He moved south, and is recorded as working as a residential social worker in a Portal Scheme.

However in May 1981 things again deteriorated, and over the next months there was a spate of dishonest and violent offending: aggravated burglary, theft of a prescription, possession of an offensive weapon; malicious wounding; possession of a fire-arm; and theft. At the same time there were further hospital admissions, and remands to custody and a further sentence of imprisonment was imposed.

This term of imprisonment commenced some six days prior to the date that Alan Kippax had planned to marry Linda Holmes with whom he had been living. They did eventually marry, but the marriage was stormy and interrupted by various periods of imprisonment of both parties, and broke down after two years.

In March 1983 he was released from prison. In 1985 following recorded "matrimonial problems" an overdose with apparent suicidal intent was followed by a hospital admission

An offence of grievous bodily harm involving an assault on his mother in which she sustained a facial fracture, incurred a term of imprisonment ending in January 1989

In 1989 a further offence of assault occurred, and in November threats to his mother led to admission to Burnley General Hospital.

In 1991 Alan Kippax was convicted of grievous bodily harm following a further assault on his mother as a result of which she lost the sight in an eye. He was released from Preston prison in March 1993.

Chapter 2

In and Out of Hospital, Blackpool 1993-1998

A New Face 1993

Alan and Sharon Kippax met while he was detained at Preston prison, when he visited the school at which she taught religious education to talk to the children about the purpose of punishment. Alan Kippax was released shortly afterwards and they quickly became close, moving to Sharon's home town of Blackpool on their marriage in June 1993. Their daughter was born in June 1994. Their marriage was quickly in difficulties. Sharon first learned of Alan Kippax's illness after the wedding, and throughout the marriage was not aware of her husband's full criminal nor psychiatric history, but the effects of illness soon became apparent, with episodes of depression and mania.

With the assistance of the GP, Dr Billington, who throughout appears to have given very responsive support, Sharon learned to recognise and attempt to deal with the onset of symptoms, which sometimes confusingly appeared to be within Alan Kippax's control. Money was disappearing, and Alan Kippax was also on occasion drinking to excess.

The onset of depression could be extremely sudden, and Sharon soon learnt not to cross her husband during these times and came to fear him following incidents when she confronted her husband about his gambling of family and other money. She felt him to be over dominant towards her with fixed ideas concerning his expectations of her behaviour.

Positive events as much as and perhaps more than negative could trigger stress and the spiral of depression, and the birth of their daughter was one such event. Alan Kippax was binge drinking by this time typically as he began to feel the effects of depression, and saw drinking as "my release". Drinking however adversely affected his mood and he could become aggressive.

Alan Kippax had become a born-again Christian in prison, a faith that he perceived as a source of strength, but which he held dogmatically and which became part of his delusions when ill, and which complicated his perception of causation, treatment and punishment. The couple received support from Church members during this period, and it was a Church

member who arranged for Alan Kippax to gain employment through his involvement with Christian care homes initially as a care assistant.

Alan Kippax then also began to gamble excessively. He is recorded as perceiving the cause as life stress of which the gambling was then both effect and further cause. This was then followed by depression, drinking and then by loss of control. His insight into the onset of his illness was characteristically good, and this is frequently remarked on in the notes.

Alan Kippax was aware that he began to suffer a relapse of mental health problems as a result of these life events, but could not at first persuade Dr Kay the hospital based consultant who then visited him at home that he required admission. Shortly afterwards his first (informal) admission to Parkwood was precipitated following the taking of an intentional overdose together with drink with expressions of suicide.

Alan Kippax gave an incomplete history on first admission in Blackpool of his treatment in Prestwich and his subsequent imprisonment. Characteristically when giving a history Alan Kippax engaged easily and was generally recorded as being frank and insightful, however comparison of accounts shows that on each occasion a partial history was given with significant omissions. We were satisfied that Alan Kippax told professionals what he wanted them to know, and it is clear to the Inquiry panel that staff were not privy to all relevant information at any time.

Dr Kay considered contacting Prestwich, among other things to discover whether previous episodes of illness were drink-related, but there is no evidence that information or records were sought at this time. The diagnosis was of mood disorder coupled with alcohol and the treatment.

A Familiar face 1995-7

The same Church contact as previously arranged further employment in a management position for Alan Kippax in a nursing home in 1995. Family recollections are that this apparent improvement in his situation increased the stress that Alan Kippax felt, and led him to take up gambling, a compulsion which he turned to available family to fund, and also allegedly to the funds entrusted to him at work, which led to the loss of this employment.

Sharon Kippax was finding that she lacked effective strategies to prevent her husband sinking into depression, and she began to access acute services on his behalf. She was then frustrated that her husband could present very differently on a professional visit, particularly if this was expected, to his presentation when alone with her.

The next admission to Ward 27 in March 1995 was with a further intentional overdose on the day following such an assessment by Dr Kay in the community. A more detailed but still incomplete history was then taken from the patient, this time giving an account of abuse in childhood. There was little mention of previous admissions, but one offence of GBH was again recorded. The victim was not identified as the mother. Sharon Kippax commented that she was never asked by staff to provide relevant information, and did not feel involved either with the assessment of need or the discussion of appropriate care.

Alan Kippax admitted experiencing persecutory delusions, including demonic possession, but remained orientated with fair insight and not presenting as depressed. The diagnosis was of manic depressive illness and acute psychosis. His alcohol consumption had escalated to daily drinking. This admission lasted for two months.

The marriage was breaking down. Sharon Kippax felt that her movements and her friendships were controlled by her husband and that his behaviour was worse than ever with frequent and extremely sudden mood swings from pleasant to threatening aggressive and destructive.

A series of arguments occurred in which Sharon and the daughter were locked out of the house culminating some days later in an assault on his wife, who was holding the daughter, which also led to the ending of the marriage.

The details of this incident do not appear on the case-notes relating to a three month admission under the Mental Health Act 1983 Section 3 which immediately followed this incident beginning on 23rd August 1995. Notes record only "marital problems". No formal risk assessment was undertaken (and/or documented)- the recorded risk is risk to self, but notes show a call was taken from Sharon Kippax warning staff of risk to others. Our understanding of this incident gives us concern that more detail was not sought and brought into risk assessment.

During this period of detention, Alan Kippax was made subject to a non-molestation order in matrimonial proceedings. Sharon Kippax's (sister and) solicitor (whose car was vandalised at this time) hand-delivered papers to the hospital to try to bring the breaches of this matrimonial injunction to attention. Sharon Kippax's affidavit retained on file details ten breaches by Alan Kippax during this admission, which caused his wife to fear for her safety and that of their daughter. His wife describes Alan Kippax's:

"Personality changes which occur on average every 3 to 4 months. His nature at this time is unpredictable and he can be withdrawn, aggressive or violent"

There is no evidence on the case-notes that these allegations led to any reflection by staff on the risk that Alan Kippax might pose to his family. There is no evidence in particular of any discussion of Alan Kippax's actions while on Section 17 Mental Health Act 1983 hospital leave. On interview his then CMHN Alison Best explained that matrimonial matters were seen as private. The hospital nursing notes record only Alan Kippax's mood in response to these problems: "pre-occupied with thoughts about access to his daughter and difficulties encountered securing this", and "wife is still trying to prevent this", "wife's attitude".

Evidence from the family and from the police suggests that Alan Kippax continued during and after the divorce to be obsessed by his former wife, and would pester her by telephone, following her and nuisance calls both at her home and at her employment. She was in substantial fear at this time, a fear which the family felt to be well-grounded.

The panel were surprised to be informed by Dr Kay that he had by this time seen the case-notes from Prestwich as there is no reference whatever to their content on the Blackpool files. The files do contain a copy of the letter of request with the annotation of a phone call chasing a response:

"Dr Kelly..said the patient was quite dangerous.." This is the only occasion the word dangerous is seen on the file.

No notes were received from Whittingham, and the Guild notes were not requested. No enquiries were made concerning Alan Kippax's health during his most recent term of imprisonment, nor the details of that or any other offending, so that it is not apparent from the notes that Alan Kippax had previously victimised family members.

It does appear that in 1996 Dr Kay was instructed to prepare a psychiatric report by Alan Kippax's solicitors in the contact proceedings, and obtained the Preston notes to prepare this. The information in this report with its details of history did not become part of the case notes. With wider knowledge this report is remarkable in the context of family proceedings in that it does not mention the nexus between Alan Kippax's difficulties with his family and his psychiatric admissions. The report does not mention the self-report of a conviction for grievous bodily harm made by Alan Kippax by this time. The assaults on his mother may not have been known to this reporter, but in any event are not mentioned. The report characterises Alan Kippax as supportive of his mother. Such a report could not be of assistance, and might indeed have been detrimental if relied on, in the decision-making of a Court considering protection from domestic violence.

Alan Kippax sought his next, two month, admission on 25/4/96 after a feeling of relapse, and discussions with Alison Best. He was maintained in hospital with extended periods of limited leave. Alcohol abuse was mentioned in the hospital case notes on the 20th May and it later transpired when he did not return from the leave then granted that on this day Alan Kippax had been arrested for dangerous and drink-driving with blood alcohol 3 times the legal limit.

The notes show Alan Kippax reportedly felt he could manipulate ward staff and do what he wanted. In interview staff referred to a perception that Alan Kippax was very much his own man, if for instance he felt like going out while on the ward for a drink he would.

One week after this discharge Alan Kippax took an intentional overdose of chlorpromazine and was admitted informally to the hospital for one week.

Characteristically the notes show that Alan Kippax's admissions were precipitated by life events. On occasion he had responded by violent or risk-taking behaviour in the community. On assessment on admission Alan Kippax typically presented as depressed but likeable, warm in affect and able to give history and display orientation and insight, and expressing suicidal ideas, but not threats to others. It was over the subsequent treatment period and then only occasionally that any aggressive and delusional behaviour became manifest.

We were concerned that while the service provided during admission was flexible in allowing Alan Kippax leave of absence, this flexibility appeared to lack boundaries. Leave both during voluntary admissions and while detained was granted without formulation of the reasons for leave, the conditions for its exercise, and criteria for allowing or determining it. This contributed to the failure of an appropriate response when leave appeared to be being misused.

Alison Best CMHN, together with Lynn Lucas social worker, and Richard Willis social worker, maintained a steady programme of contact with Alan Kippax in the community throughout this period, frequently picking up the behavioural changes precipitating admission. Dr Kay in a letter dated 11 2 1997 reported: "Alan's mental state has remained reasonably stable, although regular controlled mild hypomanic episodes do occur in the early stages, identified by Alan because of a disruption in his sleep pattern, and which Alan addresses by increasing his oral dose of Chlorpromazine."
The impression of the care given was that the health care professionals, in general practice, in-patient and community teams, were responding reactively in response to Alan Kippax's own perception of need from time to time. Alan Kippax to a great extent controlled the information he gave about his circumstances and his symptomology. The notes contain almost

no reference to outwardly manifest symptoms or signs of relapse, but rather Alan Kippax's impression that he was relapsing.

There is no mention of plans or objectives in the notes of Alan Kippax's care, and Alan Kippax spoke to us of his frustration at the lack of planning in his care and his increasing hopelessness for the future. He spoke for instance of agencies accepting that he would be unemployable without offering any suggestions for him to ameliorate his position. While towards the end of this period he was felt by Dr Kay to be improving, certainly in his management of his illness, Alan Kippax felt he was in the middle of the worst period of manic depression of his life, but he felt the care he received was very good, Dr Kay was always accessible and he had a good man to man relationship with him.

Changing Faces 1997-1998

In February 1997 Dr Kay handed over Alan Kippax's care to Dr Molodynski as part of the reorganisation of the service into sectors. The notes available support the presentation of a reasonably stable manic depressive illness maintained without "going off" for three years. The documented handover does not however mention criminal history, substance abuse, or potential danger to self or others, and the notes do not contain sufficient information for an accurate picture of these matters to be gained from them. Dr Kay does recall discussions concerning Alan Kippax, but we did not find that Dr Molodynski could recall extensive information about Alan Kippax's history and indeed had not been sure even at the date of the internal review following the murder whether there had been even one offence of grievous bodily harm.

Six days following the change in psychiatrist Alan Kippax admitted himself to hospital following an unexplained fire in his kitchen, which he could not remember causing, leading to the realization that he was disinhibited and a danger to himself. However on assessment he presented as having no obvious symptoms of illness and took his discharge the following day saying he had come in for his social worker's peace of mind.

Staff recall that while Dr Molodynski was less available, his staff grade doctor Dr. Boak did make herself available to the community team attending at the team headquarters, The Beeches. Nevertheless, CPA reviews were not specifically planned, but took place "tagged on at the end of ward-rounds, and at out-patients".

Alan Kippax's next admission, for one month, was in March 1998 with severe depression following an intentional heroin overdose. Problems had begun to emerge in relation to contact with his daughter. He absconded

during this admission and was brought back under Section 3. Although discharged with and supported by the Beeches, he was thought to be in need of additional support, and there is evidence of professionals offering support in a deteriorating situation over the next months and his being seen as a serious suicide risk. Even so staff relied on his description of how he was feeling to assess mental state, as there was little observable change in his presentation.

The second in a series of changes in key personnel took place in May 1998. Alison Best, Alan Kippax's CMHN since 1994 handed over to Clare Kozakiewicz, who was recently recruited into post, but who had known Alan Kippax since her time working on ward 27. This was a planned change with good handover. To ensure continuity, key-worker responsibility went to Lynn Lucas, the experienced social worker who again had been working with Alan Kippax for some years, and by all reports also had good insight into Alan Kippax, and also knew how certain events could affect him.

On the last admission 27th July 1998 the recorded risk factor is that Alan Kippax: "feels like taking risks – dangerous pursuits". We were advised that this term comprised a group of behaviours: taking drugs, binge drinking, driving recklessly. He reported short-term memory loss. Alan Kippax discussed his extremely emotional feelings concerning difficulties in exercising contact with his daughter with the relationship stretched by his ex-wife's move to Wigan. His CMHN anticipated that a major crisis would be precipitated by these life events.

It is noted that Alan Kippax was greatly affected by the death at this time of a friend, Matthew Brennan, at whose inquest he was later to be a witness. No full or accurate account of these matters appears in the notes, they are mentioned in passing to explain mood. They do not appear to have been used for risk assessment, or to inform the care of Alan Kippax except as a reason for needing support in the interim. As matters developed over the next months, with family and former friends pursuing and harassing Alan Kippax, whom they held to be responsible for this death, the notes record uncritically how these events immediately affected Alan Kippax without more analysis or projection.

Alan Kippax continued in hospital with frequent leave, on occasion staying absent without leave. In August Alan Kippax was still pre-occupied and agitated over the blame and threats he was attracting from the friends and family of Matthew Brennan. It appears that Alan Kippax suspected that it was his former close friend, Richard, Matthew Brennan's brother who was principally responsible for victimising him.

On one occasion he returned home to find his name and "murderer" daubed on the flat landing, and thereafter expressed reluctance to return

to hospital "in case something else happened". When he did return he was very unsettled and went AWOL. Over the next days, although able to state that he was coping, and involving the community police officer in attempting to identify his persecutor, Alan Kippax's behaviour was erratic, and he was misusing a range of substances including alcohol and prescribed and non-prescribed drugs, with frequent returns to the ward when on leave, and frequent walk-outs.

On the 10th August 1998 a ward round conducted by Dr Boak planned: "

1. Alan to continue as an in-patient
2. To always inform staff if leaving the ward
3. Advised to avoid alcohol and talk through his problems"

Despite this plan, later that evening Alan Kippax again absconded from the ward and went drinking in the Blackpool clubs. He did not return, and the following day his mother phoned to say Alan was with her and wished to stay out because he needed to see his solicitor, as his former wife was stopping visits to his daughter.

It is again remarkable that no attempt was made to establish what behaviour by Alan Kippax might have led to such an application in matrimonial proceedings. Events were received as from Alan Kippax's point of view, and the perspective is implicit in the tone of the nursing notes that this additional stressor was significant only as giving a rationale to Alan Kippax's next expressed wish to be discharged from the hospital ward: "as he feels it is detrimental to his court case re access to his daughter as his wife is using his mental health as the issue why he is not allowed access"

Alan Kippax was reluctant to return to the ward, and when he did was asking for discharge. In the event he saw neither his key-worker nor Consultant, but was discharged by Dr Boak, Staff Grade on the 20th August 1998.

We understand that at this time Sharon Kippax had a new relationship, and had moved to Bolton with the daughter as a consequence. Contact between father and daughter became less and less frequent because of the difficult journey and Alan Kippax's mental state, and significantly it is denied that contact was in fact objected to as Alan Kippax had claimed. In any event as it transpired Alan Kippax only saw his daughter three times between June and December.

Records and accounts of the next several weeks between Alan Kippax's final discharge from hospital and the killing of Gary Warburton give an impression of an increasing pace of fragmentation in Alan Kippax's care, with established relationships with experienced professionals being lost, and new less experienced staff replacing them.

In September Lynn Lucas died suddenly, and there was a lacuna in social work support. Alan Kippax was very distressed at finding out about Lynn Lucas's death by chance, and he expressed need for social work support. The new social worker, Louise Hicks, a newly qualified worker, only met Alan Kippax once, at an introductory visit on her planned appointment on the 19th November.

Alan Kippax found out about the death of Lynn Lucas by chance, and the discovery was followed by a crisis, a drinking bout and a call to crisis intervention. Clare Kozakiewicz arranged for his informal admission for 30th September, but on her visit on the 30th September found Alan Kippax unwilling to proceed. He had been abusing substances, and asked if he felt suicidal replied that he couldn't answer as if he did Clare: "would go mad and make him go into hospital".

In October Clare Kozakiewicz left the employment of the Trust, and this time the nursing handover was not so effective as it had been to her. The new CMHN was again newly qualified, but did not have prior knowledge of Alan Kippax from his work on the wards. Neither was there any overlap period, and Steve Bracewell picked up Alan Kippax's case on the 19th October with the rest of the caseload of his predecessor in a verbal introduction by his supervisor. These several changes of worker provided an ideal opportunity for Alan Kippax to be re-assessed or reviewed. Sadly these opportunities were missed.

At an out-patients appointment On the 12th October, Dr Molodynski recommended Alan Kippax should, in the future, halve his dose of anti-depressant medication as he did not present as being significantly depressed, Alan Kippax however recalls feeling unstable at this time.

There is no doubt that within the available skills and resources Alan Kippax continued to receive a good level of support in terms of time devoted to his case with the new professionals working to establish rapport and provide assistance: but such depth of knowledge and interpretation as had been present in the case had been lost, as professionals with experience of Alan Kippax moved on, and file material was insufficient to provide an accurate picture.

Steve Bracewell reviewed the notes available to him on handover and picked up the note that Alan Kippax had been involved in an offence of grievous bodily harm. There is no evidence that he was ever aware that the victim had been his mother. There was little on the file about the circumstances of Matthew Brennan's recent death. Steve Bracewell visited diligently, and clearly identified the importance to Alan Kippax of contact with his daughter and the fact that a move would be needed to facilitate this because of difficulties in travelling to see her. Perhaps

surprisingly he did not appear to pick up that practical difficulties meant that the contact discussed did not actually take place.

Steve Bracewell had eight contacts (five phone calls- one leading to a visit- and three planned visits) with Alan Kippax over the six weeks that he was his CMHN. He did not have any frame of comparison with Alan Kippax's earlier state and did not observe signs of relapse into mental illness. He recorded that while Alan Kippax was agitated and reported feeling bad, he was rational and not under the influence of substances. There is no record of PC Connell's concerns about the danger Alan Kippax might pose to those he felt were threatening him, and the risk mentioned in representations to housing agencies is the risk of relapse.

Steve Bracewell's main focus during the six weeks that he knew Alan Kippax was housing, as Alan Kippax wished to move closer to his daughter and his mother. Steve Bracewell encouraged the move, and remained unaware at interview of any factors which might make relationships between Alan Kippax and his mother problematical. Visiting weekly, he reported Alan Kippax as ready to communicate and establish rapport, and perceived him as bright in mood. Alan Kippax's own view of his relationships with professionals is that he had thought of Dr Kay as a friend who would have recognised that he required admission to hospital in the November. He did not feel understood by Dr Molodynski. He had felt supported and understood by Alison Best and Lynn Lucas over a long term, and he had felt he had a relationship with Clare Kozakiewicz as he had known her from the wards. He had felt devastated by Lynn's death and did not feel he established any sort of relationship with Louise Hicks. He perceived Steve Bracewell as being a "typical male ward nurse" and did not engage with him beyond the superficial. He would "tell them what they wanted to hear until they go." His relationships with all the new professionals were superficial.

On the 17th November Alan Kippax received a letter "a horrible threatening malicious letter which absolutely shocked me to the core" enclosing a family photo and apparently making threats against his and his daughter's lives and well-being. This appeared to be a further threat following on from the death of Matthew Brennan. He reported the matter to the police and was anxious that it was pursued. He then telephoned Steve Bracewell who talked him through medication and the mechanics of contacting crisis intervention. In a subsequent visit to introduce Louise Hicks his CMHN recorded that he had rationalized the event despite some concern over his mental state. He did cite the threat in a letter to a housing agency as an additional stressor on Alan Kippax's fragile mental state and one that gave another reason and some urgency to the request for re-housing. All the case notes of this time mention the agitation felt by Alan Kippax as a result of the threat he had received, but record the CMHN's perception that Alan Kippax was coping: but none indicate the

events were considered to assess whether they presented any risk to others.

This positive view is in contrast to that of the community police officer involved in the investigation of the threatening letter. PC Connell- having known Alan Kippax for some time- felt that he was close to breaking point, likely to exact retribution against any person he felt was responsible for the threat against himself and his daughter, and was involving the police partly because he was preparing his justification for any such acts. PC Connell recalled that his concern had been sufficient for him to contact The Beeches to express it. PC Connell also recalls frequent resort to alcohol by Alan Kippax since the summer, a consistent picture with that of Clare Kozakiewicz, while Steve Bracewell does not recall any visible alcohol abuse. It was discussed, but Alan Kippax told him that he had now stopped using alcohol or cannabis.

From all the information available it does appear that Alan Kippax was drinking more heavily, and was associating with problematic company, and was experiencing obvious stressors from a combination of factors, not least the proposed house move, albeit this was seen by others as positive.

The GP Dr Billington was the last person to see Alan Kippax before the critical incident. On the 27th November Alan Kippax visited the surgery to thank the practice for all their support, as he was anticipating his imminent house move. Dr Billington recollects he was in a very positive mood and not throughout this time exhibiting any psychotic behaviour.

Alan Kippax reported to us that on the morning of the murder he had not been feeling well and felt at this time he was in a condition which some of his former professional carers would recognise as leading to admission. He reported to us that on this morning he phoned The Beeches and left a message for Louise Hicks because he knew he wasn't right but his call was never returned. This phone call is not mentioned in the records or elsewhere in evidence.

Another face

All the information about the murder of Gary Warburton and what followed has come from sources other than mental health professionals involved in Alan Kippax's care. The only person who was involved before and after the event was Val Hargreaves, Team Leader at The Beeches who attended as Appropriate Adult at the police station while Alan Kippax was interviewed, and she declined to attend the Inquiry.

It is therefore not entirely surprising that a different picture of Alan Kippax emerges from these accounts to that painted by those involved in his care. The difference in perspective is not though entirely explained by the lack of knowledge within the Trust about the critical events. There is also a dimension of stance in the perception that the Alan Kippax revealed by those events and their aftermath is not recognizable to the professionals involved with him up to that time. As there is a great deal of congruence between these critical events and important events in the history, the conclusion must be: that the perception of the professionals involved in care was inaccurate, and that this is because there was not enough understanding of the history.

Gary Warburton was Alan Kippax's next-door neighbour, had a similar history: a short period in the army; and two failed marriages; his physical health was poor and he had an alcohol problem. He also was seen by the Council as a vulnerable tenant, having been victimized in the past, and socially isolated. He had been accustomed to visit Alan Kippax regularly. On the 30th November he collected two bottles of vodka from his father and went round to Alan Kippax's. A third friend (a former schoolmate of Gary Warburton, who had met Alan Kippax four or five months previously through his wife's attendance at Parkwood) was accustomed to drink with them often and joined them for a time on this afternoon while they drank one of the bottles of vodka and left them with the other, "slightly drunk but happy".

Some forty minutes later Alan Kippax left his flat, still in nightclothes, and agitated. It is likely Gary Warburton was already dead. Alan Kippax had been in the habit of phoning Sharon Kippax when drunk, and phoned her now to tell her that he had killed Gary Warburton because he had been "saying things" about their daughter. Later, at the police station he initially told officers: "I'm not going to deny I killed him, but he said he was going to kill my daughter". The following day, in formal interview, Alan Kippax could not recollect alleging that Gary Warburton had made statements about the daughter, and explained that the trigger for the assault had been Gary Warburton telling Alan Kippax he liked little girls, which Alan Kippax took to be a sexual innuendo, in the course of these remarks he pointed to a photo of Alan Kippax's daughter, saying "Like that there", after which Alan Kippax can recollect nothing until seeing Gary Warburton lying on his kitchen floor bleeding heavily and not breathing.

Gary Warburton had been severely battered with fists feet and a knife in a number of locations in Alan Kippax's flat.

Alan Kippax was adamant that he was not going to "blame mental illness" for this crime, but did agree when prompted on police interview that his prescribed medication, diazepam, in combination with drink could make

him violent if his mood was such. On this occasion he felt that it was the threat to his daughter, in the light of his situation and experience that he could not rationally deal with. There was no build-up, no shouting, he blacked out and Gary Warburton was then dead.

There was no evidence of psychoses, hypomania, or depression immediately following his arrest. In the interim period in custody before trial Alan Kippax suffered a severe hypomanic episode, when his medication was reduced. Since this time his medication regime has been returned to previous levels, and in prison he is well, stable, and is achieving educational progress. His own view of these matters is that he deeply regrets Gary Warburton's death and that he does not attribute the killing to mental illness. Insight into the symptoms of mental illness he has suffered appears good, but his view of the causation of his previous offending and non-offending difficult behaviours is paradoxical. At times he ascribes behaviours to misunderstood mental illness, at times he refers to the same behaviours as voluntary or sometimes alcohol induced acts.

Chapter 3

The Use and Disclosure of Patient Information

As can be seen from the above narrative, when Alan Kippax arrived in Blackpool little was known by mental health services of his previous history beyond information given piecemeal on admissions to hospital. Further significant information was known to his family, but not sought by mental health services, and history of previous admissions was obtained tardily and not recorded on the local file.

There was no contact with the prison or probation service to obtain information about relevant medical history or the offence of grievous bodily harm, as this was considered to be unavailable.

HSG(94) 27 "there must be effective links between local agencies and supra-district services such as..prisons, so that agencies know for which patients they will eventually have to accept responsibility and can work jointly with the discharging unit to develop effective arrangements for continuing care."

The Report of the Inquiry into the Care and Treatment of Christopher Clunis criticised a number of agencies for failing to pass on information and this failure was stressed in *Building Bridges* to have put the public at risk.

In this case information was scattered because of Alan Kippax's movements around the country and admissions to hospitals in various

locations. Nevertheless there was sufficient information available both from records, and from contemporaneous accounts to indicate that there was significant risk, particularly to identifiable individuals, but the information was either not sought or its significance was not recognised.

While under the care of Blackpool Mental Health services, the following records were maintained:
- Hospital nursing notes
- Medical notes
- Community mental health nursing notes
- Social Services notes

These sets of notes frequently contained different information, or upon which information arrived at widely differing times. There is little documentary evidence of communication between the different professionals involved in care.

There is no evidence in either Alan Kippax's CMHN or SW notes of what could be construed as an assessment of his needs or a formulation of his difficulties both of which are the foundation on which care and good practice are built.

UKCC Guidelines for records and record-keeping "The best record is one which is the product of the consultation and discussion which has taken place at a local level between all members of the inter-professional health care team and the patient or client. It is an invaluable way of promoting communication within the team and between practitioners and their patients or clients. Good record-keeping therefore is both the product of good team work and an important tool in promoting high quality health care"

Chapter 4
Joint Working in the Community Team

The *Building Bridges* Guidance sets pertinent standards for community teams: "Have operational policies been drawn up for the team, laying down policies for caseload and case-mix, client groups, allocation of referrals etc?";

And: "effective team-working is demanding. Teams can be undermined for a variety of reasons, including professional misunderstandings, reluctance to change working practices and poor support";

The Guidance also warns that effective management is needed, and that while less hierarchical models may be utilised, direct and consistent management within such teams has been found to be most effective.

We heard that at this time the CMHN/CMHT service underwent a period of re-organisation the aims of which appeared to be a recognised need for service provision to be more targeted/focussed on the needs of the seriously mentally ill whilst at the same time trying to respond more appropriately to requests for assessment in primary care. In order to achieve these aims one team became the long term team and one the short term team, with the weight of experienced staff being in the short term team.

At this time there was one clinical manager of both the inpatient wards and the community mental health teams. Below this level interviewees displayed some confusion over whether management or just supervisory responsibility had been passed to the CMHT Team Leader and whether in turn the "E" grade nurses were supervised or managed by the "G" Grades. In February 1998 the co-ordinators are described as being responsible for "co-ordination and administration", with clinical and line management responsibility remaining within the individual professional groups.

It appears that prior to the re-organisation management of the G grades had been performed by the clinical manager of the mental health service. Steve Clow, was an H grade who became on re-organisation Team Co-ordinator. He had an allowance of 1-2 days per week for work within this role description, continuing with his clinical workload for the rest of the time. The Team Co-ordinator managed nursing and administrative staff, while for social services staff accountability remained as it was prior to the re-organisation. The Co-ordinator was to report to the Directorate managers on all issues relating to the function of the team.

Professional staff were line managed by Steve Clow and Val Hargreaves, Senior Social Worker respectively within their professional disciplines. There was a further functional split in that the Team Co-ordinator was also team leader of the short-term/assessment team, and Val Hargreaves senior social worker was team leader for the long-term team. This split is not anticipated in the role description. That these splits in function and responsibility were felt to be unhelpful is referred to in an audit of the CPA referred to below.

We were also advised that the above arrangements were still very much in their infancy at this time and were not formalised. It does appear however that the decision to utilise a part-time Co-ordinator rather than a fully managed service at the Beeches, meant that the team lacked a formal structure- supported by audit and relevant policies in which it examined and reviewed how it was exercising its functions.

After re-organisation each team would have allocation meetings at which new cases would be discussed. Dr Molodynski did not attend allocation

meetings. Dr Boak was delegated to attend on his behalf on a general basis. It is evident that this was problematic for the community team who expressed their view strongly in Minutes of a team meeting of November 1997: "It was felt that the Consultants attendance was absolutely necessary to make their own decisions about referrals and that non-involvement was unacceptable" These concerns were explained to us as expressing two perceived needs- to establish the medical view of the history and needs of a particular patient; and to gain the commitment of the consultants to multi-disciplinary working in the community team.

Workloads in the community team were reportedly high at 35-45 cases for G grades and 30 for E grades. At the monthly supervision of E grades therefore 2 minutes could be given to each service user if all were discussed. Given the complexity of the caseload this does not seem to be adequate.

Much time was reportedly wasted (particularly that of the more senior assessment team nurses) -through inappropriate GP referrals, which did not on investigation meet the remit of the Blackpool South team. It did not appear that there was any formal ceiling on workloads, and there were no service standards by which cases were allocated to Grades within defined ranges of need beyond the Trust's CPA guidelines which required Level 3 clients to be allocated to grade G or above.

The division of staff into short-term and long-term teams in effect dictated allocation of case to grade of nurse, as the short-term team was staffed with G grades and above, while in the long term team E grades worked under the supervision of one G grade. At allocation then the team took all that came in and divided the work between themselves with the most serious and complex cases going to the most experienced nurses and all below that to E grades. The use of properly supported E grades may be satisfactory, but such members of staff might be expected to be inexperienced in community work, and would require considerable structured support.

In a pilot group report prior to the introduction of the team functional division, the split was seen as a means of responding in part to the problem of direct referrals of patients outside the target group who required initial specialist assessment to determine clinical priority and need.

The service was seen to be struggling with high caseloads The same report notes that while resources are based on national norms, the area's needs, as reflected by the then 1997 Mental Illness Needs Index is 111.9 for Blackpool., and that Blackpool had the highest MINI score of any urban centre in Lancashire.

Other contributory factors to the perceived team stress included: inappropriate referrals of patients with less severe problems; inadequate referral information from GPs; limited medical and consultant involvement; a lack of structure and co-ordination in assessment methodology; and poor access to training for staff.

Staff were already concerned that there was a wide variety of need within the actual client group, including those with severe and enduring mental illness, considerably demanding of time and skill. It was already a concern that there were problems balancing the service to meet the needs of both new and existing clients.

After re-organisation there would be a danger that this potential imbalance would be exacerbated, as the most skilled nurses were now within the short-term team, with the long-term clients being allocated to relatively inexperienced staff. This was recognized in that the scheme allowed for some retention by assessment team members of a caseload of clients with enduring needs. It appears though that all those so retained would have been on CPA level 3, and that over the ensuing months other patients were passed on. Certainly this could only ever be an interim solution and could not address the problem of allocating new clients, or re-allocating clients whose needs increased up to a more experienced nurse and out of the divided teams after the initial team split had taken place, and the procedures are clearly deficient in not recognising this issue.

In the service plan there is again stress: "the move towards effective team operation will require greater presence and involvement from consultant psychiatrists and their junior medical staff"

The **Pathways** study found that while consultants reported being involved in regular joint visits with community staff and general practitioners, he was unable to attend community based meetings because of workload and managerial assignments. Staff recall that this was particularly the case with Dr Molodynski who was at the time Medical Director. Dr Boak would contribute to allocation meetings in his stead.

General communication functioning as informal support through ad hoc discussions between colleagues was reported to be quite good at this time. Such good working relationships are essential to the delivery of good mental health care. They also provide support and a culture in which ideas and practice can be fostered and developed. It is a credit to such individual workers that such relationships were fostered, but such informal systems are not sufficiently robust to ensure these outcomes without the support of a formal managed structure which addresses them in a focussed way. Notably we heard of deterioration in mutual support

when there were changes of staff, and workloads became high, as it is reported began to be the case towards the end of this period.

As exemplified by this case it appeared that allocation meetings were used for discussion of new patients but not necessarily for discussion of existing patients requiring re-allocation because of staff changes. Alan Kippax's case was re-allocated outside the forum. When the team split occurred in early 1998, Alison Best did not hand over his care immediately, but retained it to ensure the change was carefully managed because of the patient's perceived needs. She then allocated the case directly to Clare Kozakiewicz who had worked with Alan Kippax during her time as a ward nurse, albeit this handover may also have been discussed within the framework of allocation.

When Clare Kozakiewicz left the Beeches in early October, there was no opportunity for such a managed handover. There was a gap of two weeks without an allocated CMHN, until Steve Bracewell took up Kozakiewicz's caseload at the end of his induction and one week after the beginning of a secondment into the team from his post as a senior staff nurse at the Bowland Unit.

It is equally true that when Lynn Lucas died in September 1998, handover was not through allocation, but that after a two month gap, the incoming newly qualified social worker picked up the case, albeit with the benefit of discussions with her supervisor, as part of the case-load that had been left vacant.

Training and supervision

Clinical supervision – doctors

A formal framework and system of clinical supervision was not in place for doctors at this time. Contributors reported informal supervision took place as part of ad hoc case discussions. These discussions would be at the request of the less senior party, and while both sides reported that access was available, other commitments would inevitably constrain these meetings

There was no formal requirement for or framework of clinical supervision for doctors. Caseload supervision was attended to informally within such meetings, relying on the junior party to make arrangements to see the consultant, and the consultant making themselves available to meet this need.

Clinical supervision - nurses

All members of the Beeches staff reported that they worked within a framework of supervision which consisted of a meeting about once a month for at least an hour with their clinical supervisor. There was no formal structure to or record of these meetings: the supervisor would expect the supervisee to bring to the meeting any particular difficulties on their case-load, rather than working through each case in turn.

The Inquiry team were shown a copy of a "Trust Strategy for Clinical Supervision" dated 1996, where supervision is defined as: "an agreement in which the clinical practitioner reflects on their clinical competence within their working environment in order to develop a reflective practice which provides a high quality service to their client".

The strategy posits a background of acceptance on a contractual basis and training for the supervisor. No model or tools are suggested, and content of sessions is suggested not prescribed. This document is essentially a position statement, and would have required considerable development to be used as a strategy.

Particularly where such junior grades as E grades carry such complex caseloads, there should be in place a training and development structure (of which clinical supervision forms a part) which:

a) ensures the functions **of** the role are being regularly reviewed
b) ensures performance **in** the role meets minimum standards and expectations
c) facilitates clinical and professional development

Training

Building Bridges "Every member of the team should aim to have at least five days training every three years. It may be helpful for team members to keep a training log indicating the courses they have attended"

Training- nurses and social workers

There was evidence that social work managers had recognised the need for systematic training in CPA for the joint work teams, and that a programme was in its early stages of development of a model, to be followed by rolling training in that model for all staff, but it had not yet reached many of the staff we interviewed.

There was a similar recognition that risk assessment models were not adequate, and that there was a training need, however this programme was at a much earlier stage, and no nursing staff interviewed had been trained in the assessment of risk.

Training – doctors

There was no evidence of a programme of training for doctors; and their training was not monitored by the Trust. There was no informal system of Consultants monitoring the training received by more junior grades. Dr Molodynski as Medical Director would have expected that Dr Boak would identify and supply her own training needs through continuing professional development, and did not recognise any role for himself in overseeing training for doctors.

The Inquiry could not conclude that there was organised training in CPA for doctors, and that similarly the need for all doctors to have undergone training in risk assessment had not been recognised.

Chapter 5

Risk Assessment

Risk assessment and management is routine work for mental health professionals. While it is fair to say that in 1998 not all services would have been using a standardised format for assessing and recording the outcomes of risk assessment, it would nonetheless have been common practice for "risk" usually of harm to self or others, or self-neglect) to have been taken into account as part of overall assessment. Indeed in 1998 a number of Inquiries had already reported on the need for a better understanding of the relationship between mental illness and risk.

The Trust's 1997 CPA guidelines presume that risk will have been assessed and include an appendix describing what risk is and setting out some risk factors for the evaluation of risk. There is though no procedure methodology or tool for evaluating risk included in these guidelines.

Emphasis is placed on the requirement to assess risk to complete the care plan. When cross-referred to that area of guidance on completing the care plan however it can be seen that risk is only there identified as an element of need, and the stress of the guidance is on the more familiar elements of need such as service provision and desirable goals. The possible conflicts inherent in assessing risk within this framework are not discussed.

We were informed by Sue Hird, representing Social Services, that risk assessment was recognized to be weak at this time, and that a formal process of risk assessment had hitherto only been practiced on the in-patient wards. The tool for this assessment had been a single sided A4 form with tick-boxes, and while it was intended to roll out this initiative into community work in order to utilise material readily to hand, it was not

felt to be itself an ideal tool, and the need for further development work was recognised.

The lack of comprehensive and standardised documentation is not sufficient justification for the lack of rigour we found in this case in the clinical team's approach to risk assessment.

The 1998 Pathways study found no clear guidelines on risk assessment or an assessment of problem severity were in place in this period. With no method for identification of risk, and no tools such as a risk questionnaire, risk assessment depended on the experience of staff and their recognition of signs and symptoms. When risks were identified patients were directed to their GP, accident or emergency or the crisis intervention team. Most admissions were also found to be unplanned via A&E and thus via junior doctors.

It is notable that contrary to this general finding: in his pattern of admission between 1994 and early 1998, Alan Kippax's admissions involved a higher number of planned admissions at the instigation of the community professionals than are shown in this study

Building Bridges reminds us that "a proper assessment cannot be made in the absence of information about a patient's background, present mental state and social functioning, and also his or her past behaviour....It is often possible to identify circumstances under which, based upon past experience, it is likely that an individual will present an increased risk"

The evidence for any risk assessment in this case outside the ward setting is at best patchy and at worst non-existent. No one in the clinical team had possession of all the relevant information about past offending behaviour. The Consultant psychiatrists did not record what relevant information they had gleaned from past notes nor was it shared with the rest of the care team including the key-worker. Key Workers did not discharge their responsibilities by making further enquiries about past offending behaviour and so their estimations of future risk were seriously inadequate.

However, even without this knowledge of past behaviour there were frequent opportunities over this period for a thorough risk assessment to be undertaken, on admission and discharge and on handovers between workers, when incidents occurred during leaves, or in the life events of the patient. As this was not done as a direct consequence there was no evidence that anyone had an understanding of the risk factors operating at any given time in his care.

The dangerous pursuits referred to during the last admission to Parkwood included substance abuse with the stated intention of risk-taking. We

discovered that these factors had been present in the death of Matthew Brennan, but could find no evidence that this had been recognised or addressed at the time. The circumstantial co-incidences between the death of Matthew Brennan, who (based on the notes of his inquest), died following a drinking and drug binge in Alan Kippax's company (which left Alan Kippax unconscious) and the death of Gary Warburton five months later, are also remarkable. The common factors were risk factors. Proper analysis of the risk profile of the former event might have led to more accurate assessment of the likelihood of recurrence.

Report of the Panel of Inquiry Appointed to investigate the case of Kim Kirkman: "Nothing predicts behaviour like behaviour"

Nowhere in the community notes for 1998 is there any formal risk assessment, community staff were not aware at interview of any Trust procedures to undertake this and had not at this time had training in risk assessment. Staff maintain that they were carrying out risk assessment constantly in the course of visits but if this was done it was not recorded.

Still Building Bridges "If agencies are correctly to predict and provide appropriate services for emergencies they must first have an agreed and comprehensive risk assessment procedure"

Substance Abuse

Substance abuse is a particular factor for risk assessment which was present in this case.

HSG(94) 27 "One American study of over 10,000 respondents showed that violence was reported more often when drug or alcohol misuse co-exist with a major mental disorder"

Known substance abuse should have been addressed explicitly in care planning and in risk assessment. There is ample evidence that Alan Kippax had a problem with alcohol and heroin abuse which had a critical impact on the degree of risk he posed to himself and others. While this fact was known, there was an absence of knowledge about the role it played. Alcohol and drug use are mentioned in the notes, but we gained far more information about its role for Alan Kippax from our interviews with non care professionals than from the medical or nursing notes, and we found no evidence that the concerned professionals had achieved any formulation of the role of substance misuse, its importance in past risk and offending behaviour, and no evidence of any targeted interventions being considered as a response.

We saw a copy of a dual diagnosis protocol due to be launched by the Trust and Social Services in September 2001. This document is designed to ensure joint working for the client group. It would appear that Alan Kippax would fall within this protocol, as suffering from one of the identified categories of mental disorder, and also having substance misuse which has a significant effect on his mental illness.

It is not clear though whether Alan Kippax would fall within the mainstream of the clients with drug and alcohol problems in the Trust for whom this protocol was written. These patients more typically presented management problems from non-compliance with medication and support; and whose behaviour was immediately unpredictable due to the direct influence of substance abuse. In the 1998/9 Pathways study staff at the Trust are reported as demanding more resources for this group who were felt to be particularly numerous in Blackpool.

Following referral to either the community mental health team or substance misuse service, the next stage is information gathering, explicitly in order to establish relevant history and level of risk and care management involving joint agencies within the framework of the CPA.

It is not possible to assume that had this protocol been in place in 1998, Alan Kippax's care would have been better managed to an extent which might have affected outcomes. He was cared for within a joint working framework which had been effective. However the dual diagnosis protocol does lay specific stress on obtaining a full and accurate history, which was absent in Alan Kippax's case, and on risk assessment in relation to substance abuse. It would also be expected that a clear plan for management of substance abuse would also appear in any Care Plan under the protocol.

Chapter 6

The Care Programme Approach and Post-discharge Review

Care Programme approach procedures and guidelines published in the Trust in February 1997 followed the Care Programme Approach, and re-state the four elements of the care process:

a) a systematic assessment of health and social care needs
b) a written plan of their care
c) a key worker who will co-ordinate their care
d) regular reviews of their care

The procedure deals with tasks on admission, assessment and care planning, and levels of need; with appendices on roles and definitions, risk

assessment, care plans, reviews, care management and disclosure of information.

Evaluating the procedures, it is possible to see that they are weak in the area of discharges, particularly in emphasising the need to ensure key workers are present for care planning at this stage. The procedures do not address how care-planning involving key workers is to be achieved given the wide-spread practice of discharge during ward-rounds, and as such would be difficult to operate. The procedures do not deal with the situation where a patient self-discharges.

In relation to reviews, the procedures are adequate and stress the need for post-discharge reviews. The review period might often differ where long-term patients have had an in-patient admission between reviews. This potential point of conflict in the system is not explicitly dealt with, and is known to have been a cause for confusion. It is very possible that this contributed to the irregular pattern of reviews and failure to tie together the various processes that were apparent in this case.

The procedures do though describe the process of formulating the care plan as being the product of a meeting of professionals where all elements of care were discussed and plans were agreed. It does not contemplate any possibility whereby CPA plans were drafted for later possible agreement, or were one agency's proposals alone. It clearly contemplates not only multi-agency involvement at the meeting but full participation of the client.

In *Building Bridges* the standard is set: "Care plans should be agreed with users and carers as far as possible".

In this case Alan Kippax (who appears knowledgeable about the care programme approach) reports that he was not involved in care planning or reviews and does not recall ever being given a copy of his own care plan or asked to sign one. The record shows one care plan was in fact signed by him, in May 1997, although others have boxes ticked that they would be transmitted to all appropriate recipients including the patient.

In this case the community record contains a copy of an unsigned and undated care plan. The last care plan prepared by a key-worker had been prepared by Alison Best. None had been prepared by Claire Kozakiewicz and the last substantive care plan was that drafted on discharge from hospital in August 1998 by a staff nurse.

The last care plan document on file was an unsigned undated draft. From the evidence but contrary to the assumption of the later Internal Review this was not the result of a CPA meeting but was a draft prepared by Steve Bracewell for his reference at a CPA review which was to take

place at some stage in the future. There is no note that any multi-disciplinary meeting that would satisfy CPA requirements was ever planned. Although it was suggested at the Internal Review that the CMHN's scheduled meeting of the 3rd December 1998 was a planned review, the evidence does not support this.

Dr Billington, the General Practitioner reported that he had not been, and would not have wished to have been, involved in care plan review meetings.

While Steve Bracewell understood himself to be the key-worker, this is not apparent from the existing care plans, where handover could be very patchily evidenced. Alan Kippax was not aware of who his key-worker was at interview.

The in-patient and community notes similarly do not indicate that there was any S. 117 three-month post discharge review diarised or in the course of being arranged. The evidence tended to indicate that post-discharge reviews were not arranged routinely, but that care was discussed at routine out-patient appointments. Alan Kippax failed to attend an out-patient appointment for 21st September, and a further appointment was made with Dr. Molodynski for 12th October which he did attend

It is of relevance here to note that as evidenced by their contemporaneous meetings the staff at the Beeches were aware that service could be improved, and the problems of poor communication and unnecessary travelling reduced, by integrating the PAS system with the other systems used by the Community team and holding clinics in the community team. In particular, the two other Consultants with whom the team worked had changed the location of their clinics so that these took place at the team's premises. Dr. Boak's and Dr Molodynski's clinics were both still being dealt with at outpatients.

Still Building Bridges The benefits of planning meetings with users, so that they and their supporters can feel comfortable and able to contribute, are self-evident. Those arranged informal settings left some users feeling uninvolved, frightened or daunted by the formality of the proceedings."

Monitoring the CPA

We met with Christine Smithson CPA co-ordinator, whose task was to monitor MHA admissions, CPA and S117 compliance with the aid from 1995 of a diary based software package. She described the development of CPA within the hospital from a limited target group in 1992, to the introduction of the revised CPA in 1995 extended to all patients in touch with the service.

The monitoring system consisted of two reminder processes. Individual workers would periodically be reminded of the patients for whom they carried CPA or 117 responsibility, and would also receive periodic reminders of those cases for whom reviews were due or overdue. The receipt of a completed CPA plan containing the necessary information was the desired trigger. As patient information systems kept by the hospital were not integrated with the system, form notifications provided information on admissions and discharges, and telephone contact by the key-worker could alert the system to changes.

As the computerised key-worker care planning reminder system was so dependent on the submission of completed care plans it is not surprising that it appears here to have fallen down, particularly where those same triggers were needed to ensure that the key-worker could be identified through successive changes.

In Alan Kippax's case, the computer record shows he was included on the CPA in 1995, ands also appeared through S117 entitlement on the new system at that date. In-patient stays amended the running record of notified CPA and 117 entitlement. The last monitoring date entered was 20/8/98 with a three month post hospital discharge review entered as due on the 20/11/98.

This case demonstrates that the system was not able to cope if key-worker changes were not recorded, and could also not show CPA review dates if CPA plans were not completed and sent in. Notes of discharges could trigger reminders for three-month reviews, but we could not find evidence that this had been effective in this case. Correspondence over protocols between centre and key-worker shows that the list could be extremely inaccurate and out of date with regard to key worker responsibilities, and this would affect the ability of the system to be a useful tool in keeping review dates.

Audit May 1997 These problems were recognized in the course of this audit which showed that CPA forms were completed in 42% of cases only, and one-third of completed forms were not signed by the client, with only one quarter of completed forms to be found in the psychiatric case-notes. The conclusion has to be that CPA was not seen as an active or useful tool by clinicians, but as a cumbersome paper process that was the responsibility of and useful mainly to community nursing staff.

Audit February 1998 discussed some of the remaining obstacles to CPA: the continuing separation of line management and accountability to the respective professional agency groups within the community teams; the lack of an integrated information system between them; and the difficulty within a geographically spread area of finding time to travel to meetings

which in themselves might be relatively short; the need for training for GPs in the operation of the CPA – there had been no joint training to date. This study also mentions the there are weaknesses at Board level, in that the Board member accountable for the operation of the CPA, Dr. Molodynski, Medical Director does not have any scheduled meetings with the CPA manager within the year.

Pathways study 1998/9

In 1998 and in 1999 about 30% of patients were seen within three months of their discharge from hospital.

That study found CPA forms were completed at discharge in 35% of patients in 1998, increasing in 1999 to 54%, and targeted to more vulnerable patients

Reported problems from that study, which resonate in this case, include: "meetings organisation, timing and getting all the relevant professionals together; workload, particularly in the community team, poor communication between wards and the CMHT; psychiatrists committed to discharging patients from the hospital bed as quickly as possible might not wait for CPA meetings to be organized or conduct ad hoc discharge meeting at ward round at which community staff were frequently not present."

A further audit was undertaken by the then CPA Co-ordinator in July 1998, which showed 84% of discharge care plans were absent from medical notes. A memorandum was issued attempting to deal with the then widespread problem of key-workers not being present at pre-discharge meetings. It advised them to rectify matters by then completing a care plan with the patient on their first subsequent visit in the community. While this is a laudable attempt to bring the documentation up to date, and allow monitoring systems to be triggered, in moving away from the centrality of the multi-professional meeting it does change the emphasis of the document to a mere record of the key-worker's understanding of the present state of the case.

Of equal note are the reasons given: that care plans were being lost in the system; that case-loads for key-workers were too large; and the assumption that CPA is a cumbersome and bureaucratic process associated with paperwork rather than the provision of care

During the conduct of this Inquiry the majority of interviewees responded that the CPA was working reasonably well in Blackpool in 1998. More importantly it was found by the internal review to be working in Alan Kippax's case. Neither statement can be supported.

Chapter 7

Reflecting on adverse events and the Internal Review

The governing procedure for the internal review was that which governs this Inquiry. The Internal Review as set up complies with the requirements as to chairing, and time-scales of reports. This Guidance obliges individual Trusts to set up their own detailed policies for such processes in order to achieve the objective: "to explore the circumstances resulting in a serious untoward incident, and to establish what if any lessons arising need to be incorporated in practice"

The process of internal review was governed by a Trust Incident Reporting policy dated 1/05/97. This indicates that the responsible manager should ensure:

7.4.1 d) appropriate written records are made of incidents reported to them...

e) an investigation appropriate to the seriousness of the incident is carried out, sufficient to establish that the circumstances were as reported and to decide on likely causation, appropriate remedial action, necessary recording and any external reporting.

The process adopted by the Directorate was:

1) Preliminary enquiries by the Directorate consisting of requesting a statement from the staff concerned
2) Internal Review Meeting 12.1.99 chaired by the Chair of the Trust, comprising also the RMO, CMHN, and Beeches team manager, and the business and clinical manager of the directorate.
3) The meeting considered statements from the care professionals present and from the senior social worker, medical and nursing records, and made findings and recommendations
4) The result of the meeting was written up by the business manager

It appears from the notes of this meeting - and this was confirmed to us by the business manager Mr Nussey who authored the report-that the meeting was conducted in committee fashion, with the conclusion being achieved on a consensus basis.

Statements were sought only concerning the care given by mental health services, no information was sought on the circumstances of the Serious Untoward Incident itself. While the matter was clearly still sub judice,

there were relevant factual matters about both Alan Kippax's circumstances in the time leading up to the offence, and the broadly undisputed factual events of the killing, which were known to various parties and which were not sought.

The content of each statement that was obtained before the meeting was primarily factual and was translated in summary into the final report. Records were used to provide that factual basis for a chronology, and were not used to test or verify the assertions contained in statements. There was no evidence of discussion of good practice guidance standards or protocols or consideration of service delivery against these external standards.

The Internal Review made the following Recommendation:

"After consideration of the outcome of their enquiries the Internal Review felt that no recommendations were necessary on this occasion"

In conducting this Inquiry we reflected to various participants at this review details from contemporaneous records which contradicted the relevant conclusions that had been arrived at within this earlier internal report: particularly in the inaccurate identifications of key-worker, absence of CPA documentation, failure to arrange reviews; and failure to obtain an accurate history of Alan Kippax's past violent behaviour or to consider the prediction of future risk. In each case our interviewees agreed that the findings of the Internal Review were not accurate. It must be concluded that its recommendation was inadequate.

The deficits could have arisen from a misperception of the purpose of internal review. It has here been approached as the achievement of a summary report of involvement. There is a tone of exoneration. It falls short of the standard set out above in the internal Trust Incident Reporting Policy in not moving from informed investigation, through the receipt and testing of evidence against received standards to conclusions of fact and then recommendations derived from those conclusions.

We found a tendency in the evidence we received to deny congruencies and minimize predictors. The witnesses who appeared least defensive were frequently those who were either not then or were no longer at the Inquiry directly involved in care.

Two reports have recently been published concerning learning from adverse events in the NHS. We include reference to them in this Section, because while they were not available at the time of this Internal Review, they are now available for reflection on that process, and they were available throughout our Inquiry.

An Organisation with a Memory identified fear of retribution as a potential barrier to local reporting by staff of adverse events, and spoke of the need to develop a blame-free culture to promote non-punitive local reporting of adverse events.

Building a safer NHS for patients described the barrier that needs to be overcome as "fear of "point-scoring" by colleagues, retribution by line management, disciplinary action or litigation". These are cultural factors. That report identified "a need to provide NHS staff with the skills required to identify, gather information on, record and report events and near misses, undertake formal root analysis"

This panel found a general difficulty, that may be cultural, in acknowledging deficits in service performance, even where in some instances the causative relation between those deficits and the events triggering the analysis might be indirect, or even so remote as to occasion no "blame". The panel found that the requisite skills required to report to, investigate and analyse these events were lacking in this Internal Review.

Chapter 8

Key Findings

FINDINGS

The mental health services in Blackpool within the constraints of high demand offered a responsive and supportive if unreflecting service to Alan Kippax

A high level of actual support in terms of facilitated admissions and number of visits was given

The mental health care given contributed to a period of stability with consistent care for this patient between 1994 and 1997/1998. After that time there was an evident deterioration in the consistency of change management and a dilution of the information and practice base

Care Programme Approach

The care programme approach was in operation however the Inquiry found no evidence of any pattern of meetings to support it at which all concerned professionals might be present other than ward rounds.

There was an out of date care plan for Alan Kippax at the time of this event.

The key worker for care programme purposes was not accurately recorded at all times, and was not systematically updated.

The latest CPA plan document on file for Alan Kippax was in draft only.

The current CMHN had not been involved in any CPA processes in relation to Alan Kippax's care except for drafting a plan based on his predecessor's model.

Alan Kippax had not been formally involved in completing or reviewing his care plans.

The general perception of the Care Programme Approach at this time is that it was not working well as a system and was not supporting the delivery of care significantly.

The CPA monitoring system was not sufficiently robust to ensure compliance with the scheme's requirements.
The key worker role at this time was not robustly pro-active and was not well communicated to the wider care team, it was not a pro-active role and responsibilities were not always discharged.

Family members were insufficiently involved in care planning.

Risk Assessment

Relevant history was not appropriately gathered and the information that was gathered was inadequately recorded to be available to the succession of professionals involved in assessing risk

Reliance was placed on the untested representation of the patient on history, current events and their interpretation - the patient effectively controlled much of the risk evaluation.

Family members were insufficiently involved in the gathering of information and in the assessment of risk.

There was no systematic risk assessment post admission, none pre-discharge or on an ongoing basis to inform the delivery of care.

The hospital based risk assessment was sketchy in itself and as it was carried out for the purposes of immediate care needs within the ward environment was not of great value in future planning.

There was no evidence of staff having been trained in risk assessment.

The stated professional reliance on implicit risk assessment was not evidence based, and assumed a shared knowledge which was not itself evidenced from file content.

Staff displayed a hazy understanding of risk factors.

Attitudes to domestic violence as a significant factor in risk assessment were of concern.

There is no evidence that current life events were explored or reflected on in the context of risk assessment.

Past behaviour is a good indicator of future behaviour; past violence is a good indicator of future violence. It is not valid to argue that such history is not still relevant, particularly when contributory factors are still present.

Records and Communication

Written communication between the care team was virtually absent. Significant matters were not recorded.

At this time three separate records: in-patient; community nursing; and social work care were operated with implications for maintaining a shared knowledge base. The style of continuation sheets of boxed entries without summarising or analysis did not facilitate the active use of records in care planning.

The clinical notes in general lack the preciseness and rigour which could reasonably be expected from qualified workers.

Staff failed to obtain all relevant past medical notes or to record in current notes information received from available past notes even in summary form, there was a systematic failure to pass on history or to use history.

Strengths and weaknesses of multi-disciplinary team approach

In the delivery of psychiatric care the informal communication that was the main channel of discussing clinical problems, diluted the knowledge base and left much to chance. It lacked formal support.

As there was reliance on informal clinical discussions across disciplines an exodus of key staff put the system under stress.

There was lack of clarity from managers about lines of accountability within the community team.

On the whole arrangements for rotating visits within the community team were good.

Allocation of patients on succession of staff displayed a lack of clarity concerning the required skill base in caring for specific patients needs.

The division of the service into long-term and short term teams required to be underpinned by clearly identified role expectation, and to be related to assessed client need and to be supported by systematic and structured supervision.

Nexus between care and this offence

Increasing stressors on Alan Kippax towards the end of 1998 were only partially recognised and there is little evidence that they were reflected upon.

The issue of alcohol abuse was never addressed in planned work, there was no evidence of assessment or recording of the extent of substance abuse, with the result that different professionals had very different perceptions of the extent of the problem. Reliance was placed on Alan Kippax's representations concerning substances rather than history and records.

There was no evidence that any agency considered the risk that Alan Kippax posed to others, other than reflection within social services on potential threat to its professionals. In view of the history professionals should have considered risk particularly to identifiable others: past victims, family members or other identifiable third parties.

None of the concerned professionals could have been aware that this murder victim was at particular risk.

Features of the murder were related to the stressors Alan Kippax was experiencing.

While it is not possible to say if there was an element of mental illness at the time of murder there is no evidence that it was the supervening or primary cause.

Alan Kippax suffers from bipolar affective disorder. The professional evidence available suggests that at the time of his offence he appeared to be in remission (ICD 10 F31.7).

Immediately post the offence the evidence available would suggest the absence of either symptoms of hypomania or depression.

Violent behaviour in general was predictable.

The only predictor of violent behaviour that could have been known to be present at the time was perceived threat, although significant alcohol consumption could have been predicted as an ongoing risk factor.

At the time he was last seen by professionals it was not possible to place him in a high risk category in the short term for serious violence as a result of mental illness.

Alan Kippax suffered from a mental disorder that was by nature relapsing, therefore the stance maintained at internal review that he was mentally well at the time of this offence is meaningless.

Internal Review

The procedure for internal review was seriously inadequate.

Staff involved did not have the requisite skills to report to, investigate and analyse these events through internal review.

Chapter 9

Recommendations

Past relevant history should be investigated and formally and comprehensively summarised by medical staff to form an active part of the clinical record.

Family members should be actively involved in information gathering and their contributions recorded and identified for appropriate use in risk assessment and care planning.

Factual details of significant current life events should be recorded on file and reflected on as potential triggers for reviews of care need.

Agreements to give leave from hospital should make clear statements concerning expectations of factors which might lead to the ending of leave or its refusal, which are specific to the individual patient.

The implementation of the Care Programme Approach in the Trust should be the subject of review to address the issues identified above and to ensure compliance with good practice standards.

Responsibility for service delivery of the Care Programme approach should rest at Director level and be monitored by the Trust's Board.

Risk assessment models should be developed in accordance with good practice models to be utilised across services and disciplines. All staff should receive training in risk assessment.

A Training Strategy should be developed to ensure that medical and nursing staff groups receive appropriate professional training in accordance with programmes outlined by the Trust, agreed with individuals and monitored at each level by line managers within the management relationship. Responsibility for performance should rest at Directorate level and be the subject of report to the Board.

The Trust should consider the introduction of a formal process of Clinical Supervision for psychiatrists.

Internal Reviews should be conducted in three distinct stages:

Information gathering;
Investigation and critical questioning;
Conclusion and report

The roles of participants in each stage of the Internal Review should be clearly delineated: the primary responsibility of those who have provided care needs to be the supply of complete and accurate information. Any investigator will need to be of sufficient clinical experience to critically question those directly involved, but be themselves removed from direct responsibility in the case, and similar detachment needs to be displayed at the report stage.

Appendices: 1- Procedure and Published Notices
2- list of witnesses and contributors;
3- internal inquiry terms of reference and conclusions;
4- background reading

Appendix 1

NORTH WEST LANCASHIRE HEALTH AUTHORITY
INDEPENDENT INQUIRY INTO THE CARE AND TREATMENT OF AK

Procedure of the Inquiry

The North West Lancashire Health Authority were obliged to commission this inquiry under the provisions of Department of Health Guidance HSG (94) 27;

The procedure adopted is to be:

1. Private meetings to establish the constitution of the panel, ways of working and to consider background documents and documentary evidence.

2. Private hearing of evidence from persons and organisations involved in the care or control of A.K.

3. Consideration of documentary materials evidence and submissions from any other interested party to the inquiry panel.

4. Report to include: findings of fact and commentary based upon those findings; comments upon service delivery and relevant factors affecting service delivery; key findings and recommendations.

Process at Hearings

1. Hearings will be held in private

2. Witnesses will be notified by letter of the procedure to be adopted at the hearing and will be asked to provide a written statement in advance to raise issues they feel will be relevant.

3. Witnesses may be accompanied at hearings by a person of their choosing, in the role of supporter rather than as advocate.

4. Witnesses contributions will be recorded and a transcript sent to them for signature. Witnesses may raise additional comments at this stage.

5. If any point of direct and significant criticism is to be made of any person, that person will be notified and given an opportunity, either at the hearing stage or subsequently, to respond.

6. Where individuals in their personal or professional capacity have or had statutory right of access to written records, access to the relevant record or that part of it will be offered and facilitated in advance of their being asked to respond to issues arising out of the interpretation of that record.

7. The report of the inquiry will be made public, evidence and documents will remain private.

Appendix 1

Private and Confidential

From : The Committee of Inquiry into the care and treatment of AK

Dear

Notice to witnesses

A Committee of Inquiry has been set up by the North West Lancashire Health Authority into the care and treatment of former patient Alan Kippax. The Inquiry is proceeding within the terms of Department of Health Guidance HSG(94)27. The Inquiry committee comprises myself Ms C Gilham, Dr O Junaid and Ms McKeever. The Terms of Reference are attached.

The purpose of this letter is to request that you attend and give oral evidence in this matter, as it appears from our examination of documents that you may be able to assist the committee. The dates set for the hearing are: 11 June (afternoon), 12 June (all day), 13 June (morning) and will be held at the NWLHA, Wesham Park Hospital, Wesham. Could you please indicate your preferred date. However if you are unable to attend on any of these dates please contact Carole Wilmer, Secretary to the Committee, at NWLHA on 01253 306304, who will discuss an alternative date. Travel expenses will be met.

To help us clarify the issues and for your ease of reference, it would be helpful if you could provide in advance of the hearing, a written statement of any information within your knowledge which is relevant to the terms of reference of the Inquiry. The original health and social services records relating to AK will be held at the Inquiry's secretariat. You may access the part of those records to which you had access at the relevant time in a professional capacity.

You may be accompanied to the hearing by any person of your choosing (with the exception of any other witness) in the role of supporter. They may not however respond to questions directed to you. Your evidence will be recorded and a copy sent to you for signature and return.

If you feel you will need medical support during this period, please contact Dr Atkinson or Sr Bilsborrow, Staff Health who will arrange this for you.

I would like to take this opportunity of thanking you for your help and co-operation in this difficult matter, and look forward to meeting you on the day of hearing.

Yours sincerely

Claire Gilham
Chairman
Committee of Inquiry

Appendix 2

LIST OF WITNESSES AND CONTRIBUTORS

Alison Best, CPN

Steve Bracewell, CPN

Steven Clow, Team Co-ordinator

Louise Hicks, Social Worker

Sue Hird, Service Manager

Mark Hook, Clinical Manager

David Johnson, Ward Manager

Henry Jordan, Staff Nurse

Clare Mendonca (formerly Kozakiewicz), CPN

David Nussey, Senior Manager Mental Health

Colina Park, Team Supervisor

Clare Singleton, Staff Nurse

Christine Smithson, CPA Co-ordinator

Rachel Willis (formerly Richard Willis), Social Worker

Dr Boak, Staff Grade Psychiatrist

Dr D Kay, Consultant Psychiatrist

Dr CJ Molodynski, Conulstant Psychiatrist

Dr Billington, GP

PC Connell

Chief Inspector K Toole

Sharon Kippax

Alan Kippax

Appendix 3

TERMS OF REFERENCE FOR AN INDEPENDENT INQUIRY INTO THE CARE AND TREATMENT OF AK

1 To examine all the circumstances surrounding the care and treatment of Mr AK, in particular:

- the quality and scope of his health and social care;
- the suitability of his treatment, care and supervision;
- the extent to which Mr AK's care corresponded with statutory obligations, the Mental Health Act 1983 and other relevant guidance from the Department of Health and local operational policies;
- the extent to which his prescribed care plans were:
  - effectively delivered;
  - complied with and monitored by the relevant agency;
- the history of Mr AK's medication and compliance with that régime.
- the adequacy of risk assessment procedures

2 To prepare an independent report and make recommendations.

Appendix 4

BACKGROUND READING

- Mental Health Act 1983
- HSG (94) 27
- DOH 1990 The Care Programme Approach
- DOH 1993 Health of the Nation
- DOH 1994 Introduction of Supervision Registers
- DOH 1994 Guidance on the Discharge of Mentally Disordered People and their Continuing Care in the Community
- DOH 1995 Building Bridges
- DOH 1996 Health of the Nation
- DOH 1999 National Service Framework for people with Mental Health Problems
- DOH 1999 Effective Care Co-ordination
- DOH 1999 Still Building Bridges
- UKCC Guidelines
- Inquiry Reports
- Safety First – National Confidential Enquiry 2001
- DOH 2000 – An Organisation with a Memory
- DOH 2000 – Building a Safer NHS for Patients
- Learning the Lessons – Zito Report
- Royal College of Psychiatrists – Council Report 53 – Assessment and Management of risk of harm to other people.